OPEN LETTER

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

Date: 24 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)

Since writing to you on 14 March the IPC guidance to which my complaint relates has been reissued by the UK-HSA / IPC Cell. I therefore find it necessary to write again to express my concern at this ever more bizarre and perplexing guidance, which fails to follow any type of science that I recognise.

The timing was rather unfortunate, with the new guidance being published the day after I wrote to you, otherwise I could have dealt with this all in one letter. Please would you therefore take this letter as a continuation of my previous letter. I also have to take issue with the assertions made in your letter of 14 March concerning the World Health Organisation, about which you are mistaken. I also have some observations to offer regarding the criteria for launching criminal investigations that you set out in the same letter.

1) IPC guidance issued 15 March 2022

The whole essence of the IPC guidance is founded on whether any given disease is transmissible by one of three routes: Airborne (inhalable aerosol), Droplets (impinging on the mucosa of the nose/mouth and eyes) and fomites (picked up from surfaces). The precautions in terms of respiratory protection depend upon these being correctly and unambiguously defined. In order to demonstrate the confused and muddled thinking of the IPC authors we should examine the wording of the last three versions of their guidance in respect of when proper Respiratory Protective Equipment (RPE) should be worn:

Infection prevention and control for seasonal respiratory infections in health & care settings (including SARS2) for winter 2021 to 2022		
24 Nov 2021	*17 Jan 2022*	*15 Mar 2022*
'A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection **spread wholly by the airborne route**, such as tuberculosis (TB) (during the infectious period)	'A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection **spread by the airborne route** (during the infectious period)	'A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when: • caring for patients with a suspected or confirmed infection **spread predominantly by the airborne** route (during the infectious period)

The November update was a somewhat futile attempt to try and exclude COVID-19 as a disease which requires respiratory protection for routine care of infectious patients, thereby seeking to justify their dangerous policy of continuing reliance upon Fluid Resistant Surgical Masks (FRSMs). They used the term "spread **wholly** by the airborne route" – citing TB as an example. This backfired on them and illustrated that the "eminent scientists and physicians" of the IPC Cell (as you describe them) appear to lack the most rudimentary knowledge of such a common, well-researched disease as TB. This does not inspire confidence in their competence in other areas such as the management of pandemic COVID-19. As I (and other stakeholders) have commented, TB is not "wholly" transmissible via the airborne route (e.g. gastrointestinal tuberculosis which can be acquired by ingestion).

Recognising this, in the next version (17 Jan) they removed the word "wholly" and the reference to TB. This definition therefore encompassed COVID-19 within its scope, given that the UK Government published information at the same time confirming the importance of airborne transmission. This left the only possible interpretation as being that RPE (FFP3 etc) is required for care of infectious patients.

However, the IPC authors in Scotland (ARHAI) with, what some commentators might refer to as 'breath-taking arrogance', decided that they knew better than the UK Government and refused to accept the statement about airborne transmission. They steadfastly refused to bring their National IPC Manual (NIPCM) into line with the 4-Nations IPC guidance. Although this is primarily a Scottish document, the other 3 nations are obliged to follow it since it has a 4-nation application. This meant that we then had the lunacy of 3 of the 4 UK nations being obliged† to follow the new IPC guidance specifying that proper **RPE** be worn, whilst at the same time also being mandated to follow the Transmission Based Precautions (TBPs) of the NIPCM specifying that **FRSMs** should be worn.

† For instance, NHS-England's policy mandates compliance with TBPs set out in the NIPCM

Whilst all versions of IPC contain provision that RPE may worn if an "unacceptable risk of transmission remains after application of the hierarchy of risk controls", as I have previously pointed out to you, none of the higher elements of that hierarchy adequately mitigate the risk of close quarter care of infectious patients – leaving PPE (RPE in this case) as the only viable option. This does not include FRSMs.

Therefore, presumably after much scratching of heads (which has taken them 2 months to accomplish) the eminent scientists and physicians of the IPC Cell have now come up with the term "**predominantly** transmissible via the airborne route", by which they seek to bring COVID-19 once again into the scope of surgical masks.

However, no hard scientific evidence has been produced to support a definition of "predominantly". If we consider the relative proportions of transmissibility as follows:

By Airborne is A%
By Droplet is D%; and
By Fomite is F%

In order to claim that droplet is 'predominant', the IPC Cell must be able to provide sound, peer-reviewed scientific evidence which will withstand rigorous scrutiny, that:

D is greater than A; and
D is greater than F.

To the best of my knowledge and belief, no such evidence exists. The fact that "droplet" transmission is "predominant" is a fanciful notion on the part of the IPC authors, without credible scientific foundation.

If these theories were correct and (a) droplet transmission is cause of infection and (b) FRSMs provide effective protection against disease transmission, then how is it that we have such a massive amount of Hospital Acquired Infection (HAI) at the present time? Reliable sources of information show that approximately 1 in 5 patients in hospital with COVID-19 caught the disease whilst in hospital – the very place which is meant to help them get better, not worse. We know of the thousands of patients who have died as a result of HAI. I ask you, is it reasonable to assume that all this in-hospital transmission only affects patients and not the staff who work there as well? However you look at it, the philosophy of 'droplet transmission' and 'FRSMs' simply does not work and needs to be exposed for the sham that it is.

So now we have a definition in the 4 nations IPC guidance "**predominantly** transmissible" which yet again is not 'in sync' with the National IPC Manual which still refers to "**wholly** transmissible".

Whilst the IPC authors sit at their meeting room tables or zoom computers pontificating on this wholly unnecessary fixation with trivial wording, healthcare workers are out there at the 'front line' of the NHS and other healthcare organisations contracting COVID-19 by inhaling the virus whilst wearing masks which they are deceived into believing will protect them from the disease. One thing that we do know for certain is that the long-term effects of the disease upon healthcare workers can be devastating, ruin their careers, their quality of life and, of course, may ultimately cost them their life.

I should explain why I refer to it as a "wholly unnecessary fixation with the wording". That is because it matters not one jot whether a disease is 'predominantly' airborne when considering whether respiratory protection is required. If a disease is airborne IN ANY PROPORTION then it is still a risk that must be controlled where a lethal virus is concerned. The ability of a disease to transmit by fomite or droplet does not negate the airborne route in any shape or form. Whilst a FRSM may provide some protection against ballistic droplets such as those which may be coughed or sneezed in one's face, the airborne/aerosol component (whether it represents 40%, 30% or even 10% of total transmission) will still be inhaled, since **surgical masks do not provide respiratory protection** (as I am now tiring of telling you, and which you very well know – and, indeed, publish on your own website). FRSMs are neither designed, constructed, tested or certified to provide respiratory protection, nor are they legal under COSHH Regulation 7(9). Thus, the aerosol component which bypasses the mask may initiate disease in the nasopharyngeal epithelia or in the alveolar cells of the lung.

If the physicians and scientists comprising the UK IPC Cell seriously believe (and try to get others to believe) that the 'droplet' and 'fomite' routes of disease transmission in some way negate the 'airborne' route, then this is such a ridiculous notion that (a) you really need to desist from referring to them as "eminent" and (b) there is a prima facie case that they should be investigated for scientific misconduct and be dealt with accordingly by their professional institutions.

Meanwhile, as regards HSE's position, you have made it very clear in your letter that you do not believe that the IPC guidance has been, and continues to be 'flawed'. The only interpretation which can be drawn from this opinion, together with your refusal to intervene, is that you clearly do support a policy which contravenes the COSHH Regulations which you are supposed to enforce.

Unless your Chief Scientific Advisor (CSA) was giving false testimony to members of Parliament that the "airborne route is the most critical" he clearly believes this to be the case. From what he said to those MPs he clearly believes that, and seems to have held that opinion since the early days of the pandemic. I personally have every faith in his integrity. I do not believe for one moment that he would have lied to the MPs in the Select Committee. He is overseeing excellent work such as 'PROTECT COVID-19' which appears to be steadily confirming airborne transmission. As such he is a credit to your organisation. The question therefore remains as to whether or not his opinion was conveyed to you and others in the HSE senior management team. There are only two possibilities here:

i. If your CSA advised the MPs of the airborne risk but failed to advise you and your management team then this would be a dereliction of his duty.
ii. If, however, he did advise you about the airborne risk, but you have failed to act† on the advice of your most senior scientist, then it would be you who, together with your senior management team, would be considered derelict in duty.

Which is it? Please explain. It has to be one or the other. No doubt this is something which will ultimately be established at the forthcoming public inquiry when the HSE's acts and omissions will no doubt be closely scrutinised.

† The action that one would reasonably expect you to have taken would be to insist that IPC guidance required 'airborne precautions' (RPE not FRSMs) to protect healthcare workers caring for infectious patients, thereby having potential to save hundreds of healthcare worker lives.

2) World Health Organisation

You state your reason for not initiating a criminal investigation against the authors of the IPC guidance as being because they have followed guidance from the "world authority" (the World Health Organisation). With respect, you fail to appreciate some basic facts. These are:

2.1) Contrary to your assertion, the current IPC guidance **does not** follow current WHO guidance. I would have expected the HSE to keep abreast of WHO guidance if it is going to use this as an excuse to justify the current RPE guidance issued by the IPC Cell.

May I therefore refer you to the update of WHO guidance published on 22 Dec 2021 which confirms that a respirator (such as FFP3) should be worn by health workers before entering a room where there is a patient with suspected or confirmed COVID-19. I note that this concurs exactly with HSE's own guidance for healthcare workers entering a room in which there is a patient known or suspected to have a SARS disease.

Since you appear to attribute such importance to compliance with WHO guidance, now that the IPC Cell have unilaterally rejected it and are working to lower standards of safety, I trust that you will now recognise their actions as reckless endangerment of healthcare workers' lives. I once again call on you to institute proceedings against them under Section 36.

2.2) You seem to hold the WHO guidance up as a pinnacle of excellence. There are hundreds of eminent physicians and scientists across the world who vehemently disagree – particularly with their dogma of "droplet transmission" and, up until May 2021, their rejection of "airborne" transmission.

You need to bear in mind that the individuals who advise and formulate WHO guidance are often the very same individuals who advise and formulate their own country's guidance. It is therefore unsurprising that the erroneous themes that we see manifest in the UK IPC guidance are carried through into the WHO guidance, which in turn gets turned full circle to justify their local guidance back in the UK.

2.3) The World Health Organisation has, through its very nature, to issue guidance appropriate to different countries, rich and poor, with varying standards of healthcare provision, different climates and different cultures. It does not, therefore, follow that a country (the United Kingdom for example) with its excellent healthcare facilities and high standards of cleanliness and medical competencies has to slavishly follow WHO guidance when it can, and should, do much better and afford better protection for its workers than WHO advises on a world-wide basis.

We now have a situation where the UK is not even keeping up with WHO standards of healthcare worker protection, let alone equalling it or bettering it. This brings shame and disrepute upon our nation with its proud record of medical excellence. As explained, this shame is particularly engendered by Scotland and the First Minister should reflect upon this.

I, together with hundreds of healthcare professionals are sick and tired of the policy-setters in the UK "hiding behind the apron strings" of the WHO guidance as a means of justifying their reckless endangerment of healthcare workers across the United Kingdom. If you do not believe me then I suggest you monitor social media on this topic.

We are equally sick and tired of DHSC and HSE assigning responsibility to UK-HSA (formerly PHE) and UK-HSA claiming that it is DHSC and IPC Cell who are equally responsible; ARHAI claiming that HSE have approved the 4-nations PPE/IPC policy‡ and the HSE saying that they haven't approved the 4-nations PPE/IPC. In times of crisis the British public and its healthcare workers expect better from those whom we trust (or, as the case may be, previously used to trust) with keeping the nation's workforce and public safe.

‡ In particular I note that Ms [redacted], CNO, DCNO, Scottish Government has stated in a recent letter to a colleague that "*the HSE has been consulted and they support the current UK IPC guidance in terms of PPE and RPE*".

You will remember that we crossed this same bridge last year when ARHAI claimed that HSE had "approved the PPE section within UK IPC COVID-19 guidance" and your Lead Inspector for health and social care emphatically denied that HSE had ever done so. As you can see from this link ARHAI are still publicly claiming the very approval that you deny having ever given. One party has to be lying and we are left to speculate whether it is ARHAI or HSE. Please clarify.

Now that it has happened again, please would you confirm whether the HSE has "supported the PPE/RPE section of the current IPC guidance" and, by way of a Freedom of Information request, please supply correspondence from and to the Scottish Government representative.

The UK stands virtually alone amongst the world's countries with advanced healthcare systems in denying RPE to healthcare workers working in close contact with infectious patients. Most people who 'clapped for carers' two years ago would have trusted and expected that the HSE, UK-HSA, DHSC and the NHS would collectively provide their healthcare workers with the best protection possible against a lethal disease. Any such trust and expectation have been betrayed.

3) HSE's Criteria for Commencing Criminal Investigations

I was pleased to note your comment that an investigation should take place if there is "a clearly identifiable contravention of health and safety at work law by an identifiable person" and I am grateful for the invitation to assist you with this. I can help you with this at three levels:

3.1 Contravention:

- Breach of the Control of Substances Hazardous to Health (COSHH) Regulation 7(9)
- Failure to provide workers with respiratory protection of an approved type.

Identifiable Person:

- I do not need to identify a person by name as there are hundreds across the UK i.e.
- The Chief Executives and/or Medical Directors being the "directing mind" of the Health Trusts and Health Boards who still issue FRSMs for personal respiratory protection of their healthcare workers working with COVID patients. i.e. all Health Trusts/Boards except approximately 34 which have recognised the fallacy of the IPC guidance, abandoned it and adopted a policy of providing FFP3s or equivalent.

3.2 Contravention:

- Breach of Health and Safety at Work etc Act 1974 (HASAWA) Section 36:
- Causing the persons identified at (1) above to commit an offence (COSHH Reg 7(b)) as a result of an **act** by another person or persons (identified below). Said **act** being the publication of IPC guidance which sets out requirements which led to the breach

of the above regulation (namely the wearing of surgical masks for respiratory protection).

Identifiable Persons: You can select from several:

- The "directing mind" of the organisation (UK-HSA) which actually publishes the above guidance i.e. Dame Prof [redacted], Chief Executive; and/or
- The Chair of the 4 nations IPC Cell who I believe to be Dr [redacted], Deputy Medical Director, Public Health Wales; and/or
- The IPC Lead for NHS-England/Improvement who I believe to be Dr [redacted] ; and/or
- The "directing mind" of NHS-England/Improvement IPC who I believe to be Professor [redacted]; and/or
- Professor [redacted], National Services Scotland

3.3) Contravention:

- Breach of HASAWA Section 36:
- Causing the persons identified at (1) above to commit an offence (COSHH Reg 7(b)) as a result of the **default of** another person or persons (identified below). Said **default** being the failure to properly give effect to the statutory powers vested in the Health and Safety Executive to ensure that duty-holders comply with the above-mentioned COSHH Regulation to ensure the safety of workers.
- Breach of HASAWA Section 3: General duty of care to persons not in their employment, namely healthcare workers whose safety the Health and Safety Executive has a statutory duty under Section 18 to protect, but failed to do so.

Identifiable Persons: Prosecutors (which cannot be the HSE) may choose from several:

- The Chief Executive of the HSE; and/or
- The Chair of the HSE; and/or
- Other Directors of the HSE; and/or
- The Lead of HSE Health and Social Care Services Sector; and/or
- Any HM Inspector of Health & Safety who:
  - Inspected a health or social care premises at which individuals infectious with COVID-19 were present; and
  - The healthcare workers were tending, in close proximity, to these infectious individuals; and
  - These workers were wearing any type of face mask (including surgical masks) which were not of a type approved by, or conforming to a standard approved by the HSE; and
  - Said inspector failed to inform the duty-holder of their non-compliance with COSHH Regulations and failed to ensure, either by verbal instruction, written instruction or enforcement notice that the duty-holder was required to comply.

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 continuing 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

QSHCR Registered Consultant

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

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