OPEN LETTER

To : Ms Sarah Albon, Chief Executive, Health and Safety Executive

Date: 14 March 2022 Your Ref: CE-04322

Dear Ms Albon

Offences committed by the members of the NHS Four Nations IPC Cell etc under section 36, Health and Safety at Work etc Act 1974 (HSWA)

Thank you for your reply to my open letter of 7th February, received this morning. You are absolutely correct in your observation that I would expect you to deny any failings on the part of the HSE. Indeed I did and my expectation has been duly fulfilled.

Neither was it a surprise to learn that the "eminent physicians and scientists" (as you describe them) of the IPC Cell do not share my opinion that their IPC guidance has been seriously flawed. With respect, it is barely surprising that the individuals accused of implementing policies which may have caused death, serious disease and long-term disability in so many people do not share my opinion. They must indeed be comforted in the knowledge that the HSE holds them and their work in such high esteem. I assure you that there are many healthcare professionals at the front line of the NHS who do not.

You are correct that I did not seek to reopen our discussion last year, since my concerns were brushed aside with repeated assertions that COVID-19 is a public health matter and not for HSE. With respect, the protection of the 1.8 million health and care workers liable to be exposed to a lethal virus as a part of their work has been (and remains) very much HSE's responsibility whether you choose to accept that or not. Please correct me if I am wrong, but I am not aware of any revocation or amendment of section 18 of the Health and Safety at Work etc Act 1974.

You say that you cannot start an investigation into my allegations because it is an "opinion". It most certainly was not "just an opinion". It was (and it remains) an allegation of a criminal offence supported by a reasoned argument founded in law, clearly setting out the breaches involved and by whom these were committed. I expect more than just a comment that *"We considered, discussed and decided not to investigate*". It was quite reasonable and appropriate for me to mention that I did not expect HSE to share the details of any investigation it might carry out with me due to confidentiality obligations.

However, that should not be taken to mean that I did not expect a reasoned, justifiable explanation as to why you reject the allegation and refuse to investigate if that was your decision. So please may I invite you, your Chief Scientific Advisor and Director of Regulation to answer just a few straightforward questions with a simple "**YES**" or "**NO**" to each. This should not take you long, given your collective expertise in this area.

1) Did your Chief Scientific Advisor, in his/EMG paper concerning COVID-19 published on 14 April 2020, confirm 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 (*the mantra of WHO/IPC Cell*) ? **YES/NO**
2) Is the SARS-CoV-2 virus therefore considered to be a potentially lethal micro-organism in an airborne state within the meaning of paragraph 6, appendix 6, HSG 53? (By way of reminder, RPE is required for these which offers a protection factor of at least 20?) **YES/NO**
3) Does paragraph 160 of L.5 the COSHH Approved Code of Practice (with all the legal compulsion associated with an ACoP) state that in order to be suitable, RPE must be capable of adequately controlling the inhalation exposure using, as a guide, the equipment's Assigned Protection Factor as listed in HSG53? i.e. with regard to (2) above, an APF of 20 **YES/NO**
4) Do Fluid Resistant Surgical Masks offer an APF of 20? **YES/NO** or even an APF of 10? **YES/NO**
5) Are Fluid Resistant Surgical Masks of an type approved by the HSE? **YES/NO** (If 'YES' please provide the evidence)
6) Do Fluid Resistant Surgical Masks conform to a standard for respiratory protection that is approved by the HSE? **YES/NO** (If 'YES' please state which standard for respiratory protection they conform to.)
7) If the answers to (5) and (6) above are both 'NO', does HSE agree that Fluid Resistant Surgical Masks are not, and never have been, designated as "Respiratory Protective Equipment"? **YES/NO**
8) If an employer (such as an NHS Trust, for instance) fails to provide employees with approved RPE in order to protect them from a potentially fatal airborne, microbiological hazard which, when encountered as an integral part of their work, clearly presents a higher risk to them than ordinary community transmission, then is that employer in breach of COSHH Regulation 7 and thereby committing an offence under criminal legislation? **YES/NO**

9) Does Section 36 of the Health and Safety at Work etc Act 1974 make it an offence for a person, or group of persons, to provide advice or instruction to a duty holder (say, an NHS Trust) which in turn causes that NHS Trust to commit an offence under, say, COSHH Regulation 7? **YES/NO**

I look forward to receiving your answers to these straightforward questions.

I note your cautionary note about "*seeing the decisions made in the early months of 2020 through the 'lens' of what we know today about the airborne transmission of COVID-19*".

With respect, that "lens" first focused on the problem of disease transmission by the airborne route many, many years before SARS-CoV-2 evolved. Arguably one can go back to the acceptance that even relatively enormous microorganisms such as the TB bacillus can become airborne in aerosol droplets. It beggars belief that even the most eminent scientists and physicians in the IPC Cell cannot seem to understand the fact that, if a TB bacillus can be transmitted by an aerosol particle, then a tiny little virus 1/260th the size can be transported in like manner.

But we don't have to go back half a century or more. We only need to look at the paper published in 2013 by various authors including [redacted] (Deputy Chief Medical Officer) and [redacted] (NHSE/I IPC, a member of the IPC Cell) who directly focused the lens on airborne transmission: ""*Protection against aerosols required filtration of inhaled contaminated air (i.e. the use of respirators*)", "*Surgical face masks do not provide protection against airborne (aerosol) particles and are not classed as RPE*".

We could also focus our 'lens' on the time when HSE, clearly knowing that SARS-CoV-1 was transmitted by the airborne route, published its guidance that healthcare workers should wear FFP3 masks when attending an infected patient. If it were not airborne, then surely a FRSM would have sufficed? Given that, at a very early stage in the pandemic, it was determined that the morphological properties of SARS-CoV-2 were highly similar to its predecessor, it would have been entirely reasonable to adopt the precautionary principle and in line with the core principles of good safety management, to work on the basis that it would also be airborne.

But we don't even have to go back to 2013. You talk about the seeing the decisions in the "early months of 2020" as if we now know that COVID is transmitted by the airborne route, but have only just discovered it. However we (including you) <u>did</u> know, in the early months of 2020 that the virus presented an airborne risk (viz the paper published by your Chief Scientific Advisor/EMG in April 2020 confirming it). So please don't pretend to me that this is something that we have only just discovered. As you very well know, it is not.

I do not have the professorial title of your Chief Scientific Advisor and I may not be considered an "eminent" scientist, but I am a scientist with a reasonable background in microbiology, biochemistry and epidemiology (having tutored the subject for several years). As soon as the pandemic struck in 2020, after a few prudent checks on the scientific data emerging and other related diseases it was patently obvious to me that the disease would be spread by airborne transmission, whilst not decrying the other modes of transmission. I suspect that, if the truth be known, it was equally obvious to HSE scientists and most of your HSE inspectors. Whether they would ever admit to that is a function of their own personal codes of ethics vs a requirement to 'tow the party line'. I expect that one day this may be tested.

Please reconsider this matter, review my previous letter and, this time, please would you now do me the courtesy of providing a substantive reply to the points I have raised.

Since this is an 'open letter' which will be publicly accessible, I propose to display any response that you might care to make alongside this letter on my website, Any personal information will be redacted. As before, I shall also make the letter and your responses available to the ByLine Times and any other media outlet which has an interest, since there is a growing interest within the healthcare sector (in the UK and abroad) about HSE's involvement in the pandemic.

Yours Sincerely

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iosh Chartered Safety and Health Practitioner

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(address and contact details provided on accompanying e-mail)

cc: Ms Sarah Newton, Chair, Health and Safety Executive