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cc : See list below

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Dear Minister,

Your correspondence with Tim Farron MP (Re: Ms Anne McConway 14/03/2025) has been shared with us as the consortium of scientific and professional bodies who provided much of the evidence to the COVID-19 Inquiry as invited core participants.

Having read your letter we are concerned that you have once again been wrongly advised, as was your predecessor, about the most appropriate scientific evidence on the transmission of Covid-19. As the Minister responsible for the response to COVID-19, but also infectious diseases more generally, this is a matter of great concern.

In your letter, you state: "The UK Government remains in line with the World Health Organization's position that COVID-19 is not predominantly transmitted through the airborne route." This is incorrect. The WHO has, over the years, reviewed and, as a result, revised their guidance on the transmission routes of Covid-19. Examples include the WHO

Interim statement in December 2021 [WHO-2019-nCoV-IPC Masks-Health WorkersOmicron variant-2021.1-eng.pdf](#)

The WHO Chief Scientist Soumya Swaminathan, when leaving her role in November 2022, also stated that her biggest regret was not acknowledging early in the pandemic that SARSCoV-2

could be spread by aerosols. (<https://www.science.org/content/article/who-sdeparting-chief-scientist-regrets-errors-debate-over-whether-sars-cov-2-spreads>)

The WHO has now reviewed their approach to the terminologies applied to transmission routes, distinguishing “airborne transmission/inhalation” and “direct deposition” (analogous to droplet transmission). [Global technical consultation report on proposed terminology for pathogens that transmit through the air](#). Within the revised approach, WHO classifies COVID-19 as a disease predominantly spread by Inhaled Respiratory Particles. This is not merely a terminological change, but one which represents a better understanding of the behaviour of particles and moves away from looking at particle size.

However, it is important to recognize that the definition of droplets still adhered to by NHSE/NIPCMs) is scientifically incorrect. Although first noted as long ago as 1934 by Wells¹, more recent studies confirm that the droplets to which the NIPCM refers are in fact aerosols². As far back as 2021, the Government-appointed experts in SAGE and the "Respiratory Evidence Panel" all accepted the Milton definition of aerosols with its 100 micron threshold: [https://assets.publishing.service.gov.uk/media/618e6822e90e07043f2b95d5/Respiratory Evidence Panel Evidence Overview.pdf](https://assets.publishing.service.gov.uk/media/618e6822e90e07043f2b95d5/Respiratory_Evidence_Panel_Evidence_Overview.pdf) So size does matter.

For further evidence please refer to the evidence to the Covid Inquiry given by the Inquiry expert, Prof Clive Beggs.

The terminology now used internationally is not reflected in the current UK IPC guidance, which still maintains a distinction based upon droplet size. Thus, if the Government aims to align with the WHO, it needs to ensure an update of the National Infection Protection and Control manual, which, although it has been reviewed, does not align with current WHO science in this area.

You further state, “The evidence given at the COVID-19 Inquiry by representatives of NHS England also aligns with current scientific evidence, and the Government's support of that remains unchanged.” It is correct that, alone among all of the witnesses, Dr Lisa Ritchie, Deputy Director of Infection Prevention and Control (speaking for NHSE), maintained that she personally believed that COVID-19 was spread by the droplet route. However, she also states that she, in her role in NHSE, was not there to determine the science. Scientific determinations were made by UKHSA (PHE), SAGE etc.

For example, as early as 22 July 2020, NERVTAG and SAGE-EMG co-produced a paper entitled the “Role of Aerosol Transmission in COVID-19” which sets out the significant shift on the part of the WHO in acknowledging aerosol transmission outside of aerosolgenerating procedures and the need for protections against aerosol transmission.

In that respect the evidence of NHSE, via Dr Ritchie, was at odds with evidence given by all other witnesses, including those working for Government advisory bodies. All accepted that scientific understanding had evolved and that “airborne transmission” played a role in causing the deaths and illness of healthcare workers and continues to do so.

The NHSE is also out of step with the government's own public health videos during the pandemic which showed the importance of ventilation to disperse aerosols produced by infected people in enclosed spaces such as the home. Furthermore, in your recent letter, you refer to the importance of ventilation. However, ventilation is only effective against airborne pathogens, demonstrating inconsistency within your response and amongst your advisers.

A paper entitled "Covid-19 and occupational impacts" still available on the government website and "Presented to Parliament by the Secretary of State for Work and Pensions" November 2022 states "The main route is airborne transmission through inhalation of aerosols" <https://www.gov.uk/government/publications/covid-19-andoccupational-impacts/covid-19-and-occupational-impacts>

Your advisors should also be aware that Baroness Hallett, Chair of the UK Covid-19 Public Inquiry, published her report for Module 1 of the Inquiry on 18 July 2024. This unequivocally stated that the "primary routes of transmission for pandemic influenza and coronaviruses are airborne and respiratory". In Modules 2 and 3, experts including Professor Cath Noakes, Professor Clive Beggs, Dr Gee Yen Shin, Professor Dinah Gould and Dr Ben Warne brought together the latest scientific evidence, confirming the importance of the airborne route by comparison with the so-called droplet route.

Again, the WHO's position on this is not the same as NHSE, having departed from the position proposed by government witnesses, which centred on droplet size distinctions. WHO focuses not only on the nature of the scientific evidence about the disease, but the context in which healthcare happens and an appropriate consideration of risk.

You go on to say: "Until scientific evidence confirms a change in transmission dynamics, current infection prevention and control measures will remain in place - these prioritise ventilation (see above), hygiene and appropriate use of personal protective equipment." WHO's position affirms that COVID-19 is spread through the air by inhalable respirable particles and by direct deposition of semi-ballistic particles. The latter requires droplet precautions (surgical mask, barriers etc.). The former requires a risk-based approach and access to adequate and suitable alternative RPE with the required Assigned Protection Factor (as well as instituting other measures from the hierarchy of control to reduce residual risk). It should be noted that droplets are never exhaled without aerosols so protection against both modalities is essential. As stated, WHO no longer requires a direct association between the transmission route and the appropriate controls required. If the Government is following NHSE's outdated approach of only considering the scientific evidence around transmission routes, as previously defined and determined incompletely by the IPC Cell's only source of literature review (ARHAI), to determine controls, then this policy is out of step with WHO. The scientific approach has nonetheless changed and findings of the National Core Study on COVID-19, funded by the UK Government,

provide a very sound evidential basis for reconsideration of the science beyond the echo chamber of NHSE.

It is worth, once again, pointing out that national IPC guidance is regarded as mandatory in England and is a means by which bodies subject to CQC inspection can meet duties under the [Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK](#). This is explicitly subject to the legal requirement that bodies comply with their duties under the Health and Safety at Work Act 1974 and associated regulation, including the Control of Substances Hazardous to Health (COSHH). COSHH requires that those with a duty to employees protect against exposures hazardous to health through all transmission routes, so far as reasonably practicable, not just the main route. Thus, even using the former approach to airborne transmission, which even your own previous correspondence (11/3/ 2025) admitted was a transmission route, there remains a duty on the government, government bodies and employers to protect workers against infection by this route and to protect health workers from breaches of that law.

Your response highlights that NHS employers are being put at risk of breaking the law and you and the Secretary of State for Health and Social Care are being set up to fail in your duty. Baroness Hallett's module 1 report raised concerns about "groupthink" within Whitehall and strongly suggests that ministers question their advisers more closely before accepting their advice. This would seem to be an opportune moment for such reflection.

As the Government struggles to battle an increasing burden in benefits costs, burgeoning numbers of people with Long Covid, mental health problems, NHS recruitment and retention issues, it seems absurd that it would continue to resist against the weight of scientific evidence in defence of a position maintained by a body it is scrapping. By abandoning the dogmatic adherence to droplet transmission as the only route to protect against COVID-19 and other seasonal respiratory illnesses, the focus can be put on how we best protect healthcare workers at times of peak demand to lessen the pressure on them and NHS finances.

Your letter will be a gift to those litigating against the NHS as it shows that the Government is continuing to promote an unlawful position which is in breach of COSHH, has failed to take into account relevant considerations, including the current guidance from WHO, takes into account irrelevant considerations, such as the scientific opinions of the IPC cell on the science of transmission and consequently is continuing to allow a situation to prevail where there is no real scientific uncertainty as to the consequences of uncontrolled exposure of workers to COVID-19.

We have included a link to our latest letter (04/03/ 2025) to the four Chief Nursing Officers [letter-to-4-nations-cnos-from-cata.pdf](#) so you are aware of our ongoing correspondence with those accountable for the oversight of IPC guidance across the UK which also brings these concerns to their attention. Given the abolition of NHSE as announced on 13/ 03 /2025, there is

an opportunity for this government to re-set where responsibility and governance for the development of IPC guidance should lie.

We would suggest that the IPC guidance needs to be immediately reviewed by a competent, inclusive and multidisciplinary panel with the future development and regulation of IPC guidance drafted to explicitly reflect statutory Health and Safety duties and COSHH. It should require formal approval by the Health and Safety Executive. Healthcare bodies are inherently conflicted between operational and spending commitments, and their obligations to provide effective controls to protect healthcare workers. As a sector including some of the UK's largest workforces, HSE should have a more direct and leading role in assuring occupational hygiene is embedded into IPC, along with compliance with Health and Safety law.

We would be happy to meet with you to discuss our letter in more detail. Yours

sincerely,

Professor Kevin Bampton, CEO BOHS

On behalf of the CATA Executive Team:

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cc Rt Hon Wes Streeting MP, Secretary of State (Health and Social Care) cc Sir Stephen Timms Minister of State (Department for Work and Pensions) cc Tim Farron MP cc APPG Long Covid cc Sarah Stanger, Bond Turner

cc Kevin Digby, GA Solicitors

cc Cyrlia Knight, Ben Curtis, Christina Ashibogu, Saunders Law

References

[1] W Wells, Am J Hyg 193430:611-616.

[2] DK Milton A Rosetta stone for understanding infectious drops and aerosols. J Ped. Inf. Dis. Soc 2020;9:413-415.

