Witness Name: Richard Gregory Brunt
Statement No.: 4
Exhibits: RGB4/01– RGB4/142
Dated: 6 June 2025

UK COVID-19 INQUIRY

WITNESS STATEMENT OF RICHARD GREGORY BRUNT

I, Richard Gregory Brunt, will say as follows: -

1. I am Richard Brunt and my position at the Health and Safety Executive [HSE] is Director of Engagement and Policy Division. I am authorised to make this statement on behalf of HSE. This statement is provided to the UK Covid-19 Inquiry to explain HSE's regulatory role and to provide details of HSE's activity prior to and during the pandemic as it related to, and impacted upon, the social care sector.

The Health and Safety Executive' role function and powers

2. The Health and Safety Executive is a UK Government agency, sponsored by the Department of Work and Pensions [DWP]. It is Britain's national regulator for workplace health and safety and operates across England, Scotland and Wales and its mission is protecting people and places.

3. HSE was established by the Health and Safety at Work Act 1974 [HSWA] to prevent work-related death, injury and ill-health through enforcing workplace health and safety in certain workplaces, mainly through HSWA (and relevant Regulations). HSE is a Category 2 Responder under the Civil Contingencies Act 2004.

4. HSE's general duty is set out in section 11(1) of HSWA, namely to *"do such things and make such arrangements as it considers appropriate for the general purposes of this Part"*. HSE is provided with a variety of powers, including enforcement powers, to assist it in achieving that duty. HSE's general powers are set out in s13 HSWA. This includes the power to do anything which is calculated to facilitate, or is conducive or incidental to, the performance of its functions (s13(1)). s16 HSWA sets out HSE's power to issue approved codes of practice [ACOPs] to provide guidance to dutyholders with regard to their legal obligations under HSWA and the associated regulations.

5. Throughout the Covid-19 pandemic, HSE retained its role as the enforcement body for health and safety in the workplace under HSWA, however, HSE was not an enforcing body for the Coronavirus Regulations. This limited the scope of HSE's responsibilities during the pandemic. HSE was concerned with ensuring employers took reasonably practicable measures, such as following Covid Secure guidelines, to mitigate the additional risks to health and safety arising from work activities during the pandemic. HSE did not regulate workplaces to ensure specific compliance with Covid-19 Regulations. That enforcing role lay primarily with the police and local authorities.

HSE's regulatory role in relation to social care sectors in England, Scotland, Wales.

6. HSE is not the primary regulator for social care in Great Britain. Social care is a devolved matter and there are different regulators in England, Scotland and Wales. In England, the Care Quality Commission [CQC] is the independent regulator for social care. In Scotland, Social Care and Social Work Improvement Scotland [SCSWIS], also referred to as the "Care Inspectorate" regulate, inspect and support improvement of care services in Scotland and provides public assurance on service quality. Care Inspectorate Wales [CIW] regulate social care and includes registration, inspection, responding to concerns about regulated services, compliance support and enforcement.

7. HSE's role in relation to regulating social care systems and how it works with other Regulators is explained in *Who regulates health and social care* which is available on HSE website produced as exhibit RGB4/01 INQ000269842.

8. HSE has an MOU with the CQC *Memorandum of Understanding between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE) (December 2017)* produced as exhibit RGB4/02 INQ000101585, a liaison agreement with Scottish Local Authorities and the Care Inspectorate, *Liaison Agreement between the Health and Safety Executive, Scottish Local Authorities and Social Care and Social Work Improvement Scotland ('Care Inspectorate')* produced as exhibit RGB4/03 INQ000529423 and an MOU with CIW and Local Authorities in Wales, *Memorandum of Understanding with Care Inspectorate Wales and Local Authorities in Wales* produced as exhibit RGB4/04 INQ000529808 (July 2019) and exhibit RGB4/05 INQ000529802 (July 2022).

9. In general, HSE does not investigate or prosecute matters of clinical judgement and practice, and the training, systems of work etc to deliver those of doctors or matters relating to the level of provision or quality of care as explained in our guidance on priorities for enforcement under s3 HSWA produced as exhibit RGB4/06 INQ000269841.

10. In England, the CQC is the more appropriate regulator to investigate matters of this nature. It also deals with major non-clinical risks to patients, for example trips, falls, scalding, electrical safety etc and has a wide range of enforcement powers that can be used if healthcare services are not meeting fundamental standards. In respect of social care, the CQC regulates the providers of social care services for adults in care homes (where nursing or personal care is provided), in the community and in people's own homes. In general, CQC, rather than HSE, will deal with the majority of patient and service user serious health and safety incidents.

11. Similarly in Wales, HSE does not, in general, investigate or prosecute matters of clinical judgement or matters relating to the level of or quality of care. However, in Wales, HSE deals with major non-clinical risks to patients as detailed in the MOU

with HIW produced as exhibit RGB4/07 INQ000269848. In respect of social care, areas where CIW may have a primary role include incidents arising from failures in the quality of care of people being looked after. Areas where the HSE or the Local Authority may have a primary role include incidents involving service users, staff or others (e.g. visitors) who are injured by the work being carried out at the premises or activities of contractors; or incidents involving installed plant for the use of anyone.

12. In Scotland, HSE will not generally investigate or act in relation to service users where other Regulators have patient / service user safety within their remit. The MOU with HIS sets out that HSE may investigate where there is evidence of systemic health and safety management failings or when established standards have not been followed, except those that may apply to clinical treatment or patient care that fall within the vires of bodies such as the General Medical Council or Nursing and Midwifery Council produced as exhibit RGB4/08 INQ000269835. In respect of social care, HSE or the Local Authority will lead on the health and safety of employees. However, they may also consider investigation of patient or service user deaths or serious injuries, where there is an indication that a breach of health and safety law was a probable cause or a significant contributory factor. The Care Inspectorate may investigate the quality of care provided to people who use a care service if an accident/incident or a series of accidents/incidents appears to warrant it.

13. Dependent on the nature of an incident, it may be reportable to HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 [RIDDOR]. If incidents are reported to HSE, it will follow its published *incident selection criteria* produced as exhibit RGB4/09 INQ000130556 and HSE's *Policy on s3 HSWA 1974* produced as exhibit RGB4/10 INQ000269833 when deciding whether to investigate, or in England, forward reports to the CQC. HSE also has guidance that assists Operations staff to make these decisions produced as exhibit RGB4/11 INQ000269881, exhibit RGB4/12 INQ000269806 and exhibit RGB4/13 INQ000269859.

The division of responsibilities between HSE and Local Authorities in relation to social care settings

14. Responsibility for enforcing HSWA is divided between the HSE and other regulators – principally, and most importantly for the purposes of the Covid-19 Inquiry, by the Health and Safety (Enforcing Authority) Regulations 1998 [EA Regulations].

15. HSE has developed guidance to assist in understanding and interpreting the EA Regulations which is published by HSE on its website produced as exhibit RGB4/14 INQ000101584. Where HSE or Local Authorities are responsible for regulation in social care sector, the Appendix to the EA Regulations published by HSE on its website produced as exhibit RGB4/15 INQ000529822 sets out the division of regulatory responsibilities between HSE and Local Authorities for different types of social care settings.

16. Schedule 1 of the EA Regulations sets out the main activities allocated to Local Authorities. Paragraph 5, schedule 1 of the EA Regulations makes it clear that Local Authorities are responsible for the regulation of premises where the main activity is the provision of residential accommodation. This includes residential care homes unless the home is owned or run by the Local Authority, when responsibility sits with HSE. HSE is responsible for the regulation of other care accommodation, including supported living services, sheltered housing and housing support services. HSE will also be responsible for the regulation of premises which provides nursing care and residential care services, where the main activity is the provision of nursing care.

17. The provision of qualified nursing care distinguishes a nursing home from a residential care home. For dual registered premises and determining the most appropriate enforcing authority, it is necessary to consider carefully the main activity and this should focus of the main purpose for which an organisation uses a premises. The time spent caring for patient or residents, the number of beds are factors which may need to be taken into account.

Domiciliary care

18. Care can often be provided within people's homes by personal assistants, care agency staff or local authority homecare services. Section 51 of HSWA restricts the application of HSWA within private homes and the Act is dis-applied in many situations involving domestic employment. Section 51 of HSWA states,

    "Exclusion of application to domestic employment.
    Nothing in this Part shall apply in relation to a person by reason only that he employs another, or is himself employed, as a domestic servant in a private household".

19. What amounts to domestic employment or domestic service will be dependent on the nature of the work and so it is important to carefully consider the employee's duties (including the terms of any employment contract). An employee will only be a domestic servant if their job roles and responsibilities are exclusively domestic in nature. Employees whose role extends beyond domestic duties are not considered to be employed exclusively as domestic servants and section 51 is not likely to apply. Domestic service is likely to include the wide range of personal services ordinarily offered to and in a household.

20. Whether the HSWA disapplication applies in specific circumstances will need to be considered on a case-by-case basis. However, as an indicative guide:

    a. if the carer works for the NHS, local authorities or employment agencies then they are unlikely to be employed exclusively as domestic workers and HSWA may apply
    b. if the care involves complex healthcare activities (such as operation of life support or palliative care equipment) then the HSWA is likely to apply
    c. if delivery of the care requires specialist training (for example, people handling and dealing with challenging behaviour) then the HSWA is likely to apply

HSE published *Guidance on Domiciliary Care and Section 51 of the Health and Safety at Work Act* is produced as exhibit RGB4/16 INQ000595120.

21. Where there is provision of on-going care in a private domestic household HSE enforcement is confined to peripatetic work activities or their effects. If a serious incident occurs, HSE's involvement will be decided in line with its policies and procedures, on a case-by-case basis. HSE will have no involvement where the HSWA is disapplied.

HSE liaison and communication with Government departments and other stakeholders during the pandemic

22. HSE engaged with a range of government departments and stakeholders across the social care sector during the pandemic predominantly in relation to the publication and sharing of data, guidance, interpreting the application of guidance and advising on good practice.

UK Government /Department of Health and Social Care

23. HSE liaison with DHSC involved consideration of DHSC and Government draft guidance and attendance at DHSC's Adult Social Care Personal Protective (PPE) Task and Finish Group, also referred to as the Adult Social Care PPE Stakeholder Working Group [Task and Finish Group] where main issues discussed related to personal protective equipment (PPE) requirements and risks assessments.

24. For example, on 3 June 2020 DHSC invited HSE to comment on a Q&A document that had been prepared to manage PPE shortages in social care. HSE provided comments to *Ensuring supply and managing shortages of PPE: Advice for care homes and domiciliary care providers* produced as exhibit RGB4/17 INQ000595021. The email request and response are produced as exhibit RGB4/18 INQ000595020 and exhibit RGB4/19 INQ000595018.

25. HSE also provided suggested amendments to DHSC in relation to Government guidance on arrangements for carers visiting out of the care home, highlighting the

importance of carry out a risk assessment to assess the transmission risk to the carer arising out of the activities arising during the visit to ensure the necessary precautions are in place. This is reflected in an email chain dated between 7 June and 22 June 2021 produced as exhibit RGB4/20 INQ000595086.

26. From June 2020 onwards, HSE was invited to attend DHSC's Task and Finish Group. The Terms of Reference produced as exhibit RGB4/21INQ000595023 reflect that the aim of the group was to ensure that social care sector was properly prepared, trained and supplied with the personal protective equipment required to keep them and their attendees safe from Covid-19. Other attendees included Public Health England [PHE], Care Quality Commission [CQC], Care England, Association of Directors of Adult Social Services [ADASS], National Care Forum [NCF], UK Home Care Association [UKHCA] and others.

27. As a member of the Task and Finish Group, HSE provided advice and guidance on a range of PPE related matters, for example during a meeting on 11 June 2020 a request was made by care providers for advice on purchasing compliant PPE as they were concerned about buying the wrong or non-compliant PPE. During the meeting HSE suggested that the PPE Specification Table might be a useful starting point. This is reflected in an email dated 12 June 2020 produced as exhibit RGB4/22 INQ000595026. *New High-Volume Manufacturers of COVID-19 Personal Protective Equipment (PPE) and Medical Device PPE* dated May 2020 is produced as exhibit RGB4/22a INQ000269668 and *Essential technical requirements for new High-Volume Manufacture of Personal Protective Equipment (PPE) and Medical Devices (MD) during COVID-19 dated* October 2020 is produced as exhibit RGB4/22b INQ000269667. HSE also provided information on the use of surgical facemasks during a meeting on 25 June 2020 which is referred to in the *Minutes of the PPE Task and Finish Group – Adult Social Care dated 25 June 2020*, produced as exhibit RGB4/22c INQ000051065 and reflected in a formal note circulated after the meeting *Note on Facemasks* produced as exhibit RGB4/22d INQ000610089. The information that HSE provided can be summarised as:

a. The main function is to filter the exhaled air from the wearer in order to protect others and the environment and are therefore classed as a medical device, not PPE
b. They also provide some protection to the wearer
c. Some facemasks have a splash resistance (identified with an "R" in their title), which give the mask the ability to withstand penetration of synthetic blood projected at a given pressure and are designed to protect the wearer where there is a risk of splashes of bodily fluids that may be carrying the COVID-19 virus.
d. Type II and IIR masks have a higher bacterial filtration efficiency than Type I medical masks and therefore offer greater protection to the care receiver
e. Type I and IR have never been considered for close personal care as they aren't as effective at preventing the spread of viruses and do not fit around the wearers face. Healthcare workers in the NHS have always worn Type II and IIR facemasks, as they are more effective in preventing the spread of the virus.
f. Carers in social care have the same exposure to the virus as healthcare workers as they are managing patients in the same way, i.e. through that close personal care, and therefore they needed to wear the same level of PPE as healthcare workers.

A copy of the agenda is produced as exhibit RGB4/23 INQ000595030. During that meeting HSE suggested that it would also be beneficial for a representative from MHRA to attend future meetings and this resulted in DHSC extending its invitation to MHRA. This is reflected in an email dated 7 July 2020 produced as exhibit RGB4/24 INQ000595031.

28. A copy of the agenda for a meeting on 10 June 2021 is produced as exhibit RGB4/25 INQ000595084. Matters to be discussed included a review of FAQs drafted by PHE *How to work Safely (care homes) guidance frequently asked questions* produced as exhibit RGB4/26 INQ000595085 and an update on the PPE portal from DHSC.

29. HSE also provided information to UK government departments when requested to do so. For example in March 2020 HSE responded to a request from DHSC to review a response to a parliamentary question in relation to plans for the wearing of personal protective equipment to be made mandatory in care homes for staff and visitors. A copy of HSE's response is produced as exhibit RGB4/27 INQ000595066.

30. In August 2020 HSE provided details on the handling of concerns in health and social care settings to the Department of Work and Pensions Select Committee. The data indicated a high level of compliance with COVID -19 measures in areas where concerns were being raised. A copy of the data supplied is produced as exhibit RGB4/28 INQ000595052.

Devolved administrations

31. HSE engaged with both the Welsh and Scottish Government alongside other agencies and stakeholders. This was generally through participation in forums or engagement on specific issues relating to the enforcement of health and safety legislation during the pandemic.

32. In September 2020 Welsh Government launched the Wales Health and Safety Forum [WGHSF] and HSE was an attendee. The Terms of Reference produced as exhibit RGB4/29 INQ000595059 reflects that the forum existed to bring together social partners, relevant enforcement agencies and others to enhance collective responsibility for health and safety at work. Each partner would share their intelligence on key and emerging issues. HSE provided data on its enforcement and inspection activities. This is reflected in the agenda for meetings that took place on 12 October 2020 produced as exhibit RGB4/30 INQ000595055, 24 June 2021 produced as exhibit RGB4/31 INQ000595097 and 13 January 2022 produced as exhibit RGB4/32 INQ000595108.

33. In February 2021 HSE delivered a presentation to the Welsh Government Fair Work Social Care Sub Group comprising Unions, WG Fair Work and Social Care Policy, Care Inspectorate Wales and Care Forum Wales on HSE's regulatory role

and service user safety. A copy of the presentation is produced as exhibit RGB4/33 INQ000595083.

34. In May 2020 HSE made a joint statement: *Scottish Government; Police Scotland; Health and Safety Executive, and Local Authorities* produced as exhibit RGB4/34 INQ000595013. In the statement Scottish Government made it clear that they were working with Police Scotland, the Health and Safety Executive and local authorities to ensure workplaces complied with relevant regulations. The statement reflects that HSE and local authorities had agreed to allocate enforcement on the same basis as that of existing health and safety at work legislation.

35. On 13 October 2020 HSE met with Care Inspectorate (Scotland) and Scottish Government to discuss Covid19 compliance in adult social care. The purpose of the meeting was to discuss CI/HSE operational co-ordination on regulatory assurance for Covid-19 compliance in nursing homes and to inform Scottish Government of HSE's intention to undertake a limited sample of spot check calls and follow up visits as the work-related health and safety regulator. HSE explained that it wanted to avoid duplicating work by the CI and that 303 CI premises already visited would be removed from potential HSE calls. HSE would share initial list of 100 premises selected for a call for CI to review and remove any they have visited. A copy of the draft notes of the meeting are produced as exhibit RGB4/35 INQ000595061.

Public Health England / UKHSA, Public Health Wales and Public Health Scotland

36. HSE liaison with PHE and UKHSA involved consideration of draft guidance, seeking clarification of requirements within guidance and attendance at DHSC's Adult Social Care Personal Protective Equipment (PPE) Task and Finish Group.

37. Examples of engagement between HSE and Public Health England include; in March 2021 HSE provided comments to Public Health England [PHE] on proposed updates to How to Work Safely in Care Homes Guidance. The email is produced as exhibit RGB4/36 INQ000595077.

38. On 21 July 2021 HSE contacted PHE following the change in restrictions in England reflected in the updated 'How to work safely in care homes' guidance. HSE sought clarity over what *'keeping a safe distance'* entailed and whether the wording intended to convey continued observance of the 2 metre social distancing practices within the care home setting, or something else given that reference to *'2m'* was still specifically quoted NHS guidance. PHE explained that the changes in language reflected the views of Cabinet Office and was in line with other government guidance including *Coronavirus: how to stay safe and help prevent the spread - GOV.UK* and that as NHS sat outside the civil service, they could enforce the 2-metre rule. This is reflected in an email produced as exhibit RGB4/37 INQ000595098.

39. HSE liaison and communication with Public Health Wales [PHW] involved sharing and clarifying information relevant to the functions of each organisation. For example in April 2020 PHW contacted HSE to explain that guidance and protocols were in place for their call advisors and professional leads to work through in setting up and managing outbreaks in care homes. HSE explained that as the enforcing authority for nursing homes they would be involved in investigating social distance and welfare concerns raised by staff in homes and reports of staff being diagnosed with Covid-19 under RIDDOR requirements if they met HSE's incident selection criteria. A copy of the email is produced as exhibit RGB4/38 INQ000595005.

40. Further, on 26 August 2021 HSE contacted PHW to clarify its understanding of social distancing requirements in health and social care settings as it was putting guidance together for inspectors following the easing of restrictions in Wales. PHW confirmed that in all workplaces settings the principle to follow in Wales was that a 2-metre distance should be maintained wherever possible. If this was not possible then a risk assessment must be completed. A copy of the email is produced as exhibit RGB4/39 INQ000595099.

41. HSE's main engagement with Public Health Scotland [PHS] following its creation in April 2020 was via the Partnership for Health and Safety in Scotland [PHASS].

The PHASS was a long-standing group set up before the pandemic. During a meeting on 1 June 2020 HSE explained that one of the top priorities that would help HSE as the HSWA co-regulator to signpost Scotland-specific information would be a single landing place for employers to go for the guidance on how to work safely during Covid-19. This is reflected in an email produced as exhibit RGB4/40 INQ000595014.

42. During the relevant period, HSE met with PHS on 1 November 2020 when it was agreed that a partnership agreement would be desirable. This is reflected in an email dated 1 December 2020 produced as exhibit RGB4/41 INQ000595069. During the meeting PHS expressed a desire to work collaboratively with HSE recognising the role of the workplace in public health and the overlaps that existed, along with the shared aims of both organisations. Following attendance at two workshops a *Public Health Scotland (PHS) - Health & Safety Executive (HSE) Collaboration Framework - Statement of Commitment* was signed on 22 August 2022. A copy is produced as exhibit RGB4/42 INQ000595117.

Welsh Local Government Association

43. The Welsh Local Government Association [WLGA] was part of the WGHSF and HSE's engagement with the WLGA formed part of the overall engagement with WGHSF.

Association of Directors of Adult Social Services, Association of Directors of Social Services Cymru and Convention of Scottish Local Authorities

44. During the relevant period HSE did not specifically liaise or communicate with the Association of Directors of Adult Social Services, Association of Directors of Social Services Cymru or the Convention of Scottish Local Authorities except to the extent to which those bodies may also have been present at meetings and forums chaired by others where HSE was also an attendee.

Care Quality Commission

45. Prior to and during the relevant period the HSE attended liaison meetings with the Care Quality Commission [CQC]. Meetings were originally instigated from the MoU that was put in place when CQC became the lead enforcing authority for patient/service user safety. Meetings took place on a quarterly basis but more frequently if required. They included representatives from HSE and CQC policy, enforcement and legal. The purpose of the meetings was to provide an opportunity for both organisations to updates on current prosecutions, work priorities, share information/issues in health and social care, update on enforcement, legal and policy matters. In addition, HSE's Chair Sarah Newton would also meet with the CQC Chair every 6 months. During the pandemic, the meetings were used to share information regarding the steps being taken by HSE to assess compliance with Covid-19 related workplace safety requirements in the adult social care sector.

46. For example, in June 2020 CQC shared information with HSE ahead of a liaison meeting which included guidance on their Covid 19 Emergency Support Framework and their Covid 19 Enforcement Principles and Decision Making Framework. This is reflected in an email dated 3 June 2020 produced as exhibit RGB4/43 INQ000595015. Attachments to the email *COVID-19 – Enforcement Principles and Decision-Making Framework* and *Guidance: The COVID-19 Emergency Support Framework* are produced as exhibits RGB4/43a INQ000567477 and RGB4/43b INQ000595017. The email set out the steps being taken by CQC to regulate during Covid-19. Whilst HSE did not input into the documents it was important that HSE was aware of them given that HSE may be regulating the same care providers from a worker perspective.

47. On 14 August 2020 HSE contacted CQC in relation to a letter that CQC had sent to I&S Hospital following an intervention. HSE was concerned that some issues related to worker health and safety issues, for example the requirement for face fit tests to be carried out, but these were not raised with the local HSE team prior to the letter being sent as per the requirements of the MoU. HSE explained that given the ongoing issues arising from Covid-19 it was highly likely that HSE

and CQC would be carrying out interventions at the same time within health and social care premises and HSE would welcome a discussion about this case and to see how closer liaison could be maintained in the future at a local level. A copy of the letter dated 7 August 2020 is produced as exhibit RGB4/44 INQ000595050 and email is produced as exhibit RGB4/45 INQ000595049. CQC responded on 17 August 2020 and explained that they would be drafting a bulletin to go to CQC staff reinforcing the importance of the MoU to support enforcement liaison at a local level. A copy of the email from CQC is produced as exhibit RGB4/46 INQ000595046. Following this, a local meeting was arranged for 24 August 2020. A copy of the calendar appointment is produced as exhibit RGB4/47 INQ000595047.

48. During a liaison meeting on 27 August 2020 HSE explained that it was currently undertaking spot checks in various industries where there were high levels/risk of Covid-19 transmission and had been asked to look at health and social care settings in England. HSE agreed to share a list of care providers where HSE had previously investigated Covid-19 concerns including PPE concerns. This is reflected in the notes of the meeting set out in an email dated 28 August 2020 produced as exhibit RGB4/48 INQ000595053. The data contained within the list was compiled from HSE systems, was limited to England only and was intended for internal use. It contained 65 entries relevant to adult social care with details of 57 care providers. Of the 65 entries 28 related to social distancing concerns and 31 related to PPE concerns. The remaining 6 entries related to 'other' or 'not known' concerns.

49. During a further liaison meeting in October 2020 CQC explained that they were carrying out inspections of care homes with a focus on residents but also looking at PPE/infection control which included social distancing in the workplace to reduce transmission. At that time, HSE were finalising proposals for spot inspections to the health and social care sector and communications were helpful to avoid duplication and reduce burden on care providers. This is reflected in a briefing note prepared for HSE's chair. *Chair - External Briefing* produced as exhibit RGB4/49 INQ000595063.

50. On 3 December 2020 HSE provided further information to CQC about its forthcoming spot checks in social care including an explanation of the 3 stage process that would be adopted. This is reflected in the *HSE / CQC Meeting – 3 December 2020* notes produced as exhibit RGB4/50 INQ000595072.

51. CQC along with HSE and others were an attendee at DHSC's Adult Social Care Personal Protective Equipment (PPE) Task and Finish Group.

Care Inspectorate Wales and Care Inspectorate (Scotland)

52. HSE engaged with Care Inspectorate Wales and Care Inspectorate (Scotland) on matters relating to compliance with regulatory requirements during Covid-19. Examples of engagement with the organisation are set out in paragraphs 33 and 35 above.

Local Authorities

53. HSE liaison with LAs involved sharing information on a range of Covid-19 related issues, hosting webinars and consideration reports logged on HSE's RIDDOR database using existing communication channels that were in place before the pandemic.

54. The Health and Safety Executive/Local Authority Enforcement Liaison Committee [HELA] was set up in 1975 to provide effective liaison between HSE and LA. HELA also provides a national forum for discussion and exchange of information on LA activity and enforcement.

55. The LA Health and Safety Practitioner Forum [PF] provides LA regulators input to matters of operational policy and operational delivery. This includes contribution to the development of operational materials to assist LAs delivery of health and safety enforcement in a targeted, consistent and proportionate manner and informing the development of LGA policy on health and safety matters and on wider regulatory issues. Members of this forum are nominated from LA liaison and regional groupings from across England, Scotland and Wales, providing a two way communication link between national and local forums.

56. HELA and the Practitioner Forum were merged in May 2020 in response to the pandemic. Instead of meetings taking place 6 months, 5 virtual meetings took place between from May 2020 and March 2021. Attendees included Local Government Association and environmental health professional bodies comprising Royal Environmental Health Institute of Scotland [REHIS], the Society of Chief Officers of Environmental Health in Scotland [SOCOEHS] and the Chartered Institute of Environmental Health [CIEH].

57. Notes from *Joint HELA/PF Meeting 8 July 2020* produced as exhibit RGB4/51 INQ000595119 reflect that two LAs had volunteered to take part in a spot check pilot. The aim was to test the potential to extend HSE's spot check telephone call service offering to LAs who might be interested. LAs would share list of businesses that were LA enforced excluding care homes but including retail/wholesale premises, offices, restaurants, pubs and close contact services such as hairdressers etc. and contact details which HSE's spot check team would then call and ask questions based on a tight script. Based on the responses and potentially a more probing follow up call, businesses may be referred back to the LA for a site visit.

58. Notes from *Joint HELA/PF Meeting 1 December 2020* produced as exhibit RGB4/52 **INQ000547966** reflects that some LAs were concerned that in relation to care homes and mass vaccination programme initiatives, help was required to try and get this workplace setting to take vaccinations because historically, there had been a poor uptake for flu vaccinations in this sector.

59. Notes from *Joint HELA/PF Meeting 31 March 2021* produced as exhibit RGB4/53 INQ000595080 reflects that HSE statisticians had been contacting LAs to verify details regarding fatalities reported via RIDDOR. This is an integral part of the verification process for the fatality data HSE publishes annually.

60. During the relevant period HSE provided HSE HELex eBulletins to local authority health and safety enforcers on a range of matters including:

    a. HSE and LA Roles in outbreak management and health and safety enforcement

b. Shared resource - COVID-19 risk assessment template
c. HSE offer to support Local Authorities with spot checks
d. Care homes spot checks webinar
e. Expanded Spot Check offer to Local Authorities
f. HSE guidance for helping businesses re-open safely
g. Update regarding Spot Check Programme
h. Workplace regulation and living with coronavirus

61. Copies of HSE HELex eBulletins dated 27 July 2020, 10 August 2020, 30 October 2020, 7 December 2020 and 3 March 2022 are produced as exhibit RGB4/54 INQ000595033, exhibit RGB4/55 INQ000595044 exhibit RGB4/56 INQ000595065, exhibit RGB4/57 INQ000595070 and exhibit RGB4/58 INQ000595111.

62. Various Covid 19 focused webinars were delivered for LA co-regulatory colleagues between April 2020 and July 2021 on a range of issues including social distancing, RIDDOR reporting, spot checks and business re-opening. Copies of webinars *Health & Social Care Briefing Session for LA teams* dated November 2020 and August 2021 are produced as exhibit RGB4/59 INQ000595067 and exhibit RGB4/60 INQ000595100. These were aimed to assist environmental health teams on spot checks of premises that fell within their remit, including residential care homes.

Health and Safety Executive Northern Ireland

63. Northern Ireland has a separate system of regulation enforced by HSENI. HSE liaison and communication included:

a. providing training material for HSE inspectors and Local Authorities colleagues on social distancing requirements,
b. Sharing training material in relation to the procurement of compliant PPE,
c. seeking clarification on NI requirements covid-19 risks assessments for pregnant women

d. sharing the outcome of judicial review proceedings on respect of PPE requirements and
e. sharing a SAGE paper on the role of ventilation in controlling Covid-19 transmission.

Care home providers

64. HSE had some liaison and communication with care home providers through its attendance at the Workforce Advisory Group [WAG] which was chaired by the United Kingdom Home Care Association [UKHCA] and the National Care Forum [NCF]. WAG was formed to support the Adult Social Care Taskforce. The remit of the advisory group and a list of members is set out *Public Output from the First meeting of the Workforce Advisory Group Meeting on the 8th July 2020* (dated 17 July 2020) produced as exhibit RGB4/61 INQ000595038. HSE's contribution to the WAG included:

    a. Advice on PPE worn by visitors - HSE could enforce issues around the protection of workers and the expectation was that members of staff would wear appropriate PPE for the situation.
    b. Guidance – General feedback highlighted that better communication and understanding of relevant guidance was required by the workforce on PPE and social distancing.
    c. Feedback - Passport schemes whereby an agreed syllabus to train all nurses went onto a passport and could be transferred between providers preventing the need for nurses to retrain thus giving greater flexibility had not moved to social care. (Nurse passport schemes refer to a variety of initiatives designed to enhance the mobility and efficiency of nurses with the healthcare system).

65. Care home providers were also represented at DHSC's Adult Social Care Personal Protective Equipment (PPE) Task and Finish Group of which HSE was also an attendee.

66. Early in the pandemic, HSE set up a Resilience Team to assist the Concerns and Advice team [CAT] to manage queries relating to Covid-19. Due to the volume of queries being received by HSE, it prepared, *HSE Briefing and Lines to Take: Wuhan Novel Coronavirus (Covid-19)* from March to September 2020 to assist the Resilience Team deal with queries quickly and effectively. The Lines to Take dated April 2020 is produced as exhibit RGB4/62 INQ000529211 and September 2020 is produced as exhibit RGB4/63 INQ000529623 provided advice across a wide range of issues, including:

    a. Shortage of Supply
    b. Supply Chain Issues for PPE
    c. How Long Should Masks Be Worn
    d. Difference Between Surgical Mask and FFP3
    e. Social Distancing

67. Requests for advice from dutyholders or stakeholders which would include care home providers that were more complex in nature were sent to the Triage team who would then forward them to the relevant team within the PPE Unit, dependent on the nature of the query and the technical or policy input required to resolve the query. Advice included:

    a. cleaning arrangements
    b. monitoring adherence to IPC and PPE requirements
    c. ventilation
    d. RIDDOR reporting
    e. distancing in staff rooms
    f. meeting arrangements

68. A document setting out the procedures *Handling Procedure for all Concerns in Health and Social Care Settings During the Covid-19 Pandemic Guidance for HSCSU* is produced as exhibit RGB4/64 INQ000269814.

Trade Unions Congress and Royal College of Nursing

69. From late 2021 onwards, HSE held meetings with RCN and other Trade Unions representing people working in the Social Care sector. The meetings were held every 6 months. This was a new engagement meeting the purpose of which was to enable HSE to gain insight into the key issues affecting people working in social care, including matters relating to the pandemic.

70. HSE also received and responded to correspondence from the British Medical Association, the RCN and other representative bodies throughout the relevant period. A number of these correspondence raised concerns or queries relating to:

    a. Infection Prevention Control Guidance
    b. Ventilation
    c. Availability and supply of PPE
    d. Fit testing and fit checking
    e. Portacount machine settings (Portacount machines are used within the health and social care sector as a means of quantitative face fit testing of Respirator Protective Equipment [RPE]. A portacount machine counts ambient particles and therefore provides a quantitative assessment of leakage from the face seal of a respirator).
    f. PPE decontamination and reuse
    g. RIDDOR reporting requirements

71. On 22 May 2020 HSE attended a Q&A session with representatives of the Trade Unions Congress [TUC] during which HSE's Chief Executive and Director of Regulation responded to questions relating to measures being taken to improve the level of enforcement in care homes and the domiciliary sector, any steps being taken to enhance the existing MOU between HSE and the CQC and measures being taken to improve communication between HSE and other Government departments. A copy of the HSE's internal notes for this meeting is produced as exhibit RGB4/65 INQ000595025.

72. On 1 February 2021 HSE's Chair met with the General Secretary of the Scottish Trade Union Congress [STUC] during which HSE explained its priorities had been Covid-19 assurance checks in schools; in NHS and social care premises; in transport and logistics sector, waste and recycling and food manufacture; investigating Covid-19 concerns; investigating RIDDOR reports of Covid-19 fatalities of workers if there was a work-related cause and supporting COPFS and the Police in investigating Covid-19 deaths of residents in care homes. This is reflected in *Briefing for Chair's meeting with Rozanne Foyer, General Secretary of the Scottish Trade Union Congress – 1 February 2021* produced as exhibit RGB4/66 INQ000595074. Reference to the term, *'Covid-19 assurance checks'* was used in this context to describe Covid-19 spot checks and inspections in care homes in England, Scotland and Wales between October 2020 and March 2021 to check they were following the government Covid-19 guidance.

73. On 8 March 2021 HSE's Chair met with TUC Executive Committee members. The *Briefing note for HSE Chair and TU meeting 8 March 2021* produced as exhibit RGB4/67 **INQ000547967** reflects the key issues in Health and Social care were around suitability of fluid resistant surgical masks, FFP3 respirators, the need for face fit testing and mechanical ventilation. In respect of RIDDOR, there was no general requirement under RIDDOR to report incidents of disease or deaths of members of the public, patients, care home residents or service users from Covid-19 as most instances do not result from an occupational exposure to the virus.

Other key stakeholders

74. In October 2020 the European Centre for Disease Prevention and Control [ECDC] was considering an update to its technical report on heating, ventilation and air conditioning systems in the context of Covid 19 and HSE provided PHE with links to its own guidance on ventilation. A copy of the email is produced as exhibit RGB4/68 INQ000595068.

75. In March 2022 HSE contacted NHS England and NHS Improvement to highlight inconsistencies between Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and the draft version of the How to Work safely in Care Homes (HTWS) guidance for adult social care in England. When considering respiratory protective equipment (RPE) when in direct contact with infectious patients HSE considered that the guidance was inconsistent across both documents. The section in the IPC guidance was not Covid specific and was qualified by reference to *'the airborne route'*. However the HTWS guidance not only specified Covid but also only referred to symptomatic patients, excluding asymptomatic yet infectious patients and also specifically mentioned working within a 2-metre distance. It did not mention the airborne route. The email is produced as exhibit RGB4/69 INQ000595112. *Guidance: Infection prevention and control for seasonal respiratory infections in health care settings (including SARS-CoV-2 for winter 2021 to 2022* is produced as exhibit RGB4/69a INQ000300389 and *A resource for how to work safely, living with COVID in adult social care settings* is produced as exhibit RGB4/69b INQ000112290.

The responsibilities of employers in the social care sector

76. The key health and safety at work legislative requirements that apply to employers in the social care sector are set out below.

The Health and Safety at Work Act 1974

77. Under s2 HSWA there is a general duty for every employer to ensure, so far is reasonably practicable, the health, safety and welfare at work of all its employees. The general duty extends to those employers working within the social care setting to look after the health, safety and welfare of its staff.

78. There is also a general duty on every employer to conduct its undertaking in such a way as to ensure, so far as is reasonably practicable, that those not in an employer's employment, are not exposed to risks to their health and safety (s3 HSWA). The general duty extends to those who are not staff employees but who

nevertheless are involved with the provision of social care services, for example, patients and contractors.

79. Employers within the social care setting must comply with s9 HSWA which provides that they shall not levy or permit to be levied on any employee, any charge in respect of anything done or provided in pursuance of a specific requirement. In the context of social care, the specific requirement was to provide PPE and therefore no charge could be made to a worker for the provision of PPE which was used only at work.

80. The Personal Protective Equipment at Work Regulations 1992 [PPEW] Regulations are the main set of Regulations relating to the use of PPE. PPE provided to protect against hazardous substances are dealt with under separate Regulations.

The Management of Health and Safety at Work Regulations 1999 [MHSW]

81. The MHSW Regulations require every employer to provide competent advice and make a suitable and sufficient assessment of the risks to health and safety of its employees and persons not within their employment to which they are exposed. During the relevant period those in the social care setting were required to ensure Covid-19 was covered in any risk assessment to ensure adequate protection from those that come into contact with the virus due to their work activity.

82. Risk management is a step-by-step process for controlling health and safety risks caused by hazards in the workplace and carrying out a risk assessment is just one part of the overall process. HSE has produced a guide to help employers understand their obligations which is publicly available on HSE's website, *Managing risks and risk assessment at work* produced as RGB4/70 INQ000595128. The guide sets out the steps needed to manage the risk which includes:

    i. Identifying hazards
    ii. Controlling the risk
    iii. Recording the findings

iv. Reviewing the controls

The Personal Protective Equipment at Work Regulations 1992 [PPEW]

83. Every employer shall ensure that suitable PPE is provided to its employees who may be exposed to a risk to their health or safety while at work, except where and to the extent that such risk has been adequately controlled by other means which are equally or more effective. In the context of social care, employers should provide appropriate PPE and training in its usage to their employees wherever there is a risk to health and safety. In order to meet with the requirement to provide PPE for their employees, it must be readily available for them, or at the very least employees must have clear instructions on where they can obtain it.

The Workplace (Health, Safety and Welfare) Regulations 1992 [WHSW]

84. The WHSW Regulations require that every employer shall ensure that every workplace complies with them and associated Approved Code of Practice [ACOPs] and guidance. In the context of social care settings, this encompasses all welfare facilities, to include welfare, rest facilities, workplace transport, temperature and general ventilation to ensure the working environment is healthy and safe for all concerned.

The Provision and Use of Work Equipment Regulations 1998 [PUWER]

85. The PUWER Regulations place duties on people and companies who own, operate or have control over work equipment. They also place responsibility on businesses and organisations whose employees use work equipment to ensure all equipment is safe and maintained. Work equipment includes any machinery, appliance, apparatus, tool or installation for use at work. The use of work equipment is widely defined and means *"any activity involving work equipment and includes starting, stopping, programming, setting, transporting, repairing, modifying, maintaining, servicing and cleaning".*

The Control of Substances Hazardous to Health Regulations 2002 [COSHH]

86. The COSHH Regulations set out the requirements in relation to the use of PPE when protecting against substances hazardous to health, where other control measures, such as engineering controls, ventilation or prevention at source cannot be achieved. The objective of COSHH is to prevent, or to adequately control, exposure to substances hazardous to health in the workplace, that cause ill health. The Regulations are supplemented by an ACOP. The provision of suitable PPE is at the bottom of the hierarchy when an adequate control of the exposure cannot be achieved by other means. During the Covid-19 pandemic protection would include the selection of appropriate PPE determined by a local risk assessment and reference to relevant Infection Prevention Control [IPC] guidance or Public Health England Guidance on Covid -19 PPE requirements as the minimum standard. Where respiratory protective equipment [RPE] was identified as a suitable control measure guidance publicly available on HSE's website *HSG53 – Respiratory protective equipment at work 2013* produced as exhibit RGB4/71 INQ000269685 provided further assistance to employers on selection and use of adequate and suitable RPE in the workplace, in order to comply with the law.

87. A COSHH risk assessment concentrates on the hazards and risks from hazardous substances in the workplace. HSE has produced a booklet which is publicly available on its website *A step by step guide to COSHH assessment HSG97 Second edition, published 2004* produced as exhibit RGB4/72 INQ000595129. The booklet sets out a framework of stages in carrying out assessment. The legal requirement is for assessment to be *'suitable and sufficient'.* More serious and complex risks require greater consideration to meet this requirement, simpler and lower risk situations will require less. It provides guidance on:

    g. Gathering information about the substances, the work and the working practices
    h. Evaluating the risks to health
    i. Deciding on the necessary measures to comply with regulations 7-13 of COSHH.
    j. Recording the assessment.

k. When the assessment needs to be reviewed.

88. Under COSHH all employers within social care settings must protect workers who come into contact with Covid-19 directly through their work, for example caring for infectious patients. In these cases, employers must still do a risk assessment and implement control measures. Employers are responsible for providing, replacing and paying for PPE for use by its workers.

89. The COSHH Regulations set out the requirements in relation to the use of PPE when protecting against substances hazardous to health, where other control measures, such as engineering controls, ventilation or prevention at source cannot be achieved.

90. Paragraph 18 of the ACOP states that COSHH does not cover situations where one employee catches a respiratory infection from another or a member of the public has infected an employee with a respiratory infection through general safety. This is because Regulation 2(2) specifies that COSHH only applies in those circumstances where risks of exposure are work related, and not those where they have no direct connection with the work being done.

91. Another common risk that may arise in a social care setting relates to risks associated with Legionnaires' disease. Employers need to take precautions to reduce the risks of exposure to legionella. COSHH provides a framework of actions designed to assess, prevent or control the risk from bacteria like legionella and take suitable precautions.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 [RIDDOR]

92. RIDDOR reporting requires employers, self-employed and those in control of premises to report specified workplace incidents. In the context of social care workers those incidents include cases of disease or deaths arising from Covid-19 when an employee has been incidentally exposed to the virus. Incidental exposure can occur within the social care setting where people are known to have Covid-19.

93. A report under RIDDOR should only be made if an incident at work has, or could have, led to the release of the virus (this must be reported as a dangerous occurrence); where a worker has been diagnosed as having Covid-19 attributed to an occupational exposure to the virus through deliberately working with it or being incidentally exposed to it (this must be reported as a case of disease due to exposure to a biological agent); where a worker dies as a result of occupational exposure to the virus through either deliberately working with it or being incidentally exposed to it (this must be reported as a work-related death due to exposure to a biological agent).

HSE advice and guidance relevant to the social care sector

94. HSE has longstanding guidance available on its website *Health and safety in care homes HSG220 (2nd edition) Published 2014* produced as exhibit RGB4/73 INQ000595123 intended to help those providing and managing care homes and to give them a better understanding of the real risks and how to manage them effectively. It describes the main health and safety risks found in care homes, and what should be done to protect both workers and those receiving care. The guidance provides information on:

    a. Reporting of incidents under RIDDOR (chapter 2)
    b. Hazardous substances, infections and diseases (chapter 8)
    c. Legionella (chapter 9)
    d. General work environment including ventilation (chapter 13)

95. In respect of infection prevention and control including personal protective equipment chapter 8.12 states,

    "Control of infection is an important consideration throughout the care home environment. There may be the potential for exposure to a range of human pathogens with the resulting risk of harm or disease. All care homes should have an infection prevention and control policy that addresses such issues as:

- *education and training of employees in infection prevention and control issues, including outbreaks of infection;*
- *protocols for hand washing;*
- *service user isolation/placement;*
- *aseptic procedures;*
- *good sanitation – disinfection and decontamination, including domestic cleaning;*
- *ill-health reporting and recording;*
- *monitoring, surveillance and audit;*
- *prevention of exposure to blood-borne viruses, including prevention of sharps injuries and immunisation policies for at-risk staff;*
- *use of PPE, including gloves;*
- *creation, collection and disposal of clinical waste".*

96. Chapter 8.13 states,

"Employees working in care homes, particularly nurses, are sometimes at risk from infections carried in blood and body fluids, including hepatitis B, C and human immunodeficiency virus (HIV). If there is a risk of becoming infected due to work activities, you need to assess these risks to decide upon suitable controls".

97. In respect of ventilation and heating chapter 13.24 states,

"Workplaces need to be adequately ventilated with fresh, clean air. However, you should provide an environment that is comfortable and suitable for their residents as well as staff. Windows or other openings may provide sufficient ventilation, but the risks of residents falling must also be considered…"

98. HSG220 is supplemented by other guidance documents available HSE's website which include:

Reporting injuries, diseases and dangerous occurrences in health and social care Guidance for employers HSE information sheet HSIS1(rev4) published 2013 produced as exhibit RGB4/74 INQ000466413

How the Lifting Operations and Lifting Equipment Regulations apply to health and social care HSE information sheet HSIS4(rev1) published 2012 produced as exhibit RGB4/75 INQ000595126

Falls from windows or balconies in health and social care HSE information sheet HSIS5 published 2012 produced as exhibit RGB4/76 INQ000595124 and *Managing the risks from hot water and surfaces in health and social care HSE information sheet HSIS6 2012* produced as exhibit RGB4/77 INQ000595125.

99. In relation to PPE, HSE published *Personal Protective Equipment at Work - Guidance on the Regulations (L25) 3rd edition (2015)* produced as exhibit RGB4/78 INQ000269664. In addition to this guidance, HSE provided employers with information on their legal obligations to provide suitable PPE on its website *Risk at Work – Personal protective equipment (PPE)* produced as exhibit RGB4/79 INQ000529832. This also included information on product safety requirements for PPE and the obligations held by employers in relation to ensuring that products met the relevant conformity requirements. Dutyholders could also access information about COSHH requirements and PPE on HSE's website *FAQs about respiratory protective equipment* produced as exhibit RGB4/80 INQ000529824.

100. HSE had additional information on its website regarding RPE. This included both advice and technical information and covered topics such as fit testing. Examples of relevant pages that were available prior to the relevant period include *What is RPE?* produced as exhibit RGB4/81 INQ000529828, *When can respiratory protective equipment (RPE) be used?* produced as exhibit RGB4/82 INQ000529829, *How good are you?* produced as exhibit RGB4/83 INQ000529826, *How do I choose the right respiratory protective equipment (RPE)?* produced as exhibit (RPE) RGB4/84 INQ000529827, *Fit testing basics* produced as exhibit RGB4/85 INQ000529825, *COSHH basics Personal Protective*

Equipment (PPE) produced as exhibit RGB4/86 INQ000529831 and *RPE COSHH essentials* produced as exhibit RGB4/87 INQ000529830.

HSE input into relevant guidance during the pandemic

101. As the regulator for workplace safety HSE provided comments to Public Health England [PHE]/UK Health Security Agency [UKHSA], NHS England and NHS Improvement on draft Infection Prevention Control [IPC] guidance. HSE was not directly involved as a member of the IPC cell but assisted when requested to do so, as a consultee.

102. The IPC principles applied to UK health and social care settings. The advice provided by HSE on the IPC guidance and associated documents such as PPE ensemble tables was focused on the duties held by employers in health and care settings to undertake a suitable and sufficient risk assessment of work related risks arising from or in connection with transmission of SARS-CoV-2 and the implementation of suitable controls, through the application of the hierarchy of controls. Version history for the IPC manual for England available on NHS England's website sets out the various iterations of the guidance from first publication of version 1.0 on 14 April 2022 to version 2.11 dated 24 February 2025. It reflects that on the 30 August 2022 version 2.2 now reflected language used by HSE. Under the hierarchy on control PPE should be the last resort to protect against risks. It requires consideration of controls in the following order with elimination of the risk being most effective and PPE being the least effective.

a. Elimination – physically remove the hazard
b. Substitution – replace the hazard
c. Engineering controls – isolating people from the hazard
d. Administrative controls - change the way people work
e. PPE – protect the worker with equipment.

103. The IPC manual for England made it clear that the was guidance for the NHS and as such should be applied by all NHS staff involved in patient care. It further

explained that the principles in the manual should be applied across all care settings (including acute, community and social care), complementing specific guidance produced for those settings.

104. PHE/UKHSA and DHSC also drafted guidance specifically for the social care sector and HSE provided comments *Personal protective equipment (PPE): resource for care workers working in care homes during sustained COVID-19 transmission in England version 2.5* produced as exhibit RGB4/87a INQ000610096. A copy of the covering email dated 21 April 2021 is produced as exhibit RGB4/87b INQ000610095. HSE also provided comments on *Personal protective equipment (PPE) resource for care workers working in care homes during sustained COVID-19 transmission in England version 2.*8 produced as exhibit RGB4/87c INQ000610098. A copy of the covering email dated 27 April 2021 is produced as exhibit RGB4/87d INQ000610097. Some of the suggested amendments were incorporated into the final version of the published guidance.

Additional guidance published by HSE during the pandemic

105. During the pandemic HSE published further ventilation guidance on its website *Air conditioning and ventilation during the coronavirus outbreak (18 June 2020)* produced as exhibit RGB4/88 INQ000595122 and *Ventilation during the coronavirus (COVID-19) pandemic (23 March 2022)* produced as exhibit RGB4/89 INQ000595121. HSE also considered draft ventilation guidance for care homes created by NHS England and NHS Improvement *Care Home Ventilation (May 2022)* produced as exhibit RGB4/90 INQ000595115.

106. HSE created *Guidance for public health bodies explaining HSE's role in test, trace and outbreak response* produced as exhibit RGB4/91 INQ000595045 due to the number of outbreaks of Covid-19 in care homes. This guidance was to help colleagues with a public health role understand how HSE could support regulatory action to control the transmission of Covid-19 where workplace regulation was shared with local authorities. It explained that HSE may be able to input into the risk assessment when a Health Protection Team was considering a cluster or potential outbreak, if the common factor under consideration is a workplace which

fell to HSE for enforcement. HSE could help public health officials to understand whether the workplace was likely to be a source of infection transmission or not.

107. During the pandemic, HSE published additional guidance and information that would assist duty holders in healthcare and social care sectors when considering how to manage workplace risks related to the transmission of Covid-19, use of PPE and links to other information and guidance published by Government departments and other bodies. These were reviewed and updated where necessary throughout the pandemic. At the start of the pandemic, information was published on HSE's website on existing pages, for example the Health and Social Care sector page or news page. In June 2020, HSE launched a Coronavirus microsite where all relevant updates, information and guidance could be accessed.

108. Examples of the webpages from during the relevant period included *PPE in health and social care during the coronavirus outbreak sources of advice*, produced as exhibit RGB4/92 INQ000529821 (June 2020), *PPE in health and social care during the coronavirus pandemic sources of advice – Removal of some Covid-19* restrictions, produced as exhibit RGB4/93 INQ000529820 (July 2021) and *PPE in health and social care during coronavirus (Covid-19) pandemic sources of advice – Latest advice on keeping workplaces safe from Covid-19* produced as exhibit RGB4/94 INQ000529819 (February 2022). Additional guidance was developed to assist dutyholders, including guidance on the use of face coverings and face masks. Examples of the guidance from during the relevant period include *Face coverings and face masks during the coronavirus outbreak produced* as exhibit RGB4/95 INQ000529812 (June 2020), *Face coverings and face masks during the coronavirus (Covid-19) pandemic* produced as exhibit RGB4/96 INQ000529811 (July 2021) and *Face coverings and face masks during the coronavirus (Covid-19) pandemic – Latest advice on keeping workplaces safe from Covid-19* produced as exhibit RGB4/97 INQ000529810 (February 2022).

109. HSE's website also contained advice and information for dutyholders in healthcare and social care sectors on fit testing. Examples of this guidance includes *Fit testing face masks to avoid transmission during the coronavirus*

outbreak produced as exhibit RGB4/98 INQ000529815 (June 2020), *Fit testing face masks to avoid transmission during the coronavirus outbreak - Removal of some coronavirus (covid-19) restrictions* produced as exhibit RGB4/99 INQ000529814 (July 2021) and *Fit testing face masks to avoid transmission during the coronavirus (Covid-19) pandemic - Latest advice on keeping workplaces safe from Covid 19* produced as exhibit RGB4/100 INQ000529813 (Feb 2022). HSE also produced other materials, for example news updates on face fit testing which were published on its website. An example of a news update published on 26 March 2020 is *Fit testing face masks to avoid transmission: coronavirus (Covid-19) Respiratory protective equipment* produced as exhibit RGB4/101 INQ000529836. To promote the proper donning and use of disposable respirators, HSE produced a guidance poster *Using disposable respirators* produced as exhibit RGB4/102 INQ000269684 on how to don RPE correctly and how to perform a user seal check in March 2020.

110. HSE provides free email updates to subscribers by way of HSE eBulletins. Subscribers are required to select specific subject topics/industries of interest to them. including health and social care. During the pandemic, HSE eBulletins for health and social care information included Covid-risk assessments, cleaning regimes, handwashing, social distancing ventilation, legionella and spot checks. HSE *England eBulletin dated March 2021* is produced as exhibit RGB4/103 INQ000595078, HSE *Scotland eBulletin dated April 2021* is produced as exhibit RGB4/104 INQ000595081 and HSE *Wales eBulletin dated August 2021* is produced as exhibit RGB4/105 INQ000595106.

The provision of advice to dutyholders in the social care sector

111. Early in the pandemic, HSE set up a Resilience Team to assist the Concerns and Advice team to manage queries relating to Covid-19. Due to the volume of queries being received by HSE, it prepared, *HSE Briefing and Lines to Take: Wuhan Novel Coronavirus (Covid-19*) from March to September 2020 to assist the Resilience Team deal with queries quickly and effectively. The LTT dated April 2020 is produced as exhibit RGB4/106 INQ000529211 and September 2020 is produced

as exhibit RGB4/107 INQ000529623 provided advice across a wide range of issues, including:

a. Shortage of Supply
b. Supply Chain Issues for PPE
c. How Long Should Masks Be Worn
d. Difference Between Surgical Mask and FFP3
e. Social Distancing

112. Requests for advice from dutyholders or stakeholders that were more complex in nature were sent to the Triage team who would then forward them to the relevant team within the PPE Unit, dependent on the nature of the query and the technical or policy input required to resolve the query. Advice included:

a. cleaning arrangements
b. monitoring adherence to IPC and PPE requirements
c. ventilation
d. RIDDOR reporting
e. distancing in staff rooms
f. meeting arrangements

113. A document setting out the procedures *Handling Procedure for all Concerns in Health and Social Care Settings During the Covid-19 Pandemic Guidance for HSCSU* is produced as exhibit RGB4/108 INQ000269814.

114. HSE did not provide training directly to care providers in the adult social care sector during the relevant period.

Inspection activity

Prior to the pandemic

115. HSE carries out its regulatory functions to prevent workplace death, injury or ill-health by using a variety of methods. HSE's aim is to influence change and assist dutyholders manage risks in their workplace and ensure compliance with all health

and safety at work law, one method is through targeted inspections. This is reflected in *Regulation of health and safety at work (HSE 51) 2014* published on HSE's website.

116. Inspections are carried out for the purposes of targeting high risk sectors / activities, for benchmarking, following an incident, and responding to local intelligence (local inspections). Inspections are also undertaken in relation to sites that are subject to a permissioning regime. Inspections are carried out by HSE staff (which includes Principal Inspectors, Inspectors, Specialist Inspectors, Visiting Officers and Regulatory Compliance Officers).

117. Local inspections are arranged on a case-by-case basis. The approach taken to arranging such an inspection may differ by industry sector but generally it is through either prior contact between the inspector and the dutyholder or the inspection is conducted unannounced. Information is published for dutyholders on the inspections process *When a health and safety inspector calls - what to expect when we visit your business* produced as exhibit RGB4/109 INQ000269846. A local inspection may be undertaken in a range of circumstances including following an incident, to assess on-going compliance following an investigation, in response to local intelligence or following the receipt of a concern.

118. During an inspection, an inspector will speak to relevant employees, observe a sample of workplace activities, conditions and practices, assess relevant documents, check whether risk controls are effective (where necessary), identify any breaches of the law and consider appropriate enforcement action. An inspector will also engage with Trade Union appointed Safety Representatives and / or Worker Safety Representatives as part of inspection activity.

119. HSE also undertakes thematic or programmed inspections. These inspections target those sectors and activities with the most serious risks and where the risks are least well-controlled. For example, HSE undertook programmed inspections in healthcare settings to look at issues such as the management of violence and aggression towards employees and manual handling in financial year 2021/22. HSE did not focus on compliance with PPE requirements in social care settings as a targeted area for inspection activity prior to the pandemic.

120. HSE inspections in the social care sector will generally not include inspections of residential care homes as responsibility falls to the relevant Local Authority under the EA Regulations. HSE will only inspect a residential care home if the premises is owned or operated by a Local Authority. HSE inspections in the social care sector will normally be limited to premises providing nursing care and residential care services, where the main activity is the provision of nursing care.

121. HSE uses a wide variety of enforcement powers to encourage and assist dutyholders to manage health and safety risks in a proportionate, targeted, consistent, transparent and accountable way. HSE's emphasis is on prevention but where appropriate, enforcement action will be taken to ensure dutyholders deal with serious risks so that they prevent harm; to ensure compliance with the law HSE takes enforcement action in line with HSE's Enforcement Policy Statement [EPS] produced as exhibit RGB4/110 INQ000269858 and HSE's Enforcement Management Model [EMM] produced as exhibit RGB4/111 INQ000269863. HSE's fundamental approach to enforcement is enshrined in the EPS. The EPS sets out the principles that inspectors should apply when determining what enforcement action to take. The EPS sets out the purpose and principles of enforcement, the enforcement methods available and how those principles relate to investigations and prosecutions.

122. If enforcement action is required to secure compliance with the law and to ensure a proportionate response to any breaches, HSE Inspectors may take a number of different actions. They may provide written information and advice regarding identified breaches and the action that the dutyholder must take to remedy the failings, also referred to by HSE as a Notice of Contravention [NOC]. Where appropriate, HSE may serve an improvement notice if an inspector is of the opinion that a person is contravening a relevant statutory provision in circumstances which make it likely the contravention will continue (s21 HSWA). Alternatively, under section 22 of HSWA, HSE may serve a prohibition notice if an inspector is of the opinion that an activity carried on by or under the control of a person involves a risk of serious personal injury.

123. Where a prosecution is being considered in England and Wales, HSE must apply the evidential stage and public interest factors within the Code for Crown Prosecutors. A prosecution cannot go ahead unless there is sufficient evidence to provide a realistic prospect of conviction and that a prosecution is in the public interest.

Inspection activity during the pandemic

124. HSE continued to undertake inspections during the relevant period but its approach to activity took account of the pressures that were being faced across social care settings. HSE recognised that it was important that its regulatory approach took a flexible and proportionate account of the risks and the challenges around the public health emergency detailed in *HSE's Covid-19 Rolling Brief (11 May 2020),* produced as exhibit RGB4/112 INQ000269857.

125. In addition to HSE's regime of inspections as described in paragraphs 130 – 135, during the pandemic, the HSE and Local Authorities introduced two additional regulatory interventions referred to as "spot checks" and "spot inspections". This followed a statement by the then Prime Minister [PM] of the UK, the Rt Hon. Boris Johnson in the House of Commons on 11 May 2020 which set out a conditional plan for the easing of Covid-19 restrictions. The term 'spot inspections' was used by the PM during this parliamentary session, specifically with regard to workers who would be returning to work because they could not work at home. He stated:

> *"We are going to insist that businesses across this country look after their workers and are covid-secure and covid-compliant. The Health and Safety Executive will be enforcing that, and we will have spot inspections to make sure that businesses are keeping their employees safe. It will, of course, be open to employees who do not feel safe to raise that with not just their employers but the HSE as well."*

126. An extract of Hansard is produced as exhibit RGB4/113 INQ000269860 at column 34.

127. Spot checks and spot inspections were undertaken by HSE and Local Authorities. Their introduction provided a means to check how businesses across all sectors were implementing the Covid Secure guidance and associated control measures they had put in place to protect employees, visitors and customers.

Developing the Spot Check Programme

128. Following the May announcement, a team was formed to establish the foundations of the operational approach to assess Covid-19 control measures in business across Great Britain. The key workstreams were developed and set out in a paper for HSE's Executive Committee [ExCo] Gold Group considered on 1 June 2020 produced as exhibit RGB4/114 INQ000269852.

129. The spot check programme adapted during the pandemic response to ensure HSE maintained alignment with policy and guidance changes and created a scalable solution to ramp up and ramp down quickly and efficiently, utilising an agile approach to cope with unexpected scenarios such as Covid-19 variants, implementation and removal of lockdowns and ultimately the closure of the programme in March 2022.

130. The selection of data for HSE spot checks initially followed the sectors covered by HSE's enforcement authority. HSE targeted high-risk sectors such as waste and recycling, metal fabrication and manufacturing (as outlined in the spot check intervention plan drafted in October 2020 produced as exhibit RGB4/115 INQ000269797) and overlaid this with a focus on priority geographic areas following local outbreaks and then local lockdowns. The programme also delivered specific campaigns with spot checks on schools, transport/logistics and health and social care settings. HSE also adapted approaches and methodologies to fit with surge testing and variant prevalence. Surge testing is increased testing (including door-to-door testing) and enhanced contact tracing in specific locations. It involves testing of people who do not have any symptoms of COVID-19.

Spot Checks and Spot Inspections – the Process

131. A 'spot check' was a proactive telephone call, visit or inspection to a (or of a) workplace, undertaken applying a 3-stage process. HSE highlighted the purpose and its approach to spot checks on its website *Regulating health and safety spot checks* produced as exhibit RGB4/116 INQ000269778.

132. The spot check process established by HSE consisted of three stages, specifically:

    a. Stage 1 - a questionnaire linked to Covid Secure / Working Safely guidance (examples are produced as exhibit RGB4/117 INQ000269826 and exhibit RGB4/118 INQ000269844). The questionnaire was completed either during a telephone call with the dutyholder or visit [spot check visit] to the dutyholder's premises / site. Where potential non-compliance was identified, the case was referred to Stage 2.

    b. Stage 2 - a more detailed discussion with the dutyholder (during a telephone call or spot check visit) where evidence was gathered, information was provided to the dutyholder in relation to relevant requirements and guidance and a decision was made as to compliance. Where a case was deemed to still be non-complaint at the end of Stage 2, it was referred to Stage 3.

    c. Stage 3 - an inspection by HSE/LA inspector.

133. If a dutyholder failed to engage in the conduct of a spot check, the matter would be escalated to the next stage of the process. All spot checks were recorded. An example of a completed spot check in produced as exhibit RGB4/119 INQ000269800.

134. The questionnaire used at Stage 1 of the process was continually reviewed and updated during the pandemic, for example amendments were made in July, August and December 2021 to take into account changes in Covid-19 restrictions. A specific health and social care sector questionnaire was developed

and implemented by October 2020 produced as exhibit RGB4/120 INQ000269794.

135. The questionnaire for health and social care included 32 questions that covered:

a. knowledge;
b. public health guidance;
c. risk assessments;
d. PPE;
e. social distancing and
f. cleansing.

136. When completing the questionnaire, dutyholders were required to provide information on matters including their risk assessment processes, the provision of advice, guidance and information to staff on matters such as the findings of the risk assessment, correct use of PPE, implementation of social distancing requirements and arrangements for cleansing.

137. In September 2021, following piloting with the Stage 2 team the programme implemented a video calling solution that enabled HSE to conduct virtual assessments of health and safety arrangements and the control measures implemented by dutyholders.

Inspections conducted in social care premises between 2019 and 2023

138. HSE records details of its inspections on a database. All regulatory activity is recorded with reference to the relevant SIC code (explained in more detail in paragraph 179). For social care, the SIC code classification (SIC 87) includes services provided to adults and young persons. The data summarised below includes all activity recorded for premises which are categorised under SIC 87 and medical nursing homes.

139. In 2019 HSE conducted 27 inspections in social care premises during 2019. These are detailed in *Copy of Covid Inquiry Data for Response - 1 April 2018 - 31 December 2019 - drawn 15 April 2025* produced as exhibit RGB4/120a INQ000611791. Of these, 2 inspections related to construction activities being

undertaken at adult social care premises. Nineteen were general inspections to assess health and safety arrangements at the premises. A number of these inspections followed a previous visit to the premises by a Visiting Officer, during which potential breaches of the legal requirements had been identified. A further 6 inspections were conducted either in connection with or following an investigation. Based on the case notes available, 6 inspections were linked to the receipt of a RIDDOR report (including one following an investigation) and 1 inspection was linked to the receipt of a concern. It is not possible to determine the nature of the concern raised from the information contained in the case notes.

140. In 12 of the cases, the highest form of enforcement action taken by HSE was issuing written advice (a NOC). In 6 cases, the dutyholder was also issued with an enforcement notice(s).

141. In 2020 HSE conducted 14 inspections across the social care sector (as defined in paragraphs 130 – 135), as detailed in *Copy of Covid Inquiry - Inspections-Healthcare - 86102 - all 87000 - From 01 January 20 to 28 June 2022 - Inspection Data TiY - April 2025* produced as exhibit RGB4/120b INQ000611792. Six inspections were conducted in England, 6 in Scotland and 2 in Wales. Two inspections related to construction activities. Seven were local inspections to assess health and safety arrangements, including attendances following visits by Visiting Officers where potential breaches had been identified. Some of these follow up inspections were conducted remotely due to premises being in isolation during the pandemic. Five inspections are recorded as Covid-19 inspections. These were either inspections focused specifically on the management of Covid-19, general or construction inspections where the adequacy of Covid-19 related control measures was also assessed or inspections conducted as part of the spot check programme. These inspections do not include spot check calls undertaken at the first 2 stages of the spot check programme.

142. HSE's database does not contain a field that requires Inspectors to record whether an inspection is conducted on site or remotely. However, based on the information contained within the case notes, it appears that 10 of the inspections were conducted on-site. Two follow up inspections had to be conducted remotely due to the premises in question being in isolation. Two other inspections were

conducted remotely, one due to a Covid outbreak at the premises and the second (a construction inspection) due to the fact that construction work had stopped due to Covid 19.

143. From the information available in the case notes, 3 of the inspections conducted during 2020 were linked to the receipt of a concern. Two of these were Covid-19 related concerns. From the information available in the case notes, one of the concerns related to an outbreak of Covid-19 at a premises. From the information available in the case notes, it is not possible to determine the precise nature of the concern raised in the second matter. However the case notes indicate that two visits took place at the premises following identification of material breaches during the first visit.

144. HSE took enforcement action following 9 of the inspections. Four dutyholders were issued with a NOC. None of these identified material breaches in relation to the management of Covid-19 related risks. In a further 5 matters, HSE also issued an enforcement notice(s) to the dutyholder. One notice included a failure to implement appropriate Covid-19 control measures. It is the responsibility of the dutyholder to undertake a risk assessment to identify Covid-19 related risks arising from work activity and to determine the control measures necessary to eliminate (where possible) or mitigate such risks. In this instance, whilst the company had prepared a risk assessment identifying Covid 19 related control measures, none of these had been implemented on site. This included lack of adequate hand washing facilities, lack of social distancing measures and lack of information provided to employees and others at the site on Covid 19 related control measures.

145. During 2021, HSE conducted 44 inspections in social care premises, as detailed in exhibit RGB4/120b INQ000611792. Twenty eight inspections were conducted in England, 7 in Scotland and 9 in Wales. Thirty one of these inspections are recorded as Covid-19 inspections. From the case notes it can be identified that some of these inspections were conducted remotely. As detailed above, these were either inspections specifically focused on the management of Covid-19, general or construction inspections during which control measures for Covid-19 were assessed or spot inspections conducted as part of the spot check

programme. These inspections also included assurance inspections where material breaches relating to the management of Covid-19 related risks had previously been identified at premises controlled by the dutyholder. Two inspections related to construction activities being conducted on social care premises. Five inspections were general inspections to assess health and safety management at the premises. Six inspections were conducted following investigations.

146. Based on the information recorded in the case notes, 28 of the inspections conducted during 2021 were on-site inspections. 2 on-site inspections were cancelled, either due to HSE having recently conducted an inspection and no material breaches had been identified or in one instance, HSE was aware that CQC were planning to undertake a full inspection at the premises. Eight inspections were conducted remotely. There are 6 instances where it is not clear from the case notes whether a site or remote inspection took place.

147. Based on the case notes available, 3 of the Covid-19 inspections were linked to the receipt of a concern. One of the concerns raised related to an outbreak of Covid-19 at a particular premises. Two concerns were raised regarding Covid-19 control measures, including one which was raised by the manager of the premises. A further 3 non-Covid related inspections were also linked to concerns. Two inspections were linked to the receipt of a RIDDOR report. These were not Covid-19 related.

148. Following the inspections, HSE issued 6 dutyholders with a NOC. Two of these followed a Covid-19 inspection. A further 3 matters resulted in the issuing of enforcement notices. One of these followed a Covid-19 inspection where an Improvement Notice was issued for failing to comply with face fit testing requirements. In a separate matter, Improvement Notices were issued to a dutyholder in relation to failing to undertake a suitable and sufficient risk assessment of risks relating to the workplace transmission of SARS-CoV-2 and failure to provide adequate training to staff on Covid-19 related control measures.

149. During 2022, HSE conducted 12 inspections in social care premises, as detailed in exhibits RGB4/120b INQ000611792 and *Copy of Covid Inquiry – inspection data*

request period 29 June 2022 to 31 December 2022 -TiY 15 April 2025 produced as exhibit RGB4/120c INQ000611793. Six inspections were conducted in England, 5 in Scotland and 1 in Wales. Of these inspections, 4 were general inspections to assess management of health and safety, 4 were construction inspections and 4 were inspections following an investigation (one of which related to construction activities). From the case notes available one of the general inspections appears to have been linked to the receipt of a RIDDOR. Five inspections are linked to the receipt of a concern although there is insufficient information in the case notes to determine the precise nature of the concerns raised. All of the inspections were conducted on-site.

150. Arising from these inspections, HSE issued 2 dutyholders with NOCs. In a further 4 matters, enforcement notices were issued to dutyholders. One matter was referred for a decision on prosecution.

151. In 2023 HSE conducted 11 inspections in social care premises. Six of the inspections were inrelation to construction activity, 3 were general inspections and 2 were inspections conducted following an investigation. Six inspections resulted in HSE issuing NOCs to dutyholders. A further 3 inspections resulted in enforcement notices being issued. One of the inspections is linked to the receipt of a concern, although case notes for 2 other inspections also make reference to concerns raised by other regulators. Three inspections are linked to the receipt of a RIDDOR report. This information is detailed in *Copy of Covid Inquiry – Data Request – Inspections HC – 1 January 2023 to 31 March 2024 – TiY 14 April 2025* produced as exhibit RGB4/120d INQ000611794.

Spot Checks and Spot Inspections conducted in social care during the pandemic

152. As previously highlighted, the spot check programme was implemented by HSE and Local Authorities in addition to HSE's regime of inspections outlined above. The programme of spot checks was implemented between 22 May 2020 and 31 March 2022. Some spot inspections conducted as stage 3 of the spot check process were recorded on HSE's database and are captured as part of the inspection data provided. However not all spot inspections were recorded in this manner.

153. Separate records compiled specifically in relation to spot check activity highlight that a total of 56 spot checks were undertaken by HSE and Local Authorities in medical nursing homes including 4 spot inspections conducted by HSE Inspectors. A total of 843 spot checks were conducted by HSE and Local Authorities, including 32 spot inspections by HSE Inspectors. Of these, 11 spot checks were conducted in premises categorised under the SIC code as residential care activities. This included 1 spot inspection. Fifty five spot checks were conducted in premises classified as residential nursing homes, including 16 spot inspections. Across premises classified as residential care activities for people with learning difficulties or suffering from mental health and substance abuse conditions, 3 spot checks were conducted including 1 spot inspection. In relation to providers classified as providing residential care activities for the elderly or disabled, 626 spot checks were conducted, including 6 spot inspections. One hundred and forty eight spot checks were conducted in premises classified as other residential care activities. This included 8 spot inspections (exhibit RGB4/135 INQ000269760). Action taken following spot checks included the issuing of 2 NOCs and a further 3 matters that resulted in the issuing of enforcement notices.

154. Spot checks and spot inspections were undertaken in England, Scotland and Wales. Across all social care settings (including medical nursing homes), 871 spot checks were conducted in England, including 26 spot inspections. In Scotland, 15 spot checks were conducted, including 3 spot inspections. In Wales, 13 spot checks were conducted, including 7 spot inspections.

Reporting under RIDDOR

155. Paragraphs 170 to 177 below build on the summary provided in paragraphs 92 to 93 above.

156. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 [RIDDOR] were made under the HSWA and provide the national reporting framework for responsible persons (usually employers, the self-employed and people in control of work premises) to report certain cases of injury, diseases and

specified dangerous occurrences to the relevant enforcing authority (HSE or local authority). The regulations apply to all sectors and workplaces in Great Britain, including social care settings.

157. The purpose of RIDDOR is to inform the enforcing authority in a timely fashion that an incident or event has occurred and allow an appropriate regulatory response to be made.

158. In making a report under RIDDOR, the responsible person is not admitting blame or wrongdoing, they are simply discharging their statutory duty to report an incident or event to the regulator. A failure by the responsible person to report as required by the regulations amounts to an offence punishable with a fine and/or imprisonment.

159. In relation to Covid-19, reports should only be made under RIDDOR when one of the following three conditions applies:

a. Dangerous Occurrence

An accident or incident at work has, or could have, led to the release or escape of coronavirus. This must be reported as a dangerous occurrence (under Regulation 7 and Schedule 2). This is usually where work is deliberately taking place with the virus, e.g. in a laboratory.

b. Case of disease

A worker has been diagnosed as having Covid-19 that is attributed to an occupational exposure to coronavirus. This must be reported as a disease due to an occupational exposure to a biological agent (under Regulation 9 (b)). "Attributed" means that there is reasonable evidence that the workplace exposure was the likely cause of the disease.

c. Case of fatality

A worker dies as a result of an occupational exposure to coronavirus. This must be reported as a work-related death due to exposure to a biological agent (under

Regulation 6(2)). "As a result of" means that there is reasonable evidence that workplace exposure was the likely cause of the worker's death.

160. Reporting of work-related incidents is subjective; the responsible person needs to exercise their own judgement as to whether an incident was work-related or not. Therefore, the strength of the RIDDOR reporting system relies heavily on two elements, a responsible person making a report; and the quality of the information in that report.

161. RIDDOR was drafted to capture single one-off unexpected events (injury incidents and dangerous occurrences). It was not intended to be used in a pandemic involving thousands of instances of infection, where an employer may be required to make a judgement as to whether a worker caught the infection as a result of a workplace exposure or from the wider community.

162. HSE manages an online reporting database for all RIDDOR reports, whether the enforcing authority is HSE or the Local Authority under the EA regulations. Depending on the business activity selected by the notifier under Standard Industrial Classification codes [SIC], the form is automatically routed within the database to either HSE or Local Authority teams. In some cases individual reports are allocated in the system to the wrong enforcing authority. If this happens the relevant team manually re-direct the form to the correct enforcing authority and further communications may be necessary between HSE and Local Authorities if there is ambiguity over where responsibility for the premises lies under EA Regulations.

RIDDOR guidance during the pandemic

163. HSE first published specific guidance on reporting Covid 19 related matters under RIDDOR on 2 April 2020. The guidance titled *RIDDOR reporting of COVID-19* produced as exhibit RGB4/121 INQ000269762 set out that the responsible person was required to make a RIDDOR report if there was reasonable evidence that a worker diagnosed with Covid-19 was exposed to the agent while at work.

164. Subsequently amendments were made to the guidance and to the RIDDOR reporting form to provide further information to dutyholders on when to report a matter under RIDDOR and to enable Covid-19 related reports to more readily identifiable. Further guidance published on 7 April 2020 *RIDDOR reporting of COVID-19* produced as exhibit RGB4/122 INQ000269763 confirmed the need to report a fatality where the cause of death was confirmed by a medical practitioner as resulting from workplace exposure to coronavirus. The guidance was accompanied by a change in the format of the RIDDOR reporting form which enabled the responsible person to record a fatality as attributable to Covid-19. The form and guidance *Changes to the RIDDOR reporting form for Occupational Disease; Cancer; and Exposure to Biological Agents (fatal and non-fatal outcomes),* were implemented from 10 April 2020 and are produced as exhibit RGB4/123 INQ000346204.

165. HSE published amended guidance on 30 May 2020 *RIDDOR reporting of COVID-19* produced as exhibit RGB4/124 INQ000269882 and *Further guidance on RIDDOR reporting of COVID 19* produced as exhibit RGB4/125 INQ000269884. This provided greater detail to assist responsible persons in understanding when a work-related exposure would require a RIDDOR report. The guidance provided can be summarised as follows:

    a. For a case of disease to be reportable due to occupational exposure to a biological agent there must be reasonable evidence suggesting that a work-related exposure was the likely cause of the Covid-19 infection.

    b. For a fatality to be reportable as a death due to an occupational exposure to a biological agent, there must be reasonable evidence that an occupational exposure to coronavirus caused the worker's death.

    c. It is the employer (responsible person) who decides when a report is required. They must make a judgement, based on the information available, as to whether a confirmed diagnosis of Covid-19 (i.e. a positive test) is likely to have been caused by an occupational exposure at work.

d. This means that not all Covid-19 infections or deaths of workers are reportable as not all infections will have been contracted by an occupational exposure at work - they could have been caught from family members or in the community.

e. There is no requirement under RIDDOR to report cases of Covid-19 infections or deaths of members of the public, patients, care home residents or service users as such cases do not arise out of an occupational exposure to the virus.

166. The guidance published on 1 April 2022 *Coronavirus (COVID-19) – Advice for workplaces* produced as exhibit RGB4/126 INQ000269883 confirms that RIDDOR reporting requirements relating to Covid-19 infections, or deaths from Covid-19, only apply where an employee has been infected with coronavirus through:

a. Deliberately working with the virus, such as in a laboratory; or
b. Being incidentally exposed to the virus (incidental exposure can occur when working in environments where people are known to have Covid-19, for example in a health or social care setting).

167. The change in guidance from April 2022 was introduced as HSE returned to its core role of regulating workplaces to ensure the safety of workers and others affected by the risks created by work activity. It resulted in the requirement to report general workplace transmission ceasing from 1 April 2022. The change was consistent with the Government's move towards living with Covid-19.

RIDDOR reports received during the pandemic

168. HSE publishes RIDDOR statistics on 'all reports', irrespective whether HSE or Local Authorities are the enforcing authority. Alongside other data sources, this helps establish the overall scale and nature of workplace injuries. Having both HSE and Local Authority enforced RIDDOR reports in one data pot also makes for easier collation and statistical reporting.

169. Within adult social care settings, there are different SIC codes that are used to differentiate between types of social care provision. They are:

a. 86102 Medical nursing home activities
b. 87100 Residential nursing care facilities
c. 87200 Residential care activities for learning difficulties, mental health and substance abuse
d. 87300 Residential care activities for the elderly and disabled
e. 87900 Other residential care activities

170. RIDDOR does not capture data at the 5-digit level of the standard industrial classification, it only captures data at the 4-digit level of the standard industrial classification. This means that the data for Medical nursing home activities (SIC 86102) is combined with Hospital activities (SIC 86101) data under the umbrella of SIC 8610.

171. Data relating to RIDDOR reports received by HSE between January 2019 and December 2023 has been extracted from HSE's database and a summary of the data *Covid Inquiry – all RIDDORS 2019 to 2023* is produced as exhibit RGB4/127 INQ000595130.

172. Between January 2019 and December 2023 across Great Britain the total number of RIDDOR reports received by HSE was 34,537. Of the 34,537 reports, 2,469 reports were flagged in the database as either non-reportable or duplicate. The total 34,537 is broken down in the following 5 tables:

Year	**2019**	**2020**	**2021**	**2022**	**2023**	**Total**
Injury reports -fatal and non-fatal	4,555	4,096	4,271	3,993	4,255	-
Reports of defined Diseases, Carcinogens, and Exposures to Biological Agents	6	6,053	3,983	2,593	426	-

including Covid-19						
Reports of defined Dangerous Occurrences	66	104	50	39	47	-
Total No of RIDDOR Reports	4,627	10,253	8,304	6,625	4,728	34,537

Injury reports (fatal and non-fatal)					
Year	**2019**	**2020**	**2021**	**2022**	**2023**
HSE enforced					
SIC 8610	6,186	5,580	5,864	5,594	5,914
SIC 8710	1,787	1,775	1,798	1,850	1,850
SIC 8720	671	461	485	396	521
SIC 8730	308	287	306	251	257
SIC 8790	392	311	383	318	345
HSE Total	**3,158**	**2,834**	**2,972**	**2,815**	**2,973**
Local Authority enforced					
SIC 8610	2	1	3	3	2
SIC 8710	51	68	51	40	63
SIC 8720	478	444	470	369	461
SIC 8730	648	533	538	562	533
SIC 8790	220	217	240	207	225
LA Total	**1,397**	**1,262**	**1,299**	**1,178**	**1,282**
HSE and LA enforced					
SIC 8610	6,188	5,581	5,867	5,597	5,916
SIC 8710	1,838	1,843	1,849	1,890	1,913
SIC 8720	1,149	905	955	765	982
SIC 8730	956	820	844	813	790
SIC 8790	612	528	623	525	570
HSE+LA Total	**4,555**	**4,096**	**4,271**	**3,993**	**4,255**

Reports of defined Diseases, Carcinogens, and Exposures to Biological Agents (incl. COVID)					
Year	2019	2020	2021	2022	2023
HSE enforced					
SIC 8610	74	5,943	3,790	1,471	413
SIC 8710	2	3,578	1,472	856	220
SIC 8720	0	259	447	214	18
SIC 8730	1	503	433	265	31
SIC 8790	0	194	176	20	2
HSE Total	3	4,534	2,528	1,355	271
Local Authority enforced					
SIC 8610	0	0	0	0	0
SIC 8710	0	151	84	239	50
SIC 8720	1	371	450	330	29
SIC 8730	2	880	758	610	74
SIC 8790	0	117	163	59	2
LA Total	3	1,519	1,455	1,238	155
HSE and LA enforced					
SIC 8610	74	5,943	3,790	1,471	413
SIC 8710	2	3,729	1,556	1,095	270
SIC 8720	1	630	897	544	47
SIC 8730	3	1,383	1,191	875	105
SIC 8790	0	311	339	79	4
HSE+LA Total	6	6,053	3,983	2,593	426

Reports of defined Dangerous Occurrences					
Year	**2019**	**2020**	**2021**	**2022**	**2023**
HSE enforced					
SIC 8610	610	558	498	435	489
SIC 8710	20	49	26	9	19
SIC 8720	1	8	2	3	8
SIC 8730	6	5	2	4	2
SIC 8790	4	3	2	0	2
HSE Total	**31**	**65**	**32**	**16**	**31**

Local Authority enforced					
SIC 8610	0	0	0	0	0
SIC 8710	2	5	1	0	1
SIC 8720	5	10	9	8	2
SIC 8730	27	17	6	8	12
SIC 8790	1	7	2	7	1
LA Total	**35**	**39**	**18**	**23**	**16**
HSE and LA enforced					
SIC 8610	610	558	498	435	489
SIC 8710	22	54	27	9	20
SIC 8720	6	18	11	11	10
SIC 8730	33	22	8	12	14
SIC 8790	5	10	4	7	3
HSE+LA Total	**66**	**104**	**50**	**39**	**47**

All reports made – injuries, diseases, dangerous occurrences					
Year	**2019**	**2020**	**2021**	**2022**	**2023**
HSE enforced					
SIC 8610	6,870	12,081	10,152	7,500	6,816
SIC 8710	1,809	5,402	3,296	2,715	2,089
SIC 8720	672	728	934	613	547
SIC 8730	315	795	741	520	290
SIC 8790	396	508	561	338	349
HSE Total	**3,192**	**7,433**	**5,532**	**4,186**	**3,275**
Local Authority enforced					
SIC 8610	2	1	3	3	2
SIC 8710	53	224	136	279	114
SIC 8720	484	825	929	707	492
SIC 8730	677	1,430	1,302	1,180	619
SIC 8790	221	341	405	273	228
LA Total	**1,435**	**2,820**	**2,772**	**2,439**	**1,453**
HSE and LA enforced					
SIC 8610	6,872	12,082	10,155	7,503	6,818
SIC 8710	1,862	5,626	3,432	2,994	2,203
SIC 8720	1,156	1,553	1,863	1,320	1,039
SIC 8730	992	2,225	2,043	1,700	909
SIC 8790	617	849	966	611	577
HSE+LA Total	**4,627**	**10,253**	**8,304**	**6,625**	**4,728**

Reviewing, analysing and taking action following the receipt of RIDDOR reports during the pandemic

Review of RIDDOR reports

173. At the beginning of the pandemic HSE recognised it would likely see in increase RIDDOR reports relating to worker Covid-19 fatal and non fatal incidents. In response HSE created additional guidance. As a regulator, HSE's overall approach to Covid-19 RIDDOR was that they were all treated in the same way

regardless of whether the reports came from the health care sector, adult social care or other sectors. HSE wrote internal guidance for operational staff who were involved in reviewing RIDDOR reports, specifically *Responding to COVID-19 RIDDOR Dangerous Occurrences, Diseases and Fatalities to employees* produced as exhibit RGB4/128 INQ000595009 and *Annex 1 Flow Chart Covid -19 RIDDOR Selection & Handling Procedure* is produced as exhibit RGB4/129 INQ000595007. The aim of the guidance was to ensure consistency in the approach taken to reviewing Covid-19 related RIDDOR reports and to support the identification of suitable cases for investigation and the early steps to be taken in the investigation process. The guidance made it clear that decisions to investigate RIDDOR reports should be consistent with HSE's Incident Selection Criteria [ISC] and investigated in line with HSE's Investigation Procedure [IP]. Any action taken as a result of an investigation should also be consistent with HSE's Enforcement Management Model [EMM] and Enforcement Policy Statement [EPS].

174. In addition to the production of the guidance, a dedicated email account was created to capture and record Covid-19 RIDDOR data. This was done because accurate information on the numbers, location and types of reports was crucial to allow HSE to assess the pressures on operational divisions and to provide information to other government departments.

175. All RIDDOR reports received by HSE (as the enforcing authority) during the relevant period were sent to Principal Inspectors in HSE's operational teams for triage. This triage process required the Principal Inspector to determine whether the incident was reportable under RIDDOR. If it was reportable, the Principal Inspector was then required to apply the Incident Selection Criteria. The guidance specifically stated that Covid-19 non-fatal RIDDOR reports of occupational disease in workers or dangerous occurrences would not meet the ISC for mandatory investigation, save for in exceptional circumstances. In such cases the RIDDOR report would need to be discussed with the local Head of Unit and by a Divisional virtual team before any decision to investigate was made.

176. For matters that met the incident selection criteria (including all fatal Covid-19 related RIDDORs), the Principal Inspector would then make any further initial enquiries required before applying the investigation procedure and submitting a

decision on whether an investigation was required for approval to their Head of Unit. Once the proposed decision was approved by the Head of Unit, it would be submitted to a Divisional Virtual Team for further review. This was to ensure that a consistent approach was being taken to the handling of Covid 19 related RIDDOR reports across all regions.

177. If following review of a RIDDOR report, a decision was taken not to commence an investigation, the RIDDOR would still be used by operational teams as a source of information which could trigger other regulatory action, in particular the conduct of a local priority inspection.

Analysis of RIDDOR reports

178. From April 2020 to March 2022, HSE produced and published monthly management information which detailed the number of RIDDOR reports received by enforcing authorities (HSE and Local Authorities) related to suspected work-related transmission of Covid 19. During this period, 73% of the RIDDOR reports received were from the health and social care sectors. *Management Information: Coronavirus (COVID-19) disease reports made by employers to HSE and Local Authorities* is produced as exhibit RGB4/130 INQ000269879.

179. In addition to publishing monthly management information, HSE undertook analysis of the RIDDOR reports with specific reference to the reporter. This analysis was undertaken to assist Operational teams identify clusters and outbreaks.

180. Whilst not part of HSE's operational analysis of RIDDOR data, HSE also led Theme 1 of the National Core Study which considered outbreaks and clusters from a scientific and modelling perspective. This work was carried out in partnership with UKHSA, University of Manchester and London School of Hygiene and Tropical Medicine. The work involved an analysis of RIDDOR reporting data and other data sources such as information relating to inspections and investigations and spot checks. Theme 1 of the National Core Study began in October 2020 with studies published from July 2021 to August 2024.

Outbreaks and clusters

181. Outbreaks and clusters were principally public health matters that were managed by PHE, PHW and local Health Protection Teams. However in circumstances where the potential source of transmission was identified as a workplace for which HSE was the enforcing authority, upon notification of an outbreak or cluster, HSE would provide assistance and advice to public health teams and also consider whether any regulatory intervention was necessary. HSE produced guidance to assist public health teams to understand its role in outbreak response (exhibit RGB4/131 INQ000269807, exhibit RGB4/132 INQ000269788, exhibit RGB4/133 INQ000269785 and exhibit RGB4/134 INQ000269838). HSE also set up a virtual team to record and process cluster and outbreak notifications and outcomes. The data indicates that HSE received notification of 22 potential outbreaks or clusters in social care settings. Four of these notifications resulted in HSE attending the site (as detailed in exhibit RGB4/135 INQ000269760). Verbal advice was given to three duty holders with no further action taken in respect of the fourth.

Action taken following receipt of RIDDOR reports

182. During the relevant period the receipt of a RIDDOR report may have resulted in a range of different interventions including engagement between the dutyholder and HSE's CAT to gather further information about the reported incident and / or the referral of the report to operational teams to conduct either an inspection or investigation.

183. Data relating to investigations in adult social care premises prompted by the receipt of RIDDOR reports between January 2019 and December 2023 has been extracted from HSE's database. *RIDDOR Request 2019_2023* is produced as exhibit RGB4/136 INQ000595131.

184. The data reflects that between January 2019 and December 2023 there were 469 RIDDOR investigations in social care settings. Of the 469 investigations 95 were during 2019, 165 were during 2020, 90 were during 2021, 69 were during 2022 and 50 were during 2023 Of the 469 investigations 14 resulted in prosecution and 4 of which resulted in notices being served. Of the 14 prosecutions 1 prosecution

relates to Covid-19 measures in a medical nursing home in Scotland, the outcome of which is pending at the date of this statement. During the investigation, HSE identified breaches of s.2 and s.3 of HSWA and reported to the Crown Office Procurator Fiscal Service [COPFS] that the duty holder was alleged to have failed to ensure that staff followed infection prevention control procedures including hand hygiene, use of appropriate gloves and appropriate environmental hygiene practices to reduce the risk posed by the SARS-CoV2 virus to residents of the home where 15 resident deaths occurred Of the 4 notices, 1 Improvement Notice relates to Covid –19 measures in a residential care facility. The Improvement Notice was complied with.

Concerns about RIDDOR underreporting

185. HSE recognised, and our guidance reflected, that the responsible person for the purposes of RIDDOR faced sometimes difficult judgements in assessing whether there was reasonable evidence to support a workplace exposure.

186. In relation to cases of disease, HSE carefully considered whether "diagnosed" in regulation 9 required diagnosis by a medical professional or confirmation by way of positive test. HSE resolved that to conclude the former would likely have resulted in very few reports as it was difficult to see how a medical professional could conclude, in the absence of the worker deliberately working with the virus, that the disease was attributable to a workplace exposure as opposed to exposure outside of the workplace or work activity. HSE therefore took the more pragmatic approach that a positive test would count as "diagnosed" for the purposes of potential RIDDOR reporting.

187. For a case of disease (or a death as a result of disease) to be attributed to a workplace exposure, HSE confirmed in the updated guidance published in May 2020 that there had to be reasonable evidence of workplace exposure and the guidance assisted dutyholders in determining that issue. The decision as to whether to make a RIDDOR report at all times remained with the responsible person.

188. As the pandemic progressed, it became apparent to HSE that there may have been both over and under reporting via the RIDDOR scheme. The initial concern was for over-reporting based on clusters of reports.

189. A paper presented to HSE's Operational and Regulatory Committee on HSE's Operational Response to Covid-19 Disease Notifications highlighted some of the challenges in relation to Covid-19 reporting, including in health and social care settings produced as exhibit RGB4/137 INQ000269829.

190. In addition to the existing published advice on RIDDOR reporting and HSE advice on Covid-19 RIDDOR requirements throughout the pandemic HSE understands that DHSC and the CQC also sent reminders regarding the RIDDOR reporting requirements to the social care sector (exhibit RGB4/138 INQ000269555 and exhibit RGB4/139 INQ000269868).

191. To aid the gathering of intelligence regarding fatalities, HSE was in contact with and met the National Medical Examiner [NME]. The numbers of fatalities recorded by the NME exceeded those reported under RIDDOR. On review, HSE identified a number of cases that would not have been RIDDOR reportable. The test applied by the NME, based upon a review of medical records and any information gathered from a deceased's family, was whether there was a "reason to suspect" that the disease was acquired at work and it seemed that if the deceased had been a frontline healthcare worker, it would be marked as an infection acquired at work. Mere suspicion has been held to mean *'a possibility which is more than fanciful that the relevant fact existed'* [R v Da Silva [2006] EWCA Crim 1654]. This was in contrast to the requirement to report under RIDDOR, which required 'reasonable evidence' that the disease was attributable to workplace exposure. Factors to take into account when deciding whether such evidence exists could include:

i. whether or not the nature of the person's work activities increased the risk of them becoming exposed to coronavirus.
ii. whether or not there was any specific, identifiable incident that led to an increased risk of exposure.

iii. whether or not the person's work directly brought them into contact with a known coronavirus hazard without effective control measures, as set out in the relevant PHE guidance, in place such as PPE or social distancing.

192. This imposes a substantially higher standard than mere suspicion based on assumptions drawn from the fact that the deceased was a healthcare worker. HSE provided assistance to DHSC (exhibit RGB4/140 INQ000269594), from whom medical examiners had sought advice, around who the responsible person might be in respect of agency workers and who they should write to where they suspected a death was work related. This was of general application across industry sectors but it is well known that agency workers are common in the social care sector.

Lessons Learned and recommendations

HSE report 'The Effect of Covid-19 in the Workplace' – January 2021

193. HSE recognised the importance of considering the effect of the pandemic in the workplace, reviewing the measures that employers had put in place to manage workplace risks and any learnings that might assist employers to manage future risks. In July 2020, the HSE Board agreed the terms of reference for a report potentially under s14(2) of HSWA on the effect of the Covid-19 pandemic in the workplace.

194. The report was finalised in January 2021 *The effect of Covid 19 in the workplace* is produced as exhibit RGB4/141 INQ000269707.

Key problems it sought to address

195. The report was to provide an interim analysis and evaluation of the impact of Covid-19 on employers, the workforce and the regulatory environment. The report aimed to identify and enable HSE to communicate any further recommendations for the (then) continuing response to the pandemic, enabling future resilience, learning and effective health and safety risk management. The report focused on

sectors identified as being significantly impacted by the pandemic, in particular health and social care.

196. In order to prepare the report, analysis was undertaken of early HSE activity between April and September 2020 addressing 4 regulatory themes, specifically:

    a. Personal protective equipment (PPE)
    b. Guidance, Freedom of Information and Correspondence
    c. The Health and Social Care response
    d. The regulatory framework

Headline conclusions and recommendations

197. Within the report, the observations and findings were set out under three separate headings:

    a. Findings from HSE activity
    b. Initial Implications for the HSE
    c. Wider implications for the health and safety system

198. The findings from HSE activity highlighted the importance of effective risk management by dutyholders. It was noted that approaches to risk management needed to keep pace with increased knowledge regarding Covid-19 and the importance of communication and the provision of updated information and guidance was acknowledged. Lessons learnt in respect of communication were to feed into HSE's on-going work in this area.

199. The findings highlighted challenges that had been experienced across the health and social care sector in relation to the application of the control hierarchy and PPE. Actions agreed in respect of these findings were to form part of wider business as usual activities across HSE. The findings also highlighted the role of HSE's product safety and surveillance team in enabling the supply of PPE to the required standard to the health and social care sector.

200. The findings noted areas for consideration in relation to the nature of HSE activity during the Covid-19 pandemic, acknowledging the novel situation presented by Covid-19. Learnings highlighted by the report were to be factored into future intervention planning. Lessons learnt in relation to methods of engagement during Covid-19 were to be fed into future work on interventions and in responding to incidents. Targeting poorly managed workplaces and employers was highlighted as a continued area of focus from HSE.

201. Finally in relation to HSE activity, the findings highlighted the impact of the Covid-19 pandemic (as a public health issue) on the wider regulatory framework for the health and social care sector, noting the regulatory responsibilities held by HSE and Local Authorities as well as other agencies and the parallel between management of infection control and worker safety in the health and social care context. Separate actions were agreed to address these matters in future engagement with health and social care regulators and local authorities.

202. The report presented a number of findings which focused on HSE's regulatory activity in response to Covid-19 as a workplace risk. When considering these findings, the steps already taken by HSE to explain its role in relation to the pandemic and its approach to enforcement activity were noted by ExCo. The actions acknowledged the importance of HSE continuing to review and if necessary, adapt its approach as the pandemic continued to evolve. It was also acknowledged that further communications would assist to ensure that stakeholders, dutyholders and the wider public understood HSE's role during the pandemic and the work that HSE was doing in response to the pandemic.

203. The importance of intelligence and information sharing was also highlighted in the report. Again, work done by the HSE in this area was noted by the ExCo and the actions reflected the on-going activity in respect of this matter.

204. The wider implications for the health and safety system section of the report considered implications in respect of employees, employers, intervention choices by HSE, legislative framework and other regulators.

205. In relation to employees, it was agreed that findings in respect of the importance of the tone of employee focused communications would feed into HSE's broader

communications work. The importance of ensuring that all employees could easily contact HSE if they had concerns was highlighted by the findings. In response it was noted that an on-going pilot in Yorkshire and the Humber focused on channels for messaging to low paid workers was relevant to this issue.

206. The report highlighted that behaviours spanning the workplace and beyond raised challenges for targeted public messaging to different groups and individuals. It was agreed that this would be picked up as part of work between HSE, public health bodies and other workplace regulators.

207. In relation to enforcement, the report highlighted that the healthy worker concept had been the subject of scrutiny. In the response to the report, ExCo noted that this issue had already been addressed in the review of enforcement during the Covid-19 pandemic.

208. In relation to employers, the findings highlighted the importance of clear advice, particularly in respect of risk assessment. The report also highlighted potential difficulties in maintaining effective risk control and the importance of the "always on" aspect of good risk management. It was agreed that there would be further consideration of messaging as part of risk management and control.

209. There was separate consideration of matters arising in connection with PPE procurement, in particular how HSE might better address the question of the "intelligent customer" and show the value of interventions at the right point in the supply chain to enable employers to make good risk management decisions. It was agreed that this would be considered as part of developing HSE's strategy and future iterations of sector/ health and work plans.

210. With regard to intervention choices, it was agreed that HSE's concept of operations should be reviewed as part of lessons learned for future novel workplace risks. It was also acknowledged that learnings from the pandemic may be relevant to future priorities, in particular areas that span the work/public health boundary.

211. The benefits of product oversight were highlighted and it was agreed that the importance of product safety as an effective route for worker protection should be

factored into future communications and HSE's broader role in product safety. The benefits of regulator led quality assurance under market surveillance arrangements were also highlighted and it was agreed that this would feed into further work focused on joined up working with other regulators.

212. The report considered factors in relation to targeting, both in relation to targeting workplaces with nominally higher risks of employee outbreaks and targeting interventions on the basis of workplace activity and workforce characteristics. It was agreed that risks in relation to employee outbreaks would continue to be monitored in light of evidence from the National Core Studies on the transmission of the Covid-19. Consideration of targeting based on activity and workforce characteristics was to feed into on-going strategy work.

213. Finally in respect of intervention choices, the report highlighted matters relevant to the application of performance measures and data recording to inform future interventions. It was noted that both issues would be addressed by an on-going workstream.

214. With regard to the legislative framework, the findings considered the boundary between workplace health and safety and public health oversight and the application of relevant legislation. It was agreed that further consideration would need to be given to whether amendments in legislation were needed and further engagement would need to take place between HSE and public health bodies. The report also highlighted questions around the application of RIDDOR. In response, ExCo noted that RIDDOR had not been drafted with a pandemic in mind, resulting in challenges around interpretation. The actions agreed acknowledged on-going work to address this including providing further clarification to NHS Trusts in line with HSE's RIDDOR/Covid-19 guidance. It was also to be addressed as part of lessons learnt work between HSE, public health bodies and other agencies.

215. In relation to other regulators, the findings noted the importance of joined up working with other healthcare regulators and engagement with labour market agencies in shaping future workplace health and safety regulatory strategy. Both findings were agreed and actions set for further consideration by relevant HSE teams.

Assigned owner and status

216. It was agreed by the HSE Board that the ExCo would decide on any proposed actions following on from the report's findings. Following further engagement with the Board, the finalised response to the report was presented to the Board on 28 September 2021 *The effect of COVID19 in the workplace – Internal Report* is produced as exhibit RGB4/142 INQ000269698. ExCo's response to the report was set out in *Annex 1*, *Annex 2* and *Annex 3* of the internal report, detailing the findings, observations from the ExCo and actions.

217. A significant number of the actions agreed by ExCo were focused on ensuring that the learnings from the report were fed into on-going and future work during the pandemic and / or wider HSE strategy planning as well engagement with fellow regulators and stakeholders. HSE continued to review and where appropriate, adapt its approach throughout the pandemic, particularly as knowledge of the virus increased. The lessons learned continued to evolve throughout the pandemic.

218. HSE does not have any specific recommendations that it would ask the Chair to the Inquiry to consider over and above those which have already been set out and addressed above.

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: 6 June 2025