Sarah Newton
Chair, Health and Safety Executive
Sarah.LNewton@hse.gov.uk

29 April 2022

cc sarah.albon@hse.gov.uk
cc Andrew.curran@hse.gov.uk
cc alison.wellens@hse.gov.uk

Dear Ms Newton,

The continuing wave of COVID-19 infections, including hospital-acquired infections, causes us to write, once again, to express our concern at the health risks which members of the undersigned health professional bodies are exposed to whilst caring for patients infectious with COVID-19.

We remain concerned that UK-HSA/DHSC policy, guidance and practice in relation to Respiratory Protective Equipment is leaving healthcare workers (HCWs) at significant risk. It is not only at odds with the scientific evidence but also with the most recent WHO guidance and it certainly does not ensure, so far as is reasonably practicable, the health and safety of HCWs.

In your letter of 15 December 2021, you dismissed the issues that we had raised with you in our letter of 25 November 2021 concerning the worker health crisis in the NHS arising from workplace exposure to the SARS-CoV-2 virus (COVID-19). Your basis for dismissing our concern was that the Department for Health and Social Care (DHSC) and the UK Health Security Agency (UK-HSA) are the government experts in public health and infection prevention and control (IPC).

With the greatest of respect, we would point out that the issue of concern to us is neither one of public health nor of IPC (which relates to the protection of patients from infection) but one of worker health and safety for which the Health and Safety Executive (HSE) are the experts and the competent regulatory authority. We reject the notion that HSE has no role to play in ensuring that HCWs are suitably and sufficiently protected from disease acquired as a part of their work activities. To the contrary, you have the foremost role to play in this.

You refer to the "experts in DHSC, UK-HSA and Devolved Administrations", but we would point out to you that, amongst the health professional bodies whom we represent, we have an equal, if not greater number of experts in this field. It is becoming quite apparent that the views expressed by our experts over the past two years of the pandemic are steadily being proved to be correct, whereas the views held by the IPC experts in the World Health Organisation (WHO) and UK IPC organisations are being proved to be wrong. We refer specifically to the fact that COVID-19 is now known to be highly transmissible via the airborne route and that COVID-19 hospital-acquired infections are far less prevalent in NHS health trusts which have adopted Respiratory Protective Equipment (RPE) as a default for staff caring for COVID-19 patients, as opposed to those which strictly adhere to the IPC guidance of wearing fluid-resistant surgical masks where no aerosol generating procedures are being undertaken. We will be happy to discuss the evidence for this with your experts, should you wish to convene a meeting.

Furthermore, we are growing increasingly frustrated at having our concerns ignored and dismissed by government organisations, whilst receiving trite platitudes along the lines of "We recognise the incredible commitment and dedication of health and social care workers during these challenging times" and "their health and safety is and continues to be a priority for us" which, you may remember, were the closing sentences of your letter of 15 December 2021. If the health and safety of the healthcare workers whom we represent is, indeed, a priority for you, then we entreat you to exercise your regulatory role by ensuring that HCW's are provided with effective RPE whenever working with COVID-19 infectious patients (as, indeed, is the recommendation of the World Health Organisation). We do not understand why HCWs across Europe, America, Canada and many other areas are routinely provided with filtering face piece respirators when treating COVID-19 positive patients when here in the UK we are denied this protection.

During the pandemic thus far, HSE has made it very clear that responsibility for policy on respiratory protection of healthcare workers rested with PHE and latterly UK-HSA. Now that responsibilities have changed, arising from the relaxation of public health rules, what does HSE now see its role to be in ensuring that the hazardous exposures to COVID and the accompanying psychological damage is being properly managed by NHS employers?

In our letter of 25 November we raised a crucial point that the mortality rates amongst clinical and non-clinical workers in healthcare indicate a sectoral issue which would prompt further investigation in any other safety-critical industry. Of all the issues upon which the HSE is called upon to address, surely death at work is the most important? Any death at work is a tragedy but, when it happens to people whose vocation is to save the lives of others, then it is even more grievous, particularly in view of the number of HCW fatalities involved. We are therefore disappointed and dismayed that, in your reply to us, you failed to even mention this, let alone make any commitment to initiate such an investigation. It must be said that this portrays the HSE as being uninterested and uncaring. We call on you once again to launch such an investigation, with particular reference to airborne transmission of the virus and respirable risk. As previously mentioned, CAPA has a number of experts in the field of occupational hygiene and occupational medicine and we would welcome the opportunity to work together with your specialist inspectors during any such investigation. We know that HSE recognises the value of consultation and collaboration with specialist representatives from industry sectors, so please let us know if you would like to take up this offer.

We have recently become aware of some correspondence with your Chief Executive which has been reported in the press. We understand that allegations have been made that the authors of UK IPC guidance should be investigated for a breach of health and safety legislation with a view to potential prosecution in the criminal courts. Please be assured that CAPA has absolutely no interest whatsoever in such matters. We are not concerned with 'blame' or holding anyone to account for advice they may have given. Our sole concern is to ensure that the thousands of members whom we represent are provided with effective respiratory protection to ensure their health and safety.

However we note that, in the above-mentioned correspondence, some very pertinent questions were asked of Ms Albon which she failed to answer. We feel that these questions are very relevant to the matters which concern us. It is not unreasonable to expect some direct answers.

Please would you therefore respond to the following:

1) Did the HSE's Chief Scientific Advisor, together with the Environmental Modelling Group, publish a paper on 14 April 2020 confirming the airborne risk presented by the virus? Did he not also confirm that inhalation exposure to fine aerosols could be a more significant part of transmission than the direct deposition of droplets onto mucous membranes? More recently, has he confirmed to a Commons Select Committee that the airborne route of transmission is the most critical?

2) Is the SARS-Cov-2 virus (the causative agent of COVID-19) deemed to be a biological agent assigned the classification of "hazard group 3" in that it can cause "severe human disease and may be a serious hazard to employees"*, thereby placing it firmly within the auspices of the Control of Substances Hazardous to Health Regulations 2002 (as amended)?

   * COSHH Schedule 3, Part 1, paragraph 2(2)(c).

3) WHO state that the virus spreads between people when an infectious person coughs, sneezes speaks or breathes. Is the SARS-CoV-2 virus therefore considered to be a "micro-organism in an airborne state" within the meaning of paragraph 6, appendix 6, HSG 53, requiring workers to be protected by RPE which offers a protection factor of at least 20?

4) Does paragraph 160 of L.5 the COSHH Approved Code of Practice state that, in order to be suitable and comply with COSHH Regulation 7(9), RPE must be capable of adequately controlling the inhalation exposure using, as a guide, the equipment's Assigned Protection Factor (APF) as listed in HSG53? i.e. with regard to (3) above, an APF of 20?

5) Do Fluid Resistant Surgical Masks offer an APF of 20?

6) Are Fluid Resistant Surgical Masks of a type approved by the HSE? (If so, please would you be so good as to provide verification of this)

7) Do Fluid Resistant Surgical Masks conform to a standard for respiratory protection that is approved by the HSE? (If so, please would you confirm which standard for respiratory protection they conform to.)

8) If the answers to (6) and (7) above are both 'NO', does HSE agree that Fluid Resistant Surgical Masks are not, and never have been, designated as "Respiratory Protective Equipment" and do not therefore provide the standard of worker protection required by the COSHH Regulations {Regulation 7(9) in particular} ?

   We have also been made aware of preparatory meetings, the first held on the 20th April, between the UK IPC cell and a clinical oversight group whose first task will be to conduct a review into the mode of transmission and whether the droplet/aerosol paradigm has served us well or needs revising. Given this admission from the IPC Cell, being the expert body advising NHS trusts, that their paradigm may be flawed, and in light of the recent revisions to the outdated AGP list, this furthers our contention that the experts upon whom the HSE are relying have been incorrect in their assertions. HSE therefore need to listen to alternative views on the existing evidence base. As previously indicated, CAPA members have considerable experience and expertise in this area and will be happy to assist your specialist inspectors with this.

9) Following recent correspondence with the Scottish First Minister, we have been informed by the Chief Nursing Officer (CNO) for Scotland that "HSE support the UK IPC Cell guidance (Winter 2021-22) in terms of PPE and RPE". Please would you confirm whether this is the case, since following similar such claims HSE has firmly denied that it has "directed, influenced or supported the PPE policy in relation to COVID-19 infection prevention and control guidance for healthcare settings". Please would you confirm whether or not the CNO is correct in her assertion.

10) Do you agree with the statement of HSE's scientists, as stated in Research Report R619 (2008) that "since there is no specified safe exposure level for biological agents … the general requirement is to reduce the exposure '**as low as is reasonably practicable**' (ALARP) and HSE's stance is that where there is a respiratory risk of infection use of FFP3 devices represents best practice and that where these are not available then FFP2 may be an acceptable, pragmatic compromise"?

We support your scientists' view on the basis that COVID-19 (as with any 'hazard group 3 or 4' pathogen) should be considered analogous to a non-threshold carcinogen, mutagen or respiratory sensitiser for which the ALARP requirement applies as per COSHH Regulation 7(7)(c). FRSMs do not reduce risk as low as reasonably practicable.

We note that in your letter of 15 December you specifically single out "healthcare workers caring for infectious patients" as coming under the protection of the COSHH Regulations and that employers are expected to use "up to date and relevant guidance". In this particular instance the most relevant guidance in connection with respiratory protection against infection from the airborne virus is the above-mentioned HSE guidance "HSG53: Respiratory Protective Equipment at Work : A Practical Guide". We note that HSG53 makes not one single reference to surgical masks, since these are not even considered PPE, let alone RPE. Since this guidance has a quasi-statutory basis by virtue of being referenced in an "Approved Code of Practice" it takes precedence over any other guidance which may be produced in relation to public health or patient care guidance such as IPC. Indeed the IPC guidance stresses the importance of compliance with Health and Safety legislation. We are therefore at a loss to understand how HSE, as the regulatory and enforcement agency, can condone the use of surgical masks for staff involved in the care of COVID-19 infectious patients. Please would you explain your reasons?

We note that Regulation 7(6)(h) imposes a duty on employees working with persons who are infected with a Group 3 agent such as SARS-CoV-2 (or suspected to be infected) to implement certain prescribed control measures set out at Schedule 3 Part II. These include a number of control measures including:

- separating the workplace from other activities in the same building,
- Maintaining workplace air at negative pressure
- HEPA-filtration on extracted air from rooms containing the infected persons
- Sealing the workplace to permit disinfection

We fully appreciate that, during a pandemic, it will not be possible for such measures to be applied in all hospitals, care homes, ambulances, and other environments where infected persons will be present. However, we mention this regulation in order to stress the point as to how seriously a group 3 pathogen must be treated, and the high standards of health and safety control measures deployed. Provision of surgical masks is simply not an acceptable control measure when providing close-quarter care of infectious patients and we call upon you to publicly recognise this instead of continually deferring to DHSC, UK-HSA etc.

We note that certain Freedom of Information requests have been submitted to HSE but which have been rejected by yourselves. These were:

1) To explain the basis for HSE considering that compliance with Public Health England Guidance concerning PPE represented "effective control measures" (as displayed online by HSE on the RIDDOR-reporting guidance pages); and
2) To provide copies of the "technical input" which HSE has provided to those responsible for the IPC guidance (Your letter 17 June 2021 ref CETO-198-21).

We consider that both of these requests were entirely reasonable, and we hereby resubmit these FoI requests collectively on behalf of CAPA. This time we hope for a more proactive and cooperative response from yourselves.

In view of the commitment made in your letter that the health and safety of health and social care workers continues to be your priority, we look forward to receiving a substantive response to the above questions and a commitment to ensuring that guidance issued from other Government departments complies with health and safety legislation, which is clearly not the case at the present time in respect of respiratory protection.

Yours sincerely,

Dr Barry Jones MD FRCP, Chair of CAPA* - Covid Airborne Protection Alliance

*CAPA

- ARTP - Association for Respiratory Technology & Physiology
- BAPEN – British Association for Parenteral and Enteral Nutrition
- BIASP – British and Irish Association of Stroke Physicians
- BDA – British Dietetic Association
- BOHS - British Occupational Health Society
- BSG - British Society of Gastroenterology
- College of Paramedics
- CSP – Chartered Society of Physiotherapy
- FreshAir NHS
- GMB Union
- HCSA - Hospital Consultants and Specialists Association
- MSDUK Med Supply Drive UK
- NNNG - National Nurses Nutrition Group
- QNI - Queen's Nursing Institute
- RCSLT – Royal College of Speech and Language Therapists
- Unite the Union
- Doctors Association UK