OPEN LETTER TO: **20 March 2023**

Ms Sarah Albon, Chief Executive, Health and Safety Executive

With copy for the attention of:

The Rt Hon Steve Barclay MP, Secretary of State for Health and Social Care
The Rt Hon Mel Stride MP, Secretary of State for Work and Pensions
The Rt Hon Steve Brine MP, Chair, Health and Social Care Select Committee
The Rt Hon Sir Stephen Timms MP, Chair, Work and Pensions Select Committee
The Rt Hon Layla Moran MP, Chair, All Party Parliamentary Group (Coronavirus)
Dr Lesley Rushton, Chair, Industrial Injuries Advisory Council (IIAC)
Ms Sarah Newton, Chair, Health and Safety Executive

Dear Ms Albon

Subject: NHS failures in RIDDOR-Reporting Healthcare Workers' cases of COVID-19

HSE failure to enforce RIDDOR-Reporting in the Health & Social Care Sector

There is no doubting that the NHS has performed wonders during this ongoing pandemic. However, there are two major issues at which the NHS failed badly, namely:

- Failure to provide its health care workers (HCWs) with effective respiratory protective equipment (RPE) against a lethal airborne disease whilst caring for infectious patients; and
- Failure to report cases of disease and deaths of HCWs arising through their work during the COVID-19 pandemic.

As regards the first point, in your last letter to me you "respectfully declined to engage in further contact", given that our two viewpoints are opposite and irreconcilable:

– mine being that HSE has failed in its statutory duty to ensure that HCWs have been properly protected with RPE whilst caring for infectious patients and you have knowingly permitted Fluid Resistant Surgical Masks (FRSMs) to be used for personal protection when they are not, never have been "PPE" and are unsuitable for protection against inhalable hazards ;
– yours being that HSE is completely blameless and responsibility for decisions about PPE and RPE rests entirely with the public health authorities.

I respect your decision and agree that further discussion between us on that topic is futile.

This letter, however, relates to a completely different matter. I raise a number of questions which are relevant to thousands of healthcare workers who acquired COVID-19 and whose cases of disease have not been RIDDOR-reported. The facts set out in this letter may give rise to suspicions that there has been an enormous, well co-ordinated cover-up intended to deliberately conceal the true impact on HCWs as the pandemic ploughed into them.

The 'Responsible Persons'[1] within NHS Trusts[2] and healthcare workers need to understand HSE's decision-making process in this matter which has been inconsistent. It will be clear from the data presented in this letter that duty-holders have found HSE's guidance and direction confusing as to whether cases of death and disease are reportable or not. From the HCW perspective it has become a postcode lottery as to whether their case of disease gets accepted as 'occupational disease' and RIDDOR-reported or not. This cannot be right and it is certainly not fair. As this is an open letter, likely to be widely circulated, they will be watching with interest to see how you respond. Any letter of response will be displayed alongside this letter on the internet.

[1] Term used in the RIDDOR Regulations: The person(s) who decide whether or not a case is reportable.
[2] Reference to "NHS Trusts" shall be construed as also referring to "Health Boards" in some UK countries.

As there are several different facets to this issue and I shall structure this letter as follows:

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1. Introduction and Background

I wish to focus your attention on the failure of NHS Trusts to report cases of COVID-19 under RIDDOR. This failure has been on a simply astronomical scale and leaves vulnerable, affected healthcare workers in an invidious situation. Many are now unable to pursue and develop their chosen careers, many now losing their jobs and facing serious financial difficulty, some losing their homes. All this coming on top of their health problems associated with the disease.

I wonder whether you watched the insightful BBC Panorama Programme "Forgotten Heroes of the Covid Front Line"? It graphically portrayed the true impact of the disease on them, coupled with the rejection they now feel from the seemingly uncaring Health Trusts whom they had faithfully served, in some cases for decades. The impact on bereaved families was plain to see. No one viewing that programme could fail to be moved. I wonder if this engendered just a twinge of self-doubt amongst executives in HSE, NHS and public health authorities as to whether they had properly handled these matters in line with the 'duty of care' that they owed these individuals and the hundreds like them.

In this letter I shall mainly consider NHS Trusts in England since I have focused my attention on "NHS Employers", who I understand only cover the one nation. However, from contact I have had with victims elsewhere in the UK, it is clear that there is a similar pattern of under-reporting in the other nations – all of which suggests that this has been orchestrated on a UK-wide basis. HSE should therefore investigate the issues identified in this letter with the other three UK nations.

I shall outline some possible reasons for this under-reporting and discuss the very real, foreseeable implications for HCWs who have been affected in this way. I shall also raise certain specific questions to which I should like answers please as, I suspect, will the Chair of the Work and Pensions Select Committee who was clearly concerned about the issue when the Committee met with you in May 2020. He and his fellow MPs will presumably not be best pleased that your promises to improve RIDDOR reporting in the NHS were not fulfilled.

1.1 Misdirection of NHS Trusts by the organisation 'NHS Employers'[3]

In order to avoid unnecessary repetition, please would you read the attached open letter to NHS Employers in its entirety. This explains the context and background to the under-reporting. There is no point in duplicating it here. Please would you then consider and respond to my points below. The "grossness" of under-reporting during the first and second waves is summarised in table 1 on pages 3 - 4 of that letter i.e. :

- Almost two-thirds of NHS employers had not made one single RIDDOR report under regulation 9(b), thereby purporting that not one HCW in their organisation had acquired COVID-19 through their work.
- Over three-quarters of NHS employers had not made one single RIDDOR report under regulation 6(2), thereby purporting that not one HCW in their organisation had died as a result of work-related COVID-19 being acquired through their work. These figures are difficult, nigh impossible, to believe. Neither do they accord with figures supplied by the NHS Business Service Authority.

It is reliably reported that, in England alone, over 40,000 people 'probably' or 'definitely' acquired Covid in hospital, of whom over 11,000 then went on to die. These are people who went into hospital for other reasons and caught COVID-19 whilst in there. In Wales the figures are reported as 5,000 and 2,000 respectively. Whilst in some cases the primary cause of death might have been attributable to other factors, it is understood that COVID-19 was a contributory factor in all cases. The former Chair of the Health and Social Care Select Committee is on record as saying that between 20 - 40% of the people who died from Covid across the country picked up the infection in hospital. Given that, at that time, the UK Covid death toll was around 127,000 this equates to a total of around 25,000 – 50,000 deaths having occurred as a result of hospital acquired infection during the first and second waves.

With this level of disease and death occurring to patients in our hospitals, it is inconceivable that every healthcare worker in two-thirds of our hospitals had some sort of extraordinary immunity from the disease whilst they were at work, but which lapsed as soon as they were outside the hospital walls, enabling them to conveniently "become infected out in the community" (as claimed by many Trusts). This is particularly pertinent during the first and second waves, when lockdowns and other restrictions were in place and legally enforceable. Furthermore, most HCWs would have been even more diligent than most citizens at complying with these measures, being only too aware of the death, suffering and misery they were seeing all around them daily at their place of work.

1.2 Evidence of under-reporting in NHS Trusts

During the enquiries which led to the above statistics, some responses came to light which colleagues and I found both puzzling and troubling. It is these that I wish to ask you about. A number of NHS Trusts had attempted to report cases of disease or death, but say that HSE either advised that they should not report them, or rejected reports that they had made and refused to enter them on their RIDDOR database. In the table below I refer to them as Trust #1, #2 etc as I will refer back to them later:

[3] 'NHS Employers' (capital E) refers to the organisation. 'NHS employers' refers to duty-holders under health and safety legislation (e.g. NHS Trusts, Ambulance Trusts, Mental Health Trusts, Primary Care Trusts etc.)

Trust #1	**Sheffield Teaching Hospitals NHS Foundation Trust** Reported two cases of disease arising from occupational exposure to COVID-19. They say that you then asked them to "put a hold on submissions". Coincidentally, a research study was undertaken in that very same NHS Trust using the analytical technique known as Whole Genome Sequencing (WGS) which, in layman's terms, is simply a form of 'fingerprinting' viruses that may be used to identify if a virus from person A passed to person B. As such, it is particularly useful for examining outbreaks of disease at a given location. The results of this WGS 'fingerprinting' proved conclusively that, during the first two waves (i.e. the period covered by our survey), 150 healthcare workers were infected from the patients they were looking after. So that left 148 cases unreported, apparently as a direct result of HSE's intervention. Once we pointed out the anomaly to them the Trust contacted HSE who then informed them that they should now report cases in line with their review process. Their review process involved completion of a questionnaire by staff about the circumstances of their infection. As a consequence the Trust went on to report another 78 cases based on these questionnaires. This left 72 cases which had been absolutely proven as "occupational exposure" by a highly sensitive analytical technique still unreported. It is possible that these cases may have been reported since. If any of the 150 subsequently died then these deaths should also have been reported and, without a shadow of a doubt, bereaved families should have received the £60,000 life insurance payment. If they have not, then they need to take this up with the employer (and probably seek legal advice as well). One wonders how many bereaved families who have been denied this payment did not have the benefit of WGS to support their case.
Trust #2	**South London and Maudsley NHS Foundation Trust** This Trust took a very responsible approach, diligently carrying out an assessment of HCW cases of disease. They concluded that the majority of cases they investigated were 'non-occupational' but came to what they describe as a 'reasonable judgement' about 78 other cases where they concluded that there was an "increased likelihood of occupational exposure" and therefore reported all 78 cases. They say that HSE then told them that should not have submitted these RIDDOR reports as they were considered to have been made "on a precautionary basis". One wonders whether these were ever entered on your RIDDOR database.
Trust #3	**Sheffield Health and Social Care NHS Foundation Trust** The Trust reported 1 death under RIDDOR. HSE informed the Trust that it did not need to be reported to RIDDOR.
Trust #4	**Yorkshire Ambulance Service NHS Trust** This Trust submitted five reports of deaths of paramedics. HSE rejected these and therefore none were entered onto your RIDDOR database.
Trust #5	**Hull University Teaching Hospitals NHS Trust** This Trust reported one death. However HSE informed the Trust that the case was not RIDDOR reportable due to the uncertainty surrounding the source of transmission.

By way of contrast, I would also like to mention three Trusts which have reported more properly, where the Trust's "RIDDOR responsible person" has clearly exercised his/her own judgement, rejecting any external influences from HSE or coercion from their Trust management not to report. These were not the only Trusts to report significant numbers of cases but, as will be seen from appendix 1, they were very much in the minority.

Trust #6	**Maidstone and Tunbridge Wells NHS Trust** This Trust reported 1,015 cases of disease due to occupational exposure under regulation 9(b) between March 2020 to Feb 2021). It is believed that, at that time, the Trust employed just over 5,000 employees. They cited HSE guidance: "*When deciding if a report is required, the responsible person must make a judgement, based on the information available, as to whether or not a confirmed diagnosis of COVID-19 is likely to have been caused by an occupational exposure, i.e. whether or not there is reasonable evidence that a work-related exposure is the likely cause of the disease. Whilst this should be considered on a case by case basis, there are some general principles which can assist in making this judgement.* *There must be reasonable evidence linking the nature of the person's work with an increased risk of becoming exposed to coronavirus.*" The Trust therefore took the stance that "***Healthcare workers undertaking work activities with known COVID positive patients would constitute as reportable.***"
Trust #7	**Southern Health NHS Foundation Trust** This Trust reported 125 cases of disease due to occupational exposure. They commented: "*Please note that the Trust reported as 'occupational exposure'* ***all cases of covid among staff members where those staff had been working on wards with covid positive patients****. This was done even when full PPE was being worn in accordance with national guidance (as in fact it was in the vast majority of the cases)*."
Trust #8	**East Kent Hospitals University NHS Foundation Trust** This Trust reported 961 cases of disease due to occupational exposure. They commented: "*The Trust has taken a broad view in determining the staff it includes in these figures, for example* ***staff that were at work at any time in the last 14 days prior to their infection"*****.**

1.3 Questions arising

In order that we may better understand the reasons for the wide disparity in reporting it would be helpful if you would please explain the rationale and any logic that may exist behind HSE's interventions to suppress reporting. For convenience of your reply I list them as Q#1, #2 etc

As regards Trusts #1 and #2 (requested by HSE not to report cases of disease):

Q#1 : Without going into details specific to these Trusts, please would you tell me what reasons or criteria did HSE apply when asking Trusts to put a hold on further submissions?

Q#2 : Approximately when were these requests made? In particular, were they before or after the hearing of the Work and Pensions Select Committee (WPSC) meeting on 12 May 2020? If subsequent to that meeting it seems a strange way to improve reporting.

As regards Trusts #3, #4 and #5 (requested by HSE not to report deaths):

Q#3 : Please would you tell me how many other NHS Trusts, NHS Boards and Nursing/Care Homes HSE has asked either to put a hold on submitting further RIDDOR reports; or rejected the reports that they had already made.

Q#4 : Without going into details specific to these organisations, please would you tell me what reasons or criteria HSE applied when asking healthcare employers not to report Covid-related deaths under RIDDOR?

As regards all of the above

Q#5 : The legislation is quite clear. It is the employer's "responsible person" who must decide whether or not to report any given case. Please would you tell me under what regulation/paragraph within RIDDOR does the HSE have any legal authority to instruct or request that a duty-holder should not report certain events, particularly once they had already investigated a case and decided that a report should be submitted?

Some guidance must have been issued by HSE management to its staff who process RIDDOR data or 'helpdesk' staff who handle questions from the public and duty-holders. As a Freedom of Information (FoI) request, please would you send me any such guidance notes (and updates to them issued since 1 January 2020).

2. Possible Reasons for Under-Reporting by the NHS

I find it interesting that the BBC Panorama programme (mentioned earlier) obtained a Freedom of Information request which revealed that, on 8th April 2020, an NHS Trust had sent an email to HSE "***As things stand, all healthcare workers could be said to be exposed to covid as a result of their work – Staff would expect cases to be reported which could be very detrimental to the already fragile morale in the workforce***". So, with this very telling statement, we are now beginning to get right to the heart of the matter. Forget the weasel words "***could be said to be exposed***", healthcare workers "***were exposed"*** to covid as a result of their work. The NHS author of that email knew that very well – otherwise why else would they have written this email in the first place? It is my contention that they knew it then, they know it now; HSE knew it then and HSE knows it now.

As a FoI request, please send me a copy of that email which was shown on the BBC Panorama programme aired 30 January 2023, together with HSE's reply and any other ensuing correspondence.

I would like to make a few further observations regarding this email:

- One has to wonder whether it was the "detriment to staff morale" that was really the NHS's true concern here, or broader issues such as:
  - If the true levels of healthcare worker infections were to become widely known, serious questions would have been asked about the policy of equipping them with flimsy surgical masks which are not even designated as "PPE" instead of proper, approved, 'fit for purpose' respiratory protective equipment (RPE) such as FFP3 respirators. In turn this may have led to further suspicions that whoever ordered the switch to FRSM might knowingly and recklessly put them into harm's way, for which they may subsequently be held accountable.

    We must remember that before Friday 13th March 2020, healthcare workers had been told that when the pandemic reached the UK they would be provided with FFP3 respirators to protect themselves from the disease. On that fateful day in March, Government policy changed and they were assured that surgical masks would keep them safe. From that day, which will live in NHS history as a day of infamy, the biggest health and safety disaster this country has ever witnessed began to inexorably unfold in the healthcare sector.

- In the email that the NHS sent you, they said "***all healthcare workers could be said to be exposed to covid as a result of their work***". It is pleasing to hear the NHS acknowledging, albeit rather evasively, that all healthcare workers are exposed to covid as a result of their work. Since this is documentary evidence that the NHS obviously did accept the principle of "occupational exposure", their ensuing failure to report adds significant culpability to the offence under section 33(1) of the Health and Safety at Work etc Act 1974. I am not aware of any defence having been accepted that a statutory duty was not complied with on the grounds that it may caused detriment to staff morale.

As you reported to the W&P Select Committee in May 2020 (Q107), there could be some misunderstanding by the NHS about the RIDDOR Regulations. The misunderstandings appear to be due to the incorrect and misleading guidance given by :

a) NHS Employers (the Organisation), with their mistaken belief, manifest by their flow chart, that a positive laboratory test is required before RIDDOR reporting is even considered; and
b) NHS employers (Trusts, Boards etc) adopting RIDDOR-reporting policies and procedures which neither align with HSE guidance nor the law of the land.

As regards point (b) above, it is noted that some NHS Trusts have brought their own interpretations to bear on the subject which are neither in line with the RIDDOR legislation nor your guidance. An example may be found at one Health Board[4], which most likely reflects RIDDOR-reporting policies in other Trusts. It contains misleading statements which you need to insist they correct, such as:

- The sentence "**It is most likely even in a healthcare setting that a case of Covid-19 will have been contracted in the community**". I doubt for one moment that many people would have been convinced by this fanciful statement when it was made, back in April 2020 (the peak of the first wave). With the benefit of hindsight the statement seems even more ludicrous, given the thousands of patients that have died in the UK from the disease which they contracted in hospital.

  Simple common sense tells us that it is far more likely that a case of Covid-19 would have been contracted in a healthcare setting, such as an ambulance or a hospital into which infectious people were intentionally brought. This is confirmed by data from numerous sources, including the Office for National Statistics, as summarised in the Industrial Injuries Advisory Council's Position Paper 48 IIAC[5] which demonstrated a significantly greater risk in HCWs compared to people in the community, even when background community rates were high. The fact that the community was in lockdown is also relevant.

- The two statements:

  "***Given the diagnostic uncertainties with Covid-19 this need be after a laboratory confirmed diagnosis***"

  and

  "***Where a healthcare worker receives a positive diagnosis of Covid-19 from a laboratory, consideration to an occupational causation should be given***"

  were also misleading since they led the NHS into the principles embodied in the flawed NHS-Employers' guidance that RIDDOR reporting should be wholly dependent upon receipt of a positive PCR test and that reporting would not be required if no positive PCR test was available. In the early days, tests were not so widely available, mistakes were made in laboratories and research shows a 'false-negative' rate of almost 1 in 10 samples submitted for PCR analysis.

[4] https://www.nhsggc.org.uk/media/260500/hr-directors-riddor-and-covid-19-in-healthcare-staff.pdf

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/964524/covid-19-and-occupation-policy-paper-48.pdf

At the time, there were several valid quantitative and qualitative criteria other than a PCR test which would inform a diagnosis sufficient to qualify for a RIDDOR report such as :

- A clinical diagnosis of COVID-19 from a registered medical practitioner† (as stated in the RIDDOR statutory instrument) which may be based solely on symptoms acceptable for a diagnosis at the time; or
- A clinical diagnosis of a COVID-19 related condition from a registered medical practitioner; or
- A positive 'anti-spike' antibody test before the employee was vaccinated; or
- A positive 'anti-nucleocapsid' antibody test, regardless of the employee's vaccination status.

† It should be noted that there is nothing in the RIDDOR Regulations to prevent persons who, themselves, are "registered medical practitioners" from making a self-diagnosis based on their own symptoms. Any such diagnosis is valid and should not be questioned or doubted by their employer. To do so would call into question their honesty and integrity and impugn their character.

- HSE should also have corrected their assumption that "***Where a HCW has not worked within Covid-19 area it would be reasonable to assume a community infection. No further investigation would be required***". HCWs who do not work with Covid patients will inevitably mingle with frontline colleagues who do, and who have become infected through lack of RPE. They are therefore at far greater risk of acquiring COVID than workers in non-healthcare premises. This aspect of transmission between staff is discussed further in section 6 below.

- Similarly, HSE should have corrected the misunderstanding evident in this NHS policy that "*Where a HCW has not worked within a Covid-19 area it would be reasonable to assume a community infection* ***unless there has been a failure in the supply of personal protective equipment (PPE).***" The point here being that each and every occasion where a HCW was provided with a surgical mask was a "failure in the supply of PPE" since, as the HSE knows very well, surgical masks are not "PPE". Thus any supply of a surgical mask was, in its own right, a "failure in the supply of PPE" and, if one were to apply their own criterion, any case of disease acquired by a HCW whilst wearing a surgical mask would have been reportable under RIDDOR.

  Even if one were to come up with a tenuous argument that FRSMs are "PPE" because they offer some limited protection against splashes and large droplets, they are still not legally classified as "PPE" and they are certainly not "Respiratory Protective Equipment" (RPE) which is needed to afford the wearer adequate protection against a hazard which can enter the body via the inhalation route.

Another reason why Trusts may fail to RIDDOR-report could be that Executives and lawyers fear culpability, reputational damage and exposure to litigation. If so, denying the truth of the matter for this reason represents the most callous betrayal of their employees.

Health and Safety practitioners who allow themselves to be 'influenced' or 'pressured' by management or lawyers into not reporting something which ought to be reported may find themselves in breach of their professional institution's code of conduct and ethical practice. Similarly, those who exert influence or pressure upon them may be guilty of an offence under section 37 HASAWA for "connivance" or "neglect" and I trust that if such cases are encountered you will not hesitate to prosecute the individuals concerned. Any such person is not fit for the office they hold.

3 Expectations of the Commons Work and Pensions Select Committee

The arrival of COVID-19 in this country led to widespread concern across the UK for the safety and welfare of healthcare workers at the front line. This concern was shared by Members of Parliament and, on 12th May 2020, you were summoned to a meeting of the Work and Pensions Select Committee (WPSC).

The Department of Work and Pensions' (DWP) subsequently produced a report, summarising their findings and recommendations: "Response to the coronavirus outbreak". They were particularly scathing of HSE in respect of RIDDOR They reported that "***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***".

Their report went on to 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***".

During the ensuing months you must (or should) have been aware that under-reporting continued, yet you and your Inspectors did absolutely nothing whatsoever about it despite the MPs' evident interest in obtaining reliable data about the impact on workers. It would have been quite easy and appropriate for you to issue Section 21 Improvement Notices requiring compliance with RIDDOR within a specified period of time.

And so, almost three years later, in your statement to BBC Panorama you openly stated that "***HSE accepts RIDDOR reporting for healthcare staff doesn't reflect the accurate number of those infected at work***". One might ask (and I hope the MPs in the Work and Pensions Select Committee will do so) why you "accepted" under-reporting. Your job, nay your statutory duty, is not to "accept" non-compliance with the legislation that you are supposed to enforce, but to make sure that duty-holders do comply with it by exercising your not-inconsiderable enforcement powers.

Some commentators might interpret your failure to enforce reporting as being "consent and connivance" with a cover-up of healthcare workers' infection rates, or maybe just "negligence" (failure in duty of care to workers). You will recognise the above terms as those used at Section 37 of the Act which you regularly bring to bear on other Chief Executives and Directors.

4. HSE Guidance on RIDDOR Reporting

It is interesting to consider the HSE guidance on RIDDOR during April-May 2020.

- 4 April 2020 : HSE publish RIDDOR guidance: "When to report a case of disease: Exposure to a biological agent". You gave, as an example of what would be "***reasonable evidence that someone diagnosed with COVID-19 was likely exposed because of their work***." The specific example you gave was "***a healthcare professional who is diagnosed with COVID-19 after treating patients with COVID-19***".

  That seems pretty clear and unambiguous to me. I would say that is the best guidance you have ever given about RIDDOR in relation to healthcare workers. I commend you for it. It is a fine example of common sense being applied in a regulatory context.

  This guidance remained in place right through until 27 May 2020, the closing days of the first wave. I mention this to pre-empt any claim you might make that you changed the guidance because of the **increasing** level of community transmission making it difficult to determine the source of infection. Infection rates were rapidly **decreasing** at that time, so any such claim would not withstand scrutiny.

  Then, for some inexplicable reason, you removed this statement. It was entirely foreseeable that removal of this helpful statement would reduce the level of reporting in the NHS, not increase it. As such, it was hardly in keeping with your promise to MPs just a few weeks earlier that you would seek to improve NHS reporting.

- 29 May 2020 : The guidance then changed, splitting into two parts, with the "further guidance" pages describing how the person responsible for deciding whether or not to report should base their decision. It retained the requirement for "reasonable evidence".

  Nevertheless, the decision was left to the responsible person to decide what was reasonable evidence as per the RIDDOR Regulations. The law says that it their decision and theirs alone – not HSE's. Health and Safety law is there for the benefit and the protection of workers, not for the interests of the HSE or the Government. Nor is it there as a political expediency to be enforced or abandoned at the whim of civil servants. If an item of legislation is provided that will enable a record to be made of a worker's occupational exposure then the HSE has no legal authority to undermine workers' rights in this respect by seeking to suppress reporting.

  So let us now consider a 'responsible person' on the 29th May 2020 faced with a decision whether to report or not to report a healthcare worker's case of disease which he/she believes could be due to occupational exposure. The helpful guidance has gone, but it is surely reasonable for them to take the view that since the HSE's guidance two days ago stated that a HCW who is diagnosed with COVID-19 after treating infectious patients is a good example of work-related exposure. What can have changed in just a couple of days? In practical terms, nothing. So the most defensible and justifiable decision for them to make would be to base it on HSE's own example and conclude that it is reportable.

  Now consider the same decision being made on the 30th May, 1st June, 2nd June – no difference, that example is still the most specific guidance available to them for reporting healthcare RIDDORs. Extrapolating to this day, there is still no more specific guidance for 'responsible persons' than that example which you, yourselves, gave. It remains the most pertinent and relevant guidance HSE have ever given for the healthcare sector and 'responsible persons' are perfectly justified in relying upon it and indeed should still be doing so.

5. Evidential Requirements for "Occupational Exposure" in RIDDOR (Burden of Proof)

5.1 "Reasonable Evidence of Occupational Exposure"

As discussed, the common theme running through all HSE guidance on reporting cases of occupational disease throughout the pandemic (and in fact since the regulations were enacted in 2013) is the criterion of "reasonable evidence", so we should explore what is meant by that fundamental principle.

At first sight the word "reasonable" seems to be a very vague, a "matter of opinion", but who's opinion? The employer's? The HSE Inspector's? A Judge's? Because the word is embedded into so many items of legislation it was only a matter of time before the Courts were asked for clarification.

You will no doubt be familiar with the "man on the Clapham omnibus" but, for the benefit of anyone reading this letter I should explain. Although the actual identity of this man is unknown (and most likely fictitious) for over 100 years the Courts have described "reasonable" to be the opinion of the "man on the Clapham omnibus", meaning a reasonably educated, intelligent, but nondescript person. In other words "reasonable" is the opinion of the ordinary man or woman on the street.

So let's imagine we could explain the circumstances to this reasonable person and get their opinion of the following (true) situation:

- A healthcare worker had served at the front-line of COVID-19 providing close-quarter care to multiple patients who were infectious with the disease, with every exhaled breath, cough or sneeze expelling virus-laden droplets and aerosols into the air around them;
- The worker was not even provided with the respiratory protective equipment needed to protect them from inhaling the germs in the air they breathed;
- Outside of work, that healthcare worker had exercised extreme caution to avoid contact with the disease from other people in line with prevailing legislation and government guidance (lockdowns etc) so contact with other people was minimal;
- The healthcare worker then developed the disease.

If we then ask the "reasonable person" on the Clapham Omnibus whether he considers it "more likely than not" that the healthcare worker was infected with the disease as a result of exposure to the disease through his occupation, the answer will undoubtedly be a resounding "yes".

We could actually do better than that, since there are millions of "reasonable persons" in the United Kingdom who stood on their doorsteps on Thursday evenings and clapped for these healthcare workers. Ask any one of those and I have no doubt about the answer you will get.

5.2 HSE's evidential requirements (Healthcare)

We have already discussed the evidential requirements for RIDDOR being "reasonable evidence" and, in all your guidance since August 2020 you have helpfully described this as "more likely than not" which equates to the legal term "on the balance of probabilities" which is the "burden of proof" in civil litigation. In other words one doesn't have to be absolutely certain about something – if equated to a "percentage certainty" it would be greater than 50%.

However, in practice the NHS Trusts are not following this guidance and, when affected HCWs seek to have their cases considered as "occupational disease", virtually challenging them to prove that the actual virus particle which triggered their disease was acquired at work as opposed to out in the community which is, of course, impossible for them to do and a quite unreasonable expectation – I am sure the man on the Clapham omnibus would agree with me on this point.

And then, into this toxic mix of denial by the NHS authorities themselves, comes the HSE. I refer to the statement that HSE gave to the BBC Panorama programme mentioned earlier. You said "***As community transmission increased it became difficult to be certain where people were infected***". As discussed, one does not have to be "certain" about where a healthcare worker was infected, just "more likely than not". If ever an organisation was so publicly hoisted by its own petard on national television, this was it.

So to this day, you are still sending out mixed messages. The public are often warned about the amount of "misinformation" that is published about coronavirus and it would be helpful if Government agencies did not contribute to this.

5.3 HSE's evidential requirements (Industry) – a comparison

We have discussed COVID-19 and the application of RIDDOR within the healthcare sector. There should be no difference in the way that RIDDOR is applied between different sectors. It is clear to me that the way RIDDOR is being applied in the context of COVID-19 and healthcare is different from other sectors. There is no reason for this. It seriously disadvantages and discriminates against healthcare workers. This is unjust and unfair.

So let us consider another biological agent, legionella pneumophila, with which we are well familiar in the terms of health and safety risks, being the causative agent of Legionnaires Disease.

A typical case of occupational disease would be where the worker's job involves work on or near a cooling tower. The employee becomes ill and a doctor confirms legionellosis (Legionnaires Disease). You will agree that this is reportable without any further criteria needing to be satisfied (as per your guidance in L.8, para 18).

There are two key points arising from this:

- It does not have to be proven that the worker actually contracted the disease from the cooling tower in question. Agreed, there are analytical methods which can be used to help confirm the source such as a PCR test known as Amplified Restriction Fragment Length Polymorphism. However there is no requirement for such a high level of proof to be supplied in order to make the case RIDDOR-reportable.

  There have been many incidents where people 'walking down the street' have unknowingly inhaled droplets/aerosols drifting from a cooling tower e.g. Corby (1996), IMCO, Glastonbury (1998), Barrow-in-Furness (2002), Edinburgh (2012) and no doubt many other similar events which have not led to death and not been reported or investigated. Whilst it is always possible that our worker in question may have contracted the disease from an unknown source it remains "more likely than not" that the source was the cooling tower.

- Whether the worker was, or was not, wearing the required PPE is absolutely irrelevant to any decision as to whether the case is reportable or not. In the RIDDOR Regulations no consideration whatsoever is given as to what risk control measures might or might not have been in place. The only criteria are (1) notification of disease and (2) reasonable evidence of occupational exposure. If these are satisfied it is reportable.

  This is confirmed by HSE guidance specific to cases of occupational exposure to biological agents and carcinogens https://www.hse.gov.uk/riddor/carcinogens.htm which gives a helpful explanation "***Work-related exposures to biological agents may take place as a result of…unidentified events, where workers are exposed to the agent without their knowledge (eg where a worker is exposed to legionella bacteria while conducting routine maintenance on a hot water service system)***". It doesn't take a great leap of imagination to relate this sentence to the circumstance of a healthcare worker being exposed to the agent SARS-CoV-2 without their knowledge whilst caring for an infectious patient.

The key point here is that the two arguments most commonly used by Trusts as an excuse not to report cases of COVID-19 both crumble to dust. They say:

- The source of the infection could not be positively confirmed as being their work, it could have been "out in the community"; and
- The Trust was fully complying with all national guidance published by the Government in respect of PPE and other measures

Such arguments are misguided, ill-informed and evidence the lack of competence present in these organisations. These misunderstandings as to how the RIDDOR regulations work have been allowed to stand uncorrected by yourselves in the HSE. As the UK's 'competent authority' in these matters, workers expect you to correct any such misunderstandings whereas, in reality, through your inertia you seem to have encouraged and supported them.

The case of our worker maintaining the cooling tower would still be reportable even if the employer considered that they were wearing the highest standard of RPE/PPE possible and all necessary risk control measures were in place..

One of the outcomes from HSE's consideration of RIDDOR reports can be that their investigation discovers that the wrong type of PPE was being used or other risk control measures were inadequate and their Inspectors' intervention may be required to ensure that improvements are implemented.

Lest it be considered that the example of Legionnaires' Disease is the only example:

- A paint-sprayer using isocyanate paints develops asthma. This clears up when he is away for extended periods of time and returns when he starts work again. An occupational health doctor diagnoses occupational asthma and reports this to the employer. Investigation shows that the employer had followed all the official guidance as regards control measures (as per INDG388) and the worker had been wearing all the PPE specified in that guidance. **The worker's case of occupational asthma is still reportable under RIDDOR despite the official guidance being followed and the PPE being used.**

- A worker who has been working in a chrome plating workshop develops sino-nasal cancer and, as above, all official guidance has been followed, workplace exposure limits complied with, PPE diligently used as necessary. **The worker's case of cancer is still reportable under RIDDOR despite the official guidance being followed and the PPE being used.**

And yet NHS Trusts are allowed to get away with the excuse that they followed official guidance and were equipping staff with the recommended PPE (which wasn't actually PPE). Workers in the healthcare sector are entitled to have equal treatment and the rule of law applied to them equitably in exactly the same way as in any other sector.

Had there been open and honest RIDDOR reporting in the healthcare sector right from the start of the pandemic, then the root cause of the massive number of cases of disease and deaths amongst healthcare workers could have been properly investigated. Any thorough investigation by competent and independent persons (i.e. independent of Government Departments and the NHS, with no political 'axe to grind') would undoubtedly have considered the suitability of PPE being provided to HCWs and found it seriously lacking.

The data and statistics obtained via RIDDOR would have been a valuable source of information and helped justify any recommendations for better respiratory protection being issued. This, in turn, could have resulted in the deaths of hundreds of healthcare workers lives being saved and thousands of cases of Long Covid avoided. I accept that this is somewhat speculative, but one thing is certain - we may never know for sure because the true impact of the disease on healthcare workers has been concealed.

In this context I hope you will appreciate that RIDDOR reporting is not just a question of unnecessary paperwork and red tape. I respectfully put it to you that had HSE diligently enforced RIDDOR reporting in the NHS as the Right Hon Neil Coyle MP asked you to do back in May 2020 then this could have translated, in real terms, into healthcare worker lives being saved and widespread illness being prevented.

5.4 Conflicting HSE guidance – "Precautionary Reporting"

Trust #2 say that HSE told them not to report because they were considered "precautionary reports". I am of course familiar with your guidance on this and that reports need not be made on a precautionary basis. My feeling is that duty-holders would benefit from some clarification as to what exactly this means in practice.

You define a precautionary report as being one "where there is **no evidence** to suggest that occupational exposure was the likely cause of an infection". You use the words "no evidence", which I take to mean no evidence whatsoever. So when a Responsible Person has some evidence (which Trust #2 clearly did have) then that is not a precautionary report and so HSE was quite wrong to instruct them not to report.

In this context, the use of the term "precautionary reporting" appears to be a thinly-disguised excuse to stop Trusts reporting where they had already formed the opinion that it was "more likely than not" that the disease had been contracted as a result of the person's work. One can only speculate whether HSE did this to reduce their workload or to "keep the numbers of healthcare casualties down" for political reasons. Given that HSE have never been expected to investigate every Regulation 9 report, it would seem more likely to be the latter.

5.5 Examples of "Occupational Exposure" – HSE's opinion?

Please would you confirm in simple, straightforward terms, the type of evidence which you expect to be provided in order to deem "occupational exposure to be the likely cause of infection". It would be helpful if you would provide some practical examples which illustrate the point in the context of hospitals and other premises where staff are diagnosing, treating and caring for people with suspected or confirmed Covid-19.

Q#6 : I should like to describe three scenarios which, as a health and safety practitioner, I personally consider would constitute "occupational exposure".

My question is "do you agree with me that these are cases of occupational exposure"?

In the 3 scenarios listed below, the HCWs had been carrying out the work activities listed below within a 14 day period prior to their infection. You may assume that the workers were not protected with effective RPE although, as discussed in section 5.3 above, the wearing (or not wearing) of the correct PPE is irrelevant to "occupational exposure" within the meaning of RIDDOR-reporting:

1) A paramedic is called to the home of a patient exhibiting the accepted symptoms of COVID-19. The paramedic takes the patient into the ambulance and cares for them until transferred to A&E staff at the hospital. The patient tests Covid positive.

   In answering this question you may wish to refer to your own guidance issued 4 April 2020 (discussed in section 4 above).

2) A healthcare worker at the hospital then provides close-quarter care of the same patient at close range. You may also wish to refer to your 4 April 2020 guidance.

3) An employee working at the hospital "***who is providing any type of service directly within the environment or facilities where testing or diagnosing whether a person was infected with COVID-19 or caring or treating a person who has, or is suspected of having COVID-19***".

You may recognise this text as a*n extract from the NHS Business Service Authority (NHSBSA) Coronavirus Life Assurance Scheme which constituted acceptable evidence of an individual being "**at high risk of contracting COVID-19**". This would include, for instance, porters and cleaners*. Should you answer "no" to this question (i.e. you do not agree this constitutes "occupational exposure") then please would you explain why HSE does not accept a criterion which satisfies the Secretary of State sufficiently to award the death in service payment to the estate of deceased HCWs. The Secretary of State is surely a higher authority than HSE?

In responding to this question you might reflect on what we mean by the term "exposure". Where better to look than COSHH Regulation 2(2)?: ***"reference to an employee being exposed to a substance hazardous to health is a reference to the exposure of that employee to a substance hazardous to health arising out of or in connection with work at the workplace."***

A person is still deemed to be "exposed" to a hazard whether or not they are wearing PPE and irrespective of whether their employer is following official guidance. I would agree that the most important consideration is whether the "exposure" to the hazard is effectively controlled or mitigated by PPE and other risk control measures. However, unless the hazard is completely eliminated, "exposure" to it still remains.

6. Transmission Of COVID-19 Between Staff In Healthcare Settings

The Sheffield study[6] also showed that 144 members of staff acquired the infection from other members of staff. In my opinion, taking a strict interpretation of the law, I would say that these are RIDDOR reportable. I appreciate that HSE will not agree with me since your guidance states that infections from other members of staff are not reportable.

I absolutely agree with you on that point in relation to ordinary non-healthcare premises where such infections would be considered no different from "community spread" (unless, say, a person such as an Occupational Health Nurse or First Aider had to attend to someone who was subsequently found to have been COVID positive).

However, when a person works in a workplace where the employer's 'undertaking' (as per HASAWAct) is to deliberately bring infectious patients into the building or vehicle (ambulance), then that is **not** a "normal" workplace. The same applies to staff who work in a care home looking after residents who are known to be COVID positive.

We know from NHS figures the extraordinarily high prevalence of Hospital Acquired Infections which, per se, evidences that these buildings present a higher level of risk to anyone in them, be they staff or patients. It therefore follows that any person whose occupation requires them to work in such a building is inevitably exposed to a higher risk of disease that is attributable to their workplace. This principle satisfies the Secretary of State (as evidenced by the NHSBSA scheme) and should therefore also satisfy you.

We come back to the point that the general level of airborne virus will have been greater in hospitals than in other workplaces. Even if "airborne transmission" was not accepted in those early days of the pandemic, it is now. Therefore cases of disease dating that far back in time need to be reviewed and reported where appropriate. Regulations 6(2) {death} and 9(b) {disease through occupational exposure} do not have time-constraints within which they should be reported in the same way as accidents and 'dangerous occurrences'.

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[6] Characterising within-hospital SARS-CoV-2 transmission events : https://www.medrxiv.org/content/10.1101/2021.07.15.21260537v1.full.pdf

7. Consequences for health and social care workers with post-covid syndrome

I am aware of a considerable number of HCWs with very severe debilitating long-Covid whose employers (Health Trusts/Boards) vehemently refuse to accept that they could possibly have acquired the disease through their work at the hospital where COVID-19 patients were present. In other words, they deny "occupational exposure".

Along with millions of others (probably including you and many of your colleagues in HSE), I and my family stood on our doorstep and "clapped for carers". I think those millions would be aghast and find it abhorrent to know the way that these brave workers who saw us through the darkest days of the pandemic are now being treated by their employers.

Recognition of "occupational exposure" will be important to HCWs who suffer long-term debilitating or career-limiting health effects arising from COVID-19. This could be in the form of financial assistance such as Industrial Injuries Disablement Benefit if, in due course, the Secretary of State accepts that COVID-19 should become a prescribed disease for occupations who were at high risk.

There is, of course, potential for litigation in the Civil Courts, which is a fundamental element of the United Kingdom's legislative framework. It enables individuals who have suffered harm may lodge civil claims. That is their right and it is not NHS Executives' place to pre-empt such cases or second-guess the outcome. However, to save HCW victims of this scandal having to face the stress, mental anguish and financial risk of engaging lawyers and taking up Courts' time and resources, it would be preferable to institute a suitably generous compensation arrangement on a "no fault" basis for these people who gave their all, only to lose so much.

8. Considerations in respect of Industrial Injury Disablement Benefit

The Industrial Injuries Advisory Council (IIAC) is currently considering which diseases and conditions associated with Post-Covid Syndrome should be recommended to the Secretary of State for prescription as "occupational disease", thereby qualifying sufferers to receive Industrial Injuries Disablement Benefit (IIDB)

The IIAC laid a command paper[7] before Parliament in November 2022 which makes recommendations for HCWs with 5 diseases (paragraph 270). It is understood that this list may be further extended, but the work of the Council has been severely hampered by the lack of RIDDOR data.

Dr Lesley Rushton, the Chair of the IIAC recently gave evidence to a meeting of the All Party Parliamentary Group on Coronavirus and I commend the following two short video clips from that evidence for your attention (which last less than 1 minute each):

- Clip 1 : Dr Rushton describes the Industrial Injuries Disablement Scheme and explains that the IIAC needs "robust evidence" to show that, within reasonable certainty that there is a link that the disease is caused by exposure at work. The standard of evidence required is on the "balance of probabilities" i.e. more "likely than not". You will of course instantly recognise this as being precisely the same burden of proof that is required for RIDDOR reporting. You will therefore appreciate how important the RIDDOR data which you ought to have been collecting throughout the pandemic would have been to the formation of Government policy in this area.

[7] IIAC Command Paper: COVID-19 and Occupational Impacts : 16 November 2022

Had Trusts reported honestly and openly, the thousands of cases of COVID-19 that HCWs have "more likely than not" acquired through their work, IIAC most likely would have been able to draw the necessary conclusions, make the necessary recommendations to Parliament and the affected workers could already be receiving IIDB.

- Clip 2 : Dr Rushton explains the need for 'robust data' relating to occupational links to Long Covid.
  The underlying information leading to a wealth of 'robust data' is still there, if only it could be collated and summarised. It is there in absolutely vast quantities which would provide the statistical validity upon which the IIAC could rely.
  By this I mean that the HCWs who contracted the disease are known to the NHS and other healthcare employers. It was reliably reported[8] that, by the end of the second wave, well over 100 thousand HCWs had developed Long Covid. Even though these cases of disease were not reported under RIDDOR, the underlying data must still be present in sickness records (DATIX etc).

  If these employers were required to review these cases and report these properly under RIDDOR, together with details of the symptoms that the HCWs experienced at the time and any that they have developed since that are recognised as being associated with Post-Covid Syndrome, then this would provide a wealth of data which should be sufficient for IIAC's purposes in respect of IIDB recommendations.

  Whether this is achieved by forcing retrospective RIDDOR-reporting or a separate survey is open to question since, strictly speaking, RIDDOR doesn't require additional details of symptoms and secondary health conditions to be provided. If such a survey is conducted it should either be conducted independently from the employer organisations, or at least overseen by persons independent of the employers so that we can be sure that the data is provided openly and freely, unfettered by the factors which has led to such gross under-reporting within the RIDDOR framework.

  It may be helpful, in any such survey, for it to be recorded whether the symptoms and secondary health conditions were confirmed by a registered medical practitioner. This would be of value for interpreting the data acquired in relation to physical symptoms but the areas of chronic fatigue and cognitive dysfunction are of equal concern and should be recorded even if this solely relies on self-reporting. Where tests are available to support such diagnoses they should be carried out.

It is hoped that the Secretary of State for Work and Pensions will soon react to the IIAC command paper and accept the recommendations that were made in respect of IIDB for the five diseases which IIAC have proposed for IIDB. Any such benefits should be payable retrospectively.

[8] The Guardian : Tens of thousands of (healthcare) staff suffer long covid : 3 April 2021

9. Summary, Conclusions and Recommendations

9.1 Summary

It will probably be apparent from the level of detail given above, that this letter has been written with the intention, not just of addressing you as Chief Executive of HSE, but also informing others in the cc list – in particular Members of Parliament who one hopes have sufficient power and influence over HSE to instruct you on the course of action you should now take.

It also sets out the facts to enable a wider discussion within the NHS Trusts and Boards, other health and social care providers, the Care Quality Commission and Trade Unions.

Equally importantly, this letter is written in the interests of the health and social care workers who have been so badly impacted by COVID-19 as a consequence of their work. They have been failed by Government Departments and Agencies and those in authority within the NHS in whom they placed their absolute trust at the start of the pandemic. Sadly this trust was misplaced and has been betrayed.

The recent BBC Panorama programme "Forgotten Heroes of the Covid Front Line" raised public awareness of this scandal. I hope this letter helps add to the compelling case presented in that programme that the country must in some way recognise the sacrifice that so many healthcare workers have made through their selfless devotion to duty. In the same way as the country needed them to care for us in our hour of need, now they need the country to care for them in their 'hour of need' which sadly, in many cases, turns into a 'lifetime of need'.

I cannot help but wonder what the greatest statesman this country has ever known would say under these circumstances. Most likely: "Never in the field of human medicine has so much been owed by so many to so many". This of course plagiarises a statement made in time of war.

The Government, the media and the NHS itself often talk about the "Covid front line workers", drawing the clear analogy with a war. So, over and above any consideration of Industrial Injury Disablement Benefit, we could do worse than institute a scheme which parallels the AFCS (Armed Forces Compensation Scheme). This provides a tax-free lump sum payment for pain and suffering, together with a tax free, index-linked monthly payment. It is a "no fault" scheme meaning that the claimant does not have to prove anything. It is sufficient that they were doing their job and illness, injury or death occurred whilst doing it.

It should be remembered that "suffering" extends beyond the physical consequences of a disease and includes mental suffering. When considering mental suffering in respect of HCWs with Long Covid, one must also take into account the additional (and completely avoidable) anguish which has been caused by the vehement denial by healthcare employers that their disease was in any way linked to their work, together with the struggle that many of them continue to have in order to get this recognised. This was plain to see in the Panorama programme. As another notable literary figure may have said "This (*denial of workplace infection*) is the unkindest cut of all" after all they have been through.

9.2 Conclusions

I am content to leave readers of this letter to form their own conclusions based on the information provided. The facts speak for themselves. However I suspect that some may conclude that:

- Health and social care employers, possibly with the connivance of (or instruction from) Government Departments and Agencies, have systematically sought to conceal the true extent of illness and death caused to health and social care workers as a result of their work at the front line of the pandemic;

- The most likely reason for this is that, in the early days of the pandemic, the Government was unable to supply sufficient respiratory protective equipment to keep workers safe which, in turn, arose from the appalling state of planning and preparedness for such a pandemic.
- In order to suppress the understandable concern and fears of HCWs (and perhaps fearing a 'refusal to work' situation developing as per the film 'Contagion') it was necessary to do three things:
  - Assure HCWs that surgical masks were a suitable alternative to RPE and would keep them safe from this airborne disease.
    - This advice flew in the face of extant credible scientific knowledge about coronaviruses;
    - It recklessly endangered HCW lives, given the knowledge that in countries already being impacted by COVID-19, HCWs were disproportionately affected. HCWs accounted for around 13% of all COVID-19 deaths in Spain and 9% in Italy.
    - Seeking some sort of justification for this flawed policy, the fanciful notion was promoted that the virus was only transmitted by droplets which would quickly fall to the ground and would not remain airborne and inhalable[†] – therefore respirators such as FFP3 would not be needed.
    - However, since current rules relating to 'High Consequence Infectious Diseases' such as COVID-19 required RPE to be provided, it was most expedient to declassify it as such, expecting people to believe that Covid-19 was not a disease of high consequence when, two days earlier, a global pandemic had been declared.
  - As the inevitable happened and HCWs began to fall ill and die, to actively suppress official reporting in order to conceal this fact, despite the will of MPs that standards of reporting be improved, in fact the opposite was done;
  - When HCWs began to challenge the inadequate protection they had been given, to robustly refute any suggestion that their work with infectious patients could possibly have caused their disease, lest this expose the misinformation fed to them by Public Health England and the World Health Organisation in March 2020. This refutal may have also been motivated by a desire to protect the individuals responsible for those fateful decisions (and those who connived with them) being exposed and subsequently held to account in Courts of law.

[†] I anticipate that your response will be, as in you previous letters, that the UK was following guidance from the World Health Organisation. Indeed so it was.

It is true that, to the immense alarm of aerosol scientists, epidemiologists and other experts in their field around the world, WHO studiously ignored their warnings that the disease is transmissible by the airborne route and continued to expound the notion that it is only spread by droplets which fall to the ground and do not remain airborne. This was, of course, very convenient for countries (such as the UK), a major funding partner.

Since, as you know, there were insufficient respirators to go round, it enabled them to use the excuse "we are following WHO guidance – we are following the science". Any credibility this excuse may once have had has long-since evaporated with the apology made by WHO's chief scientist last year for the fact that they did not acknowledge the airborne route of transmission early in the pandemic.

9.3 Recommendations

HSE should:

- Consider prosecution of the organisation "NHS Employers" under section 36 of the Health and Safety at Work etc Act 1974 for causing others (NHS Trusts etc) to commit an offence (non-compliance with RIDDOR) by providing guidance in the form of their misdirecting flow chart.
- Instruct NHS Employers to remove (or satisfactorily amend) the offending flow chart, using your enforcement powers if necessary.
- Issue Section 21 Improvement Notices to each and every NHS Trust and Board where there is evidence of under-reporting (in many cases no reporting at all) requiring RIDDOR reports be submitted for each and every healthcare worker who developed COVID-19 following close-quarter contact with infectious patients. It may help you identify culprits by reference to appendix 1 below, although they are by no means the only ones.
- Given the administrative burden likely to be involved, you may feel it appropriate to suggest that cases could be prioritised which have had a significant adverse outcome, i.e. death, long term illness, or where the HCW has requested that a RIDDOR report be made for their case of disease.
- In order to further reduce the administrative burden, you may wish to provide a mechanism for 'batch reporting' which will enable Trusts to submit relevant data by uploading files containing multiple records.
- Although not specifically a requirement of RIDDOR, it would go a long way towards redressing the wrong that has been done to HCWs by HSE, NHS and the public health authorities if, during the administrative process of preparing the above-mentioned RIDDOR records, healthcare employers were required to record details of individuals' symptoms and sequelae where possible. I believe this would greatly assist the IIAC with their current deliberations relating to Industrial Injury Disablement Benefit.

  It may therefore be helpful (with employees' permission) to also record their NHS number so that NHS Digital can perform an automatic 'look-up' against medical records in order to flag up whether a covid-related disease or condition and/or, the code for "Post-COVID-19 syndrome" has been recorded for them. By searching records for appropriate values under the National Clinical Coding Standards and/or relevant SNOMED Codes HCWs could be identified who have been affected by the disease and its after-effects. I would advise an early discussion with interested parties, including and especially the Chair of the IIAC.
- Issue a suitable guidance document in the "Legal" series of HSE documents which properly and unambiguously gives guidance such as HSE provided up until 2012 (L.73). Alternatively (and preferably) publish the document as an "Approved Code of Practice" with the additional status that this would carry in law. Current RIDDOR guidance is disparate and fragmented.
- Make recommendations to Government that they should abandon their ill-considered proposal to revoke the RIDDOR and other health and safety regulations via the "Retained EU Law (Revocation and Reform) Bill. Workers across the country (not just healthcare workers) have a reasonable expectation that deaths, injuries and occupational diseases will be subject to statutory reporting.

- Finally, as mentioned at the beginning of this letter, although it is not my main purpose in writing to you, I would be derelict in my own professional duty if I failed to reiterate one of the points previously made to you, despite your refusal to engage further on the matter.

  HSE should instruct relevant Government Departments, NHS and other healthcare employers that HCWs must be provided with HSE-approved respiratory protective equipment when providing close-quarter care to patients known or believed to be infectious with COVID-19 and similar life-threatening diseases whose causative biological agents are classified as Hazard Group 3 or 4 (unless there is sound, indisputable evidence that the disease is not transmissible via the airborne route).

  Where such instructions are met with refusal then HSE should use the statutory powers with which it has been granted by Parliament (and therefore by the will of the people/workers of this country) to ensure that they comply. This may include prosecution in the Courts, which would most definitely be adjudged as "in the public interest".

- In particular, HSE should exercise its statutory powers over the group which oversees the publication of the National Infection Prevention and Control Manual (NIPCM).

  This main purpose of this manual is to prevent cross-infection between staff, patients and service-users in health and social care settings. Based on the unacceptably high rates of hospital acquired infection that we continue to see, it has manifestly failed in this purpose. It is also central to ensuring the health and safety of workers which, again, it has abjectly failed to do. In fact many would say just the opposite and that its flawed guidance has contributed to the carnage which has been inflicted upon healthcare workers during the pandemic.

  According to section 2 of the current NIPCM, the document is currently being reviewed and further developed by a group known as the "Clinical Oversight Group". These people, who presumably replace the secretive and notorious "IPC Cell" (now-disbanded), need to receive direct and unambiguous instruction from HSE that their manual must be brought into compliance with health and safety legislation and recommend RPE (not surgical masks) for routine care of patients who are known or suspected to be infectious with COVID-19.

  In particular, they need to be disavowed of their mistaken belief that surgical masks are "Personal Protective Equipment". This fundamental misunderstanding lies at the root cause of the tragedy we are witnessing. The members of this group would benefit from the HSE providing some clarity on this and this could easily be achieved by directing their attention to the statement which HSE displays on its web page in relation to pandemic diseases:
  - "Surgical masks do not provide full respiratory protection against smaller suspended droplets and aerosols"
  - "Surgical masks are not regarded as Personal Protective Equipment (PPE)"
  - "A filtering facepiece (FFP3) is a mask which is certified to the PPE Directive"
  - "It will provide an effective barrier to both droplets and fine aerosols".

Yours Sincerely

DFJ Osborn BSc CMIOSH SpDipEM

iosh Chartered Safety and Health Practitioner

QSHCR Registered Consultant

Director, Trident HS&E Ltd (address and contact details provided on accompanying e-mail)

Appendix 1: NHS Health Trusts (England) – Zero RIDDOR Reporting

The following Trusts in England and Health Boards in Wales did not report any cases of COVID-19 disease amongst healthcare workers between 1 March 2020 and 2 September 2021 (First and Second Waves). The Trusts/Boards shown in red also did not report any deaths of healthcare workers associated with COVID-19 during the same period.

ENGLAND	
Ashford and St Peter's Hospitals NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust
Barnet, Enfield and Haringey Mental Health NHS Trust	Northampton General Hospital NHS Trust
Barnsley Hospital NHS Foundation Trust	Northamptonshire Healthcare NHS Foundation Trust
Bedfordshire Hospitals NHS Foundation Trust	Northern Devon Healthcare NHS Trust
Birmingham Community Healthcare NHS Foundation Trust	Nottinghamshire Healthcare NHS Trust
Birmingham Women's and Children's NHS Foundation Trust	Oxford University Hospitals NHS Foundation Trust
Black Country Healthcare NHS Foundation Trust	Pennine Care NHS Foundation Trust
Bradford District Care NHS Foundation Trust	Portsmouth Hospitals University NHS Trust
Bridgewater Community Healthcare NHS Foundation Trust	Queen Victoria Hospital NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust	Royal Berkshire NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust	Royal Devon and Exeter NHS Foundation Trust
Cambridgeshire Community Services NHS Trust	Royal National Orthopaedic Hospital NHS Trust
Camden and Islington NHS Foundation Trust	Salisbury NHS Foundation Trust
Central and North West London NHS Foundation Trust	Sandwell and West Birmingham Hospitals NHS Trust
Central London Community Healthcare NHS Trust	Sheffield Childrens NHS Foundation Trust
Chelsea and Westminster Hospital NHS Foundation Trust	Sheffield Health and Social Care NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust	Sherwood Forest Hospitals NHS Foundation Trust
Croydon Health Services NHS Trust	Shropshire Community Health NHS Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Solent NHS Trust
Derbyshire Healthcare NHS Foundation Trust	South East Coast Ambulance Service NHS Foundation Trust
Devon Partnership NHS Trust	South Tees Hospitals NHS Foundation Trust
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	South Tyneside and Sunderland NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust	South West London and St George's Mental Health NHS Trust
Dorset HealthCare University NHS Foundation Trust	South West Yorkshire Partnership NHS Foundation Trust
Dudley Integrated Health and Care NHS Trust	Southport and Ormskirk Hospital NHS Trust
East and North Hertfordshire NHS Trust	St George's University Hospitals NHS Foundation Trust
East Cheshire NHS Trust	St Helens and Knowsley Hospitals NHS Trust
East Lancashire Hospitals NHS Trust	Stockport NHS Foundation Trust
East London NHS Foundation Trust	Surrey and Borders Partnership NHS Foundation Trust
East of England Ambulance Service NHS Trust	Surrey and Sussex Healthcare NHS Trust
Frimley Health NHS Foundation Trust	Sussex Community NHS Foundation Trust
Gloucestershire Health and Care NHS Foundation Trust	Sussex Partnership NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust	Tameside and Glossop Integrated Care NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust	Tavistock and Portman NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust	The Christie NHS Foundation Trust
Herefordshire and Worcestershire Health and Care NHS Trust	The Clatterbridge Cancer Centre NHS Foundation Trust
Hertfordshire Community NHS Trust	The Dudley Group NHS Foundation Trust
Hertfordshire Partnership University NHS Foundation Trust	The Princess Alexandra Hospital NHS Trust
Homerton University Hospital NHS Foundation Trust	The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
Hounslow and Richmond Community Healthcare NHS Trust	The Rotherham NHS Foundation Trust
Hull University Teaching Hospitals NHS Trust	The Royal Marsden NHS Foundation Trust
Humber Teaching NHS Foundation Trust	The Royal Orthopaedic Hospital NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust	The Royal Wolverhampton NHS Trust
Kent Community Health NHS Foundation Trust	The Shrewsbury and Telford Hospital NHS Trust
King's College Hospital NHS Foundation Trust	The Walton Centre NHS Foundation Trust
Kingston Hospital NHS Foundation Trust	University College London Hospitals NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust	University Hospitals Birmingham NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust	University Hospitals Bristol and Weston NHS Foundation Trust
Lewisham and Greenwich NHS Trust	University Hospitals Dorset NHS Foundation Trust
Lincolnshire Community Health Services NHS Trust	University Hospitals Plymouth NHS Trust
Lincolnshire Partnership NHS Foundation Trust	University Hospitals Sussex NHS Foundation Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust	Walsall Healthcare NHS Trust
Liverpool University Hospitals NHS Foundation Trust	Warrington and Halton Teaching Hospitals NHS Foundation Trust
Liverpool Women's NHS Foundation Trust	West Hertfordshire Hospitals NHS Trust
London North West University Healthcare NHS Trust	West London NHS Trust
Manchester University NHS Foundation Trust	Wirral Community Health and Care NHS Foundation Trust
Medway NHS Foundation Trust	Worcestershire Acute Hospitals NHS Trust
Mid and South Essex NHS Foundation Trust	Wye Valley NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust	Yeovil District Hospital NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust	Yorkshire Ambulance Service NHS Trust
Milton Keynes University Hospital NHS Foundation Trust	
Moorfields Eye Hospital NHS Foundation Trust	**Wales**
Norfolk and Norwich University Hospitals NHS Foundation Trust	Aneurin Bevan University Health Board
North East Ambulance Service NHS Foundation Trust	Cardiff and Vale University Health Board
North East London NHS Foundation Trust	Swansea Bay University Health Board

Note: Some healthcare employers are to be credited with making what seems to have been an open and honest amount of RIDDOR reporting and their senior management and health & safety personnel are to be commended.

For instance the following Organisations reported the following numbers of 'cases of disease':

Maidstone and Tunbridge Wells NHS Trust (1,015) : Blackpool Teaching Hospitals NHS Foundation Trust (436)

East Kent Hospitals University NHS Foundation Trust (961) : Betsi Cadwaladr University Health Board (735)