The Covid Airborne Transmission Alliance

Briefing for

SAFER HEALTHCARE BIOSAFETY NETWORK

patient safety learning

CATA and the UK Covid-19 Public Inquiry

Presented by

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CATA – Aims and Objectives

CATA's intentions are closely aligned with the those of the Inquiry itself, namely to examine the UK's response to the Covid-19 pandemic and the impact it has had, particularly in the context of the health and social care sector.

Our over-riding objective is to learn lessons for the future so that we may be better prepared for future pandemics.

In order to learn these lessons, policies, decisions and actions of individuals and organisations need scrutiny. However the purpose is not about blame or recrimination.

CATA seeks to assist the Inquiry with its investigations by providing evidence which it has obtained, together with the lived experience of its members.

In this presentation I shall outline CATA's current views and opinions, although these may change as more evidence comes to light during the course of the Inquiry. They should be regarded as tentative and provisional, but we hope that CATA's input will assist the Inquiry in its investigation and production of recommendations for the future.

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CATA – Origins and Evolution of the Alliance

January 2020 :

- **Novel coronavirus identified as a close relative of SARS (2003), a respiratory disease transmissible by airborne route (aerosols/droplets)**

- **Early IPC guidance reflected this and confirmed that the 'Precautionary Principle' would apply**

The "Precautionary Principle" : Where there is a risk of serious or irreversible harm, a lack of full scientific certainty shall not be used as a reason for postponing the implementation of effective risk control measures.

- **The NHS geared itself up for widespread use of respirators such as filtering face-pieces** (e.g. FFP3).

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CATA – Origins and Evolution of the Alliance

March 2020 :

- **The highly questionable and controversial decision was made to downgrade staff protection from RPE to Fluid Resistant Surgical Masks** (FRSMs)
  - except for AGPs and ICU / ITU / HDU

- **Reference to the "precautionary principle" was dropped from the IPC guidance**

- **The disease was no longer designated as 'High Consequence'.**

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CATA – Origins and Evolution of the Alliance

- **Many Professional/Medical Colleges and Associations recognised that certain medical procedures/activities which presented a high risk of infection were not included in the official list of AGPs, putting their members at extreme risk of disease whilst carrying them out e.g.**
  - ***Nasogastric Tube Insertion***
  - ***Dysphagia Assessment***
  - ***Chest Physiotherapy***
  - ***Cardiopulmonary Resuscitation***
- **A common factor being the physiological response resulting in expulsion of infectious materials.**

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August 2020:The AGP Alliance is Formed

- **In a move, unprecedented in NHS history, these organisations and trade unions joined together in an alliance to campaign for better protection for workers, their mission being to PREVENT DISEASE AND DEATH :**

- BAPEN – British Association for Parenteral and Enteral Nutrition
- BASP – British Association of Stroke Physicians
- BDA – British Dietetic Association
- BSG - British Society of Gastroenterology
- The College of Paramedics
- CSP – Chartered Society of Physiotherapy
- HCSA - Hospital Consultants and Specialists Association
- NNNG - National Nurses Nutrition Group
- RCSLT – Royal College of Speech and Language Therapists
- Unite the Union
- Unison
- GMB UNION

Liaising closely with RCN and BMA

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The AGP Alliance Campaigns…

- **Press Releases**
- **Open Letters to:**
  - ***The Prime Minister, Ministers and MPs***
  - ***The Secretary of State for Health and Social Care***
  - ***Public Health England (later UK-Health Security Agency)***
  - ***Committees (e.g. NERVTAG)***
  - ***World Health Organisation***
  - ***Commons Select Committees***
  - ***NHS (Chief Medical / Nursing Officers***
  - ***The Health and Safety Executive***
- **OUTCOME:**
  - ***Either completely ignored (no response at all);***
  - ***Or mostly just received 'platitudes' but no acceptance of the key points raised. NO CHANGE FROM ' DROPLET-BASED' POLICY*** 7/30

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2021: The Alliance Expands

- **Other organisations join the Alliance:**
  - ***ARTP - Association for Respiratory Technology & Physiology***
  - ***CBS – Confederation of British Surgery***
  - ***FreshAir NHS***
  - ***Medical Supply Drive UK***
  - ***QNI – Queen's Nursing Institute***
  - ***Doctors Association UK***
  - ***The British Occupational Hygiene Society***
  - ***Trident HS&E.***

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2021: The Alliance Broadens its Scope

- Scientists demonstrate that simple coughing can generate equivalent levels of airborne aerosols as some AGPs
- The Alliance now considered the official AGP List irrelevant and RPE should be provided for ALL direct (close-quarter) care of patients not just AGPs, ICU's etc
- Since the name 'AGP Alliance' no longer reflected the organisation's core principles it changed its name to **CAPA**, the **Covid Airborne Protection Alliance**

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The UK COVID-19 Public Inquiry

- Some CAPA member organisations preferred to take other routes to the Inquiry
- The 10 organisations which remained were joined by:
  - *Patient Safety Learning*
  - *BIASP British and Irish Association of Stroke Physicians (formerly BASP)*
  - *Plus 7 individuals with specific background knowledge and/or personal front-line experience (including Long-Covid)*
- This revamped organisation adopted the name CATA (Covid Airborne Transmission Alliance)
  - *CATA is a Core Participant at the Public Inquiry (module 3)*
  - *CAPA remains as the campaigning arm of the Alliance.*
- CATA appointed Saunders Law as its legal representative.

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CATA's key points of submission to the Inquiry

- Poor planning and preparation for pandemics
- The airborne route of transmission of SARS-Cov-2
- Failure to provide Respiratory Protection to HCWs
- Failure to consider post-viral syndromes
- Recognition of 'Occupational Exposure' / RIDDOR.

Poor Planning and Preparation for Pandemics

- Mismanagement of the PPE stockpile
- Failure to consider diversity of the workforce
  - *Racial and religious factors not considered*
  - *RPE (eg FFP3) modelled on Caucasian males*
  - *Unsuitable for some women, smaller people and those from non-Caucasian ethnic backgrounds (facial characteristics important)*
  - *Tight-fitting RPE unsuitable for men with beards (as in some religions)*
  - ***Seemingly no consideration of the Equality Act 2010***
- Abandonment of 'general ward' and paramedics to FRSM (NERVTAG sub-committee / Pandemic PPE 2016)
  - **"All general ward, community, ambulance and social care staff to wear single use FRSMs for close patient contact".**

COVID-19 Transmission Routes

CATA's main contention:

- **COVID-19 is transmitted by the airborne route i.e:**
  - ***Via inhalation of infectious aerosols released through normal physiological processes including:***
    - Coughing
    - Sneezing
    - Singing / Speaking / Shouting
    - Tidal breathing
- **CATA acknowledges the other 2 routes of transmission may also have some relevance:**
  - ***Ballistic droplets impacting on susceptible mucosa (mouth, nose and eyes);***
  - ***Fomites (touch transfer from deposits on surfaces).***

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The Airborne Route of Transmission

The airborne transmission of beta-coronaviruses:

- ***Was already well established before the pandemic struck***
- ***Was accepted as such by IPC guidance (Jan 2020)***
- ***No further research was needed***
  - **Viruses do not change to a less favourable route of transmission from an evolutionary point of view.**

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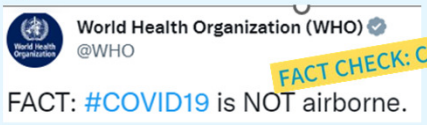
COVID-19 Transmission Routes

CATA further contends that widespread MISINFORMATION that "COVID IS NOT AIRBORNE" emanated from :

1) THE WORLD HEALTH ORGANISATION (March 2020):



2) DHSC / PHE / NHS and, in particular, the group known as the "4-Nations IPC-Cell" who published IPC Guidance supported by "ARHAI" in Scotland.

Q. WHY DOES THIS MATTER?

A. Because Healthcare Workers were denied the respiratory protection they needed to keep them safe.

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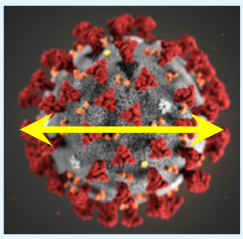
Comparison : Tuberculosis vs Covid-19

Relative sizes of Mycobacterium tuberculosis bacillus vs SARS-CoV-2



0.146 microns

Relative size of SARS-CoV-2 virus to TB bacillus (to scale)

Since it is accepted that a TB bacillus is spread via airborne route, entrained in aerosols, then it would be a perverse logic to deny that relatively tiny objects such as a respiratory virus cannot also become entrained in aerosols and follow the same route of transmission

EVIDENCE CONFIRMS THIS.

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COVID-19 Transmission Routes

- **24 November 2022 :**
- **World Health Organisation Chief Scientist regrets stance on airborne transmission**

- **Soumya Swaminathan :**
  - ***"We should have acknowledged aerosol transmission much earlier, based on the available evidence"***
  - ***"We were not forcefully saying 'This is an airborne virus'. I regret we didn't do this much much earlier".***

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Failure to provide Respiratory Protection

- **Surgical Masks (incl FRSM) are not, and never have been 'Personal Protective Equipment'**

Whilst they will provide a physical barrier to large projected droplets, they do not provide full respiratory protection against smaller suspended droplets and aerosols.

That is, they are not regarded as personal protective equipment (PPE) (PPE Regulation 2002 SI 2002 No. 1144)

Source : https://www.hse.gov.uk/biosafety/diseases/pandflu.htm#ref15

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Failure to provide Respiratory Protection

- **Surgical Masks (incl FRSM) are not, and never have been 'Personal Protective Equipment'**
- **NHS Procurement advice** (online May 2020 – Jan 2022)

Type I, I R, II and II R face masks are medical masks tested in the direction of exhalation (inside to outside) and take into account the efficiency of bacterial filtration. Surgical masks of this type stop the wearer from infecting the surrounding environment. They are not effective at protecting the wearer from airbourne diseases such as coronavirus.

N.B. Bacteria, not viruses

Source: https://nhsprocurement.org.uk/covid-19-a-guide-to-face-masks/25 May 2020

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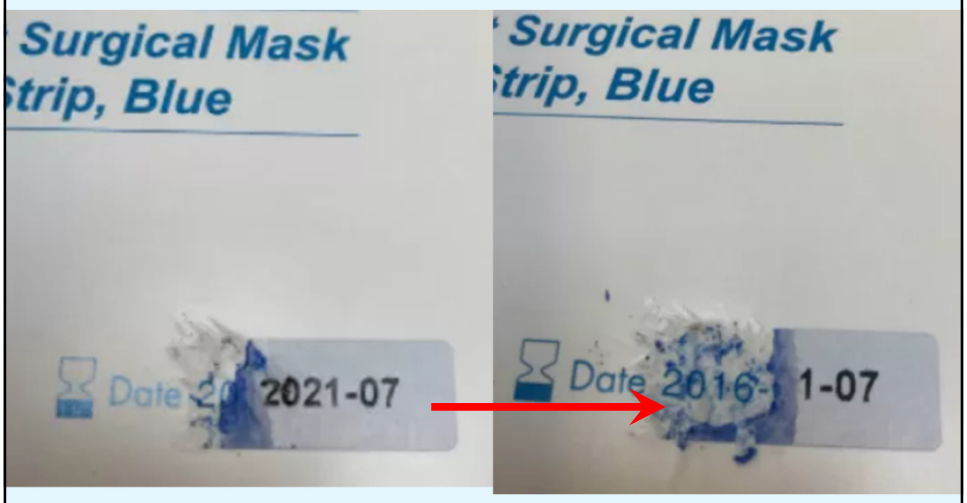
Failure to provide effective Respiratory Protection

- **HCWs were issued with RPE & FRSM way past expiry date**



Source: BBC News

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Failure to provide effective Respiratory Protection

- HCWs were issued with RPE & FRSM way past expiry date
- Concerned HCWs were reassured that these had undergone 'stringent' testing to prove that they were safe

The Department of Health and Social Care (DHSC) said equipment underwent "stringent tests" and was given a "new shelf-life" where appropriate.

- CATA will offer evidence to the Inquiry suggesting that the tests were far from 'stringent', nor that 'a new shelf-life' was appropriate.

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Failure to provide effective Respiratory Protection

- IPC guidance was prescriptive : "FRSMs must be worn when delivering direct care within 2 metres…"
- Yet COSHH requires RPE with a protection factor of 20 for biological hazards in an airborne state
- FRSMs are so poor at protection that they cannot even be properly assigned a protection factor and have a 100% fit test failure rate!

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Recognition of 'Occupational Exposure' / RIDDOR

CATA is concerned at the apparent failure by HSE to enforce the RIDDOR Regulations within Health and Social Care and considers this worthy of further investigation by the Inquiry. We believe:

- **This resulted in massive under-reporting of Covid deaths and ill-health by H&SC employers (especially NHS)**
- **'NHS Employers' contributed to this by publishing incorrect and misleading guidance on RIDDOR reporting**
- **These failings:**
  - *Prevented the Government, the HSE or other interested parties such as healthcare workers themselves from maintain an overview of where and how failures in personal protection were resulting in infection, serious illness or death; and*
  - *May have deprived healthcare workers of routes to compensation, insurance payouts and state benefits.*

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Recognition of 'Occupational Exposure' / RIDDOR

HSE were heavily criticised in Parliament

Report of the Work and Pensions Select Committee : 12th May 2020

250. **HSE concedes that the number of occupational deaths it has recorded through RIDDOR reporting is likely to be significantly lower than the reality, particularly in NHS settings. We are not persuaded that its efforts to tackle under-reporting have gone far enough or fast enough. In early June, it was still working on new guidance.**

251. ***We recommend that the Health and Safety Executive (HSE) quickly adopts a more proactive response to ensuring that the risks and deaths linked to workplace coronavirus exposure are properly recorded by care homes, NHS bodies, and other workplaces where there is a high risk of exposure to the virus.***

The recommendations of these concerned MPs were seemingly ignored

Recording of C-19 deaths and occupational disease) did not improve

Instead of proactively improving reporting, CATA has identified multiple instances of HSE proactively discouraging or rejecting RIDDOR reports

We have questioned HSE on these occurrences but they remain silent. 24/30

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Recognition of 'Occupational Exposure' / RIDDOR

Freedom of Information Survey revealed massive under-reporting during the first and second waves of COVID-19:

	Number	Percentage
Number of Trusts sent Freedom of Information Requests	214	
Number of Trusts which returned data	210	98%
Number of Trusts which reported zero in respect of Regulation 9(b) *i.e. claiming that not one HCW in their Trust acquired work-related COVID-19*	124	59%
Number of Trusts which reported zero in respect of Regulation 6(2) *i.e. claiming that not one HCW died as a result of work-related COVID-19*	172	82%
Number of HCW deaths reported in total	95[4]	

Table 1: *Summary data concerning RIDDOR reports made to HSE by NHS Trusts in England*

124 Trusts made not one single report of occupationally-acquired C-19 disease

172 Trusts made not one single report of an HCW death due to occupational C-19

CATA has called upon the Inquiry to investigate whether any underlying policy decisions were involved.

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Recognition of 'Occupational Exposure' / RIDDOR

RIDDOR reports concerning occupational disease are required when there is "reasonable evidence that someone was diagnosed with the disease was likely exposed because of their work"

An example of 'reasonable evidence' given by HSE during the height of the 'first wave':

"A healthcare professional who is diagnosed with Covid-19 after treating patients with covid-19".

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Recognition of 'Occupational Exposure' / RIDDOR

NHS Trusts/Boards refuse to report on the basis that the employee did not have a positive Covid test result

They are absolutely wrong!

The Regulations simply require a diagnosis of the disease by a registered medical practitioner. This can be based on symptoms alone – no test is required by the law

Access to testing was not always possible and PCR tests have quite a high 'false negative' rate (~9% according to some research) and there is evidence that laboratory errors can occur.

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Recognition of 'Occupational Exposure' / RIDDOR

NHS Trusts/Boards refuse to report on the basis that they were "providing PPE in line with national guidance"

Again, absolutely wrong!
This has no legal basis whatsoever

In any workplace, if an employee sustains injury, disease or death through their work, it is reportable regardless of whether or not any PPE was being worn.

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Recognition of 'Occupational Exposure' / RIDDOR

NHS Trusts/Boards refuse to report on the basis that it could not be proven that the employee caught the disease through their work

Again, absolutely wrong!

This has no foundation whatsoever within RIDDOR

The test is that of the "balance of probabilities" or "Is it more likely than not" - NOT ABSOLUTE PROOF

If a HCW caught the disease, say, working 12-14 hour shifts with highly infectious patients. Clearly "yes", particularly when lockdowns were in place. 29/30

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Recognition of 'Occupational Exposure' / RIDDOR

The net result is that healthcare workers who have been dismissed by NHS Trusts/Boards on the grounds of long-term ill-health, with no official record that their disease was, more likely than not, due to occupational exposure

This may have serious long-term consequences for them when it comes to claiming any State Benefits or compensation that they might be entitled to should the State decide to support these forgotten heroes of the front line. 30/30

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The End

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