

Dr Barry Jones MD FRCP

Chair of the Covid Airborne Protection Alliance (CAPA)

Chief Executive

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Dear Dr Jones,

Thank you for your letter of 29th April 2022, on behalf of the Covid Airborne Protection Alliance. As the issues you have raised are primarily operational in nature, Sarah Newton has asked me to respond to you directly on behalf of the Health & Safety Executive (HSE). In addition, I am aware that you have also written to a number of HSE's non-executive board members directly on these matters - this response should be also be considered HSE's response to those items of correspondence, in addition to the letter to our Chair. I would like to stress that we continue to take your views seriously and to address the concerns that you have raised.

In considering my response, I have liaised directly with senior scientific and regulatory colleagues within HSE, including Professor Andrew Curran, our Chief Scientific Adviser and a member of the Scientific Advisory Group for Emergencies (SAGE). With reference to the specific supplementary questions that David Osborn asked following his first open letter, I have already made it clear that I do not intend to add anything further to my original response.

Coronavirus (COVID -19), like other infectious diseases, remains first and foremost a public health matter. Whilst, as you have noted, other experts may disagree with them, as we have made clear in previous correspondence, DHSC, working closely with UKHSA and the devolved administrations are the government experts in public health and infection control. They lead the Government response on how to manage COVID-19 and other respiratory infections both in the community and in the workplace.

Since April 2022, HSE no longer expects every business to explicitly consider COVID-19 in their risk assessment or to have specific measures in place. However, where employees will come into contact with a biological agent due to their work activity, for example in researching the virus in laboratories or health and social care workers caring for infectious patients, the Control of Substances Hazardous to Health 2002 Regulations (COSHH) will apply. In these cases, employers are expected to assess the risks to their workers created by these work activities and to implement appropriate measures to

control risks in accordance with the hierarchy of control, which should take into consideration factors such as the approved classification of the biological agent. Further information on the COSHH regulations can be found [here](#).

In making the assessment, employers are expected to use up to date and relevant guidance. The four nations guidance, [Infection prevention and control for seasonal respiratory infections in health and care settings \(including SARS-CoV-2\) for winter 2021 to 2022 - GOV.UK \(www.gov.uk\)](#) has been, and remains, HSE's regulatory benchmark for the minimum standards for COVID PPE in healthcare settings. We consider this the most up to date and relevant guidance and it is more specific than the more general guidance for RPE in HSG53 to which you refer in your letter.

Scientific evidence is used to inform a risk assessment, which is an integral part of systematic risk management. This approach requires employers to consider the context in which a hazard is encountered (e.g. environment, organisational culture, work practices etc) as well as the scientific evidence to ensure that control measures that are identified reduce the risk effectively in the specific context in which it is encountered.

The Environmental Modelling Group's paper on 14th April 2020 highlighted that "The dispersion of virus is due to a complex interaction between people either generating or interacting with virus particles and conditions defined by the local environment. This includes the layout of the space and conditions including air movements and ventilation rates, temperature and humidity. It is more nuanced than a simple distinction between airborne and contact driven, and there is a pressing need to understand potential risks with a finer degree of granularity than in current population epidemic models". [SAGE paper Apr 2020 Final-redacted.pdf \(publishing.service.gov.uk\)](#)

[At the Select Committee session on 26th October 2021](#) Professor Curran also highlighted that the relative importance of the three main routes of transmission were part of a continuum of risk, and the importance could vary from scenario to scenario. He agreed that, in the first part of the pandemic, the role of aerosol transmission may not have been fully realised but that, 'It is very difficult to say that one route is more important than another because the key issue is that we are dealing with complex systems, and, when risk factors accumulate in particular settings, the mix of risk factors could mean that a different route of transmission is more important in that particular setting compared to another setting.'

This scientific evidence base is constantly evolving. The SAGE EMG Group and the National Core Study (NCS) team, of some 160 researchers and more than 15 academic and public research groups, have been keeping this under review, and, in the case of NCS, developing new knowledge. HSE is leading one of the National Core Studies, which is specifically investigating the transmission of SARS-CoV-2. We have convened a large group of experts who are looking at the characteristics of the virus, the specific risk factors in relation to the environments in which it can be encountered and the human behaviours which can lead to transmission in these environments. The following website gives more information, and is updated with publications from this work ([PROTECT COVID-19 National Core Study | \(manchester.ac.uk\)](#)). In relation to

your question regarding scientific report R619 (2008) all HSE scientific reports are the opinion of the individual researchers and not HSE as a whole. In addition, when forming regulatory standards, it is important to look at the breadth of evidence and not focus on one specific study. Also, R619 (2008) was delivered at a time before any knowledge regarding SARS-CoV-2, so its conclusions need to be considered in the context of the pandemic and not just the “laboratory conditions” used in the research project.

In the health care sector, there are only a small number of activities where, according to the UK government’s infection prevention and control guidance, respiratory protective equipment (RPE) such as a tight-fitting FFP3 respirator is recommended as a control measure to manage the risks of exposure to COVID 19 - principally whilst performing aerosol generating procedures (AGPs), or unless a local hierarchy of control risk assessment identifies a need for RPE, for example as a result of inadequate ventilation, where a tight-fitting respirator is required to be worn, then it should have a protection factor of at least 20 and must have an adequate seal with the wearer’s face, in order to provide this protection. This is achieved through fit testing by a competent person and is a requirement set out in HSE’s guidance including [L5 Control of substances hazardous to health, Approved Code of Practice.](#)

If RPE is necessary, then Fluid Resistant Surgical masks would not be appropriate. Type IIR surgical masks have always been classified as medical devices and are regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). This position has not changed during the pandemic. Whilst the main purpose of type IIR surgical masks is to mitigate wider transmission by providing source control, they have been manufactured to a recognised European standard and tested to provide a certain level of fluid resistance (this is the R designation in type IIR) and so they can be used to reduce direct transmission of large droplets/splashes through the nose and mouth and, thus, afford some protection to the wearer.

The WHO and IPC guidance are under constant revision as more scientific information on SARS-CoV-2 is developed. How the two pieces of guidance feed into each other and how they use the global scientific research that is available to them is outside HSE’s remit. Likewise, it would be inappropriate for HSE to agree to a meeting with CAPA to discuss a matter on which they are not the Government expert and do not lead.

You are correct that there has been a meeting of the Clinical Oversight Group for the National Infection Prevention and Control Manual for England and this meeting included discussions about the evidence and literature reviews and methodologies to be applied. If you want to know more about this work you should contact NHS England and NHS Improvement.

In previous correspondence with you, Sarah Newton informed you of the inspection and enforcement work carried out at NHS Boards or Trusts in connection with the management of COVID risk, including investigation of work-related COVID-19 deaths and I do not propose to reiterate that. Suffice it to say that we take our role as independent regulator extremely seriously and ensure that employers are adequately

controlling risks to their workers in accordance with the most appropriate standards and guidance as outlined.

You have asked whether HSE would consider investigating health worker related deaths as a sectoral issue. We do not consider this is necessary at this time as the UK COVID Inquiry, under its draft terms of reference intends to review the impact on health and care sector workers during the pandemic.

HSE will respond to any outstanding Freedom of Information requests separately.

I thank you for your correspondence and I hope this response is of use. As you would expect, we will keep our position under review as new information emerges

Yours sincerely

A handwritten signature in black ink, appearing to read 'Sarah Albon', written in a cursive style.

Sarah Albon

Chief Executive