OPEN LETTER TO: **20 March 2023**

Mr Danny Mortimer, Chief Executive, NHS Employers
Ms Caroline Waterfield, Director of Development and Employment, NHS Employers

With copies 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 Committee
The Rt Hon Layla Moran MP, Chair, All Party Parliamentary Group (Coronavirus)
Ms Sarah Albon, Chief Executive, Health and Safety Executive
Ms Sarah Newton, Chair, Health and Safety Executive

Dear Mr Mortimer, Ms Waterfield

Flawed advice by NHS Employers resulted in breach of RIDDOR Regulations

Recognition of Health and Social Care Workers' Occupational Exposure to COVID-19

As a health and safety consultant I have been involved with cases of post-COVID-19-syndrome (Long COVID) amongst a number of healthcare workers (HCWs) who acquired the disease during the first two waves of the pandemic. During this period, they worked in close proximity to infectious COVID-19 patients for whom they were caring. They were infected with the disease and, to this day (three years on), are still suffering with serious, life-changing effects of Long COVID. A common theme in all these cases is that, without exception, their employers have vehemently refused to accept that their cases of disease were linked with their work.

Furthermore, the majority of these employers refused to make reports to the Health and Safety Executive (HSE) as is required by regulation 9(b) of the 'Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013' (RIDDOR). This requires employers to report cases of disease attributable to occupational exposure to a biological agent (namely the SARS-CoV-2 virus in this instance).

As you are aware, RIDDOR also requires reporting of other types of incidents (deaths caused by occupational exposure to biological agents and accidents involving the escape or release of biological agents).

Throughout most of the pandemic, HSE guidance has stated that, for a case of disease to be considered 'occupational exposure', "there must be **reasonable evidence** linking the nature of a person's work with an increased risk of becoming exposed to COVID-19" and "for 'occupational exposure' to be judged as the likely cause of the disease it should be 'more likely than not' that the person's work was the source of exposure to COVID-19".

My inquiries and professional judgement have led me to the firm conclusion that it was indeed 'more likely than not' that these healthcare workers' cases of COVID-19 were acquired through occupational exposure to the virus. This conclusion was reached primarily by the fact that their occupation involved regular and prolonged contact, often at close range, with patients who had the disease.

A contributory factor was that they were not provided with respiratory protective equipment (RPE) such as FFP3 respirators which would have provided far more efficient protection and made it far less likely that they would have caught the disease in the first place. However, as discussed in the attached letter to the HSE, the wearing of PPE is irrelevant to any decision whether or not to report under RIDDOR. It matters not whether they were wearing the right PPE for the work activity being undertaken, the wrong PPE or indeed no PPE at all.

I concluded that their employers should have reported their cases to the HSE under RIDDOR. They should still submit those reports since, unlike some other aspects of RIDDOR, there is no time limit for reporting cases of disease under regulation 9(b).

To the 'forgotten heroes of the Covid front line'[1] it is particularly important that their disease is properly recorded and officially reported as occupational exposure since their status in respect of future state benefits such as Industrial Injuries Disablement Benefit may depend upon it. If the disease has compromised their ability to work then they should be entitled to it – and frankly, society owes it to them.

My purpose in writing to you is to highlight a malpractice which has pervaded the NHS throughout the pandemic and for which you, as executives of NHS Employers, appear to be largely responsible.

I am writing to complain, in the strongest possible terms, that advice published by NHS Employers has misled NHS Trusts throughout England into RIDDOR under-reporting on a simply astronomical scale. It may well have also had similar influence on the other three nations of the UK.

I trust that the MPs to whom this letter is copied will ensure that the situation is rectified without delay and the consequences of the under-reporting addressed in favour of the healthcare workers who are innocent victims of what has now become a national scandal.

I first became aware of this issue during the summer of 2021 when I began to hear that NHS Trusts were responding to HCW concerns about non-reporting by saying that they were "following the flow chart". I was curious to know what this flow chart was. I found it displayed on your website[2], and is still there to this day.

The section of your flow chart which relates to the reporting of occupational exposure under regulation 9(b), reproduced at figure 1, is quite wrong. It bears no resemblance to either the Regulations (the statutory instrument) nor to any guidance that HSE have ever published on their website.

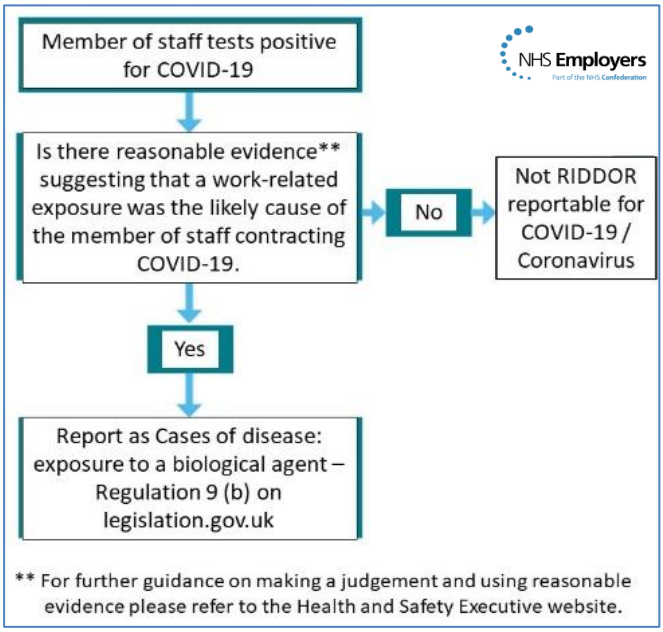

Figure 1 : NHS Employers' guidance in respect of reporting disease under RIDDOR Regulation 9(b)

[1] An insightful BBC Panorama documentary which exposes the physical, mental and financial suffering endured by these workers.

[2] I have provided a link to an archived version in the expectation that you will soon remove the offending flow-chart which is to be found at https://www.nhsemployers.org/system/files/2021-07/RIDDOR-flow.pdf

As can be seen, the entry into this flow path is dependent upon whether the employee has had a positive COVID-19 test. I note that further down the flow path you refer the user to the HSE's RIDDOR guidance pages, which provides useful and authoritative advice. However, in cases where there has not been a positive COVID-19 test, anyone looking at your flow chart will see that first question and not even bother to enter the flow path, so they will not reach your link to the HSE advice, and no report will be made. This is the fundamental flaw in your guidance.

Besides the fact that scientific evidence[3] puts the 'false negative' rate of PCR tests at almost 10%, so clearly cannot be solely relied upon, there is **no requirement whatsoever** in the RIDDOR regulations for the disease to have been confirmed by a laboratory test of any sort. It is the receipt of a **diagnosis** of the disease by a registered medical practitioner which initiates the RIDDOR process – not a test result.

The only mention of test results published in HSE's guidance is that "in the highly unusual circumstances of the pandemic, official confirmation of COVID-19 infection … such as the results of a test performed at a public testing body … may be considered as being equivalent to a 'diagnosis' by a registered medical practitioner and reported to HSE accordingly". It should be remembered that in the early days of the pandemic the availability of COVID-19 tests was quite limited.

The fact that your author(s) cited the exact sub-paragraph number of 9(b) demonstrates that they had studied the Regulations in sufficient detail to have known the correct reporting criteria. Some commentators might even go so far as to accuse them of wilfully misleading duty-holders (the Health Trusts, Ambulance Trusts and other employers in the healthcare sector). Motives for this may have been either to minimise potential civil law liabilities (a fear of personal injury claims) and/or to conceal from the HCW community and the wider public the sheer extent of disease and death being inflicted upon them as the pandemic took hold.

Furthermore, there is prima facie evidence that the author(s) of this guidance and/or yourselves (as the "guiding minds" of the organisation) have committed an offence under section 36(1) of the Health and Safety at Work etc Act 1974, since the offences committed by the above-mentioned duty-holders (i.e. non-reporting under RIDDOR) may be directly attributable to fault on your part in having provided false and misleading guidance to them.

Earlier, I mentioned "under-reporting on an astronomical scale". I should like to elaborate upon this point. Enquiries have been made as to the number of RIDDOR reports that were made to the Health and Safety Executive by NHS Trusts in England between 1 March 2020 and 2 September 2021. The resulting information is presented at table 1 below:

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

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

[3] False Negative rate of COVID-19 PCR Testing: a discordant testing analysis

[4] Note: the figure may could be as low as 62 since, in a small number of cases, the Trusts could not provide the exact figures since release of data might have enabled identification of the deceased. So, when Trusts reported (for instance) "less than 10", the figure 10 was used in the above table.

The fact that almost two-thirds of the Trusts deny having had one single healthcare worker acquire the COVID-19 disease attributable to their work is staggering and frankly very hard to believe, given that a figure was published by ONS in April 2021 of over 122,000 HCWs having Long COVID.

The fact that over 80% of Trusts deny that they have had one single HCW death attributable to occupational exposure to COVID-19 is also extremely difficult to believe. This is highlighted by the fact that the NHS Business Service Authority (NHSBSA) had, at the time of this survey, already approved 613 "life assurance lump-sum payments" for families of HCWs who had died of COVID-19 acquired through their work.

This figure of 613 contrasts sharply with the mere 95 deaths reported under RIDDOR. This evidences the extensive under-reporting and non-compliance with RIDDOR.

When preparing your guidance for NHS Trusts, you should perhaps have referred to the criteria for (a) RIDDOR reporting and (b) qualification for the life assurance lump-sum payment under the NHSBSA scheme, from which you will see many similarities:

Requirements for a RIDDOR report	**Requirements for the NHSBSA scheme**

• Has a diagnosis been confirmed, either by
  ○ a registered medical practitioner; **or**
  ○ other official confirmation of COVID-19 infection (e.g., test results)?
and
• Is there **reasonable evidence linking the nature of a person's work with an increased risk** of becoming exposed to COVID-19?
• Is it more likely than not that the disease was a result of occupational exposure to the SARS-Cov-2 virus?
	The Secretary of State must be reasonably satisfied that the disease was wholly or mainly the cause of death,
	and
	There is **evidence that the individual was exposed to a high risk** of contracting COVID-19. Circumstances deemed likely to expose the individual to a high risk of the disease are where the individual was **either**:
	• Testing or diagnosing whether a person was infected with COVID-19; **or**
	• Caring for or treating a person who has, or is suspected of having COVID-19; **or**
	• Involved in any type of service being provided directly within the environment or facilities where such diagnosis or care is occurring[5,6].
	Further, the individual must have been at work, performing the duties which put them at risk in the 14 days before the start of their symptoms[7].

Table 2: *A comparison of RIDDOR and NHSBSA criteria for determining 'occupational exposure'*

It is pleasing to see the 'common sense' approach taken by the NHSBSA scheme. It unambiguously states that an individual is considered to be at high risk of contracting COVID-19 if they are "caring for, or treating a person who has, or is suspected of having, COVID-19". This alone seems to satisfy the RIDDOR requirement for "reasonable evidence linking their work with an increased risk of becoming exposed to COVID-19".

[5] This wording does not restrict eligibility just to those HCWs providing close-quarter care at less than two metres. Just being in the same environment (e.g. ward or room) is sufficient.

[6] It should be noted that in Wales these criteria are extended to "engaging with a person in relation to the carrying out of social care functions who has or is suspected of having COVID-19".

[7] N.B. There is no requirement for a test result.

So, there was no requirement to prove that the actual individual virus particle which initiated the disease entered their body whilst they were at work, as opposed to "out in the community". Neither was there any reference to whether the NHS Trust was "fully complying with Public Health guidance". Both of these are frequently used by NHS Trusts as excuses for denying "occupational exposure" and refusing to report under RIDDOR.

When considering the "evidence of exposure" test, the NHSBSA scheme did not even require any of the tests which require judgements to be made such as "reasonable evidence", "more likely than not" or "on the balance of probabilities". With no such opinions having to be formed by decision-makers within the health trusts or even at Secretary of State level this leaves the award of compensation very clear cut and unambiguous.

So, all that was required to satisfy the overall requirement was:

i. evidence that COVID-19 contributed to the death (e.g., mentioned in part 1(a), 1(b) or 1(c) under "cause of death" on the death certificate, or other evidence such as a Coroner's verdict; and
ii. that they had been at 'high risk' (e.g., had cared for, or treated a COVID-19 patient).

You will note that there is no reference whatsoever within the NHSBSA criteria to whether the individual was wearing the right PPE (or any PPE at all).

Please take note of a recent coroner's ruling that the deaths of two healthcare workers were categorised as "Industrial Disease" despite the protestations of their employer, who had not reported these deaths under RIDDOR. They had not reported any other deaths, or even a single case of disease. This, alongside last week's ruling concerning the death of an ambulance worker, changes the landscape of RIDDOR reporting for all healthcare worker deaths and diseases, and you need to adapt your guidance accordingly, making it far easier for HCWs to have their 'occupational exposure' recognised.

In order to resolve this highly unsatisfactory situation, I request that you:

1) **Remove the flow chart from your website or replace it with one which properly outlines the RIDDOR-reporting process.** However, please be mindful of NHS guidance ahead of the forthcoming Public Inquiry and ensure that you retain copies of the flow chart currently displayed and all correspondence which led to its development. These items may be required as evidence which could be helpful to the Inquiry.

2) **Write a letter to the Chief Executives of every NHS Health Trust and any other type of organisation or charity which relies upon your advice.** In that letter you should:

   - Explain (and I suggest apologise for) the incorrect guidance you have given them;
   - Set out the correct criteria which they should apply when determining whether any given case of disease or death has resulted from 'occupational exposure'. For simplicity and consistency of message, I recommend that you apply the same criteria for RIDDOR as are already being used by NHSBSA, as in the right-hand column of table 2 above.

     If these criteria are good enough to satisfy the Secretary of State about 'occupational exposure' then they should also be good enough for the persons in Health Trusts who are responsible for determining 'occupational exposure' in the context of RIDDOR. It should also satisfy the Health and Safety Executive who are subservient to the Secretary of State.

   - Request that they forward the above information to all their subcontractors and temporary staff and ask subcontractors to share the information with their employees, including all employees within their supply chain. This is in line with the NHSBSA instruction to Trusts in respect of the lump-sum payments for coronavirus deaths. No lesser a duty should apply in respect of reporting incidents under RIDDOR.

- Request that the above information should also be forwarded to voluntary organisations (RVS, WRVS, chaplains, etc.), since they also have duties under RIDDOR (volunteers being considered 'employees' within health and safety legislation).
- Request that they review all cases of HCW infection and death that have occurred within their organisations, based on the above guidance, and identify those cases where the criteria for RIDDOR-reporting have not been correctly applied.
- Explain that, for strict compliance with the RIDDOR Regulations, all cases should still be reported, given that there is no time-limit on reporting under Regulations 6(2) and 9(b). To ease the administrative burden on Trusts you might explore with HSE whether they would put in place a mechanism for "batch submission" of data, rather than entering reports one by one online.

  You may feel it appropriate to acknowledge that due to the significant administrative burden this may cause NHS Trusts, 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.
- Explain that the person normally responsible for making RIDDOR reports should be free to form their own unfettered, professional opinion on the question as to whether any particular case is reportable. In most organisations the person usually assigned this responsibility would be either:

  a. the 'competent person' appointed under regulation 7 of the Management of Health and Safety Regulations 1999 (usually the Health and Safety Director/Manager/Advisor); or

  b. the person assigned the responsibility for RIDDOR in the organisation's written health and safety policy (which usually is the person in (a) above); or

  c. the organisation's Occupational Health doctor/nurse/advisor, who may submit the RIDDOR report themselves (usually after consultation with the person in (a) above).

  These people will usually be required by their professional institutions (e.g., IOSH, FOM, BOHS, etc.) to follow ethical codes of practice. They should not, therefore, allow themselves to be influenced by any pressure or coercion from management or lawyers not to report certain cases or to participate in a site-wide cover-up, as seems to have been the case in most of the Trusts in England. At the Public Inquiry they may well be called as witnesses and required to truthfully explain their reasons for not reporting. So, if they did participate in a cover-up, now is the right time to remedy that situation either to do the right thing and stand up against coercion and submit the reports that were withheld or to 'whistleblow' to the Care Quality Commission and the HSE. As mentioned, there is no time-limit for reporting under RIDDOR regulation 6(2) (Covid-related deaths) or 9(b) (Covid disease).

3) In order to satisfactorily close out this complaint, when you have sent the above letter, please would you copy it to myself and the Honourable Members mentioned above, to whom this letter is copied.

   This open letter will be displayed on the internet. As a courtesy to you, I would of course display any letter(s) you may send me in reply.

I trust that I have comprehensively set out the issue for you and that you will respond appropriately since these are legal requirements that are binding upon all NHS employers.

However, apart from the strict legal issues involved, there is a moral and ethical aspect to this matter that we should consider. NHS staff and other healthcare workers across the UK have given their all to support the citizens of this country through this awful pandemic. Despite knowing the risks they would face, they followed their vocation and cared for patients as they struggled to cling to life – in many cases saving those lives, but on other occasions comforting them in their final hours of life, alone and separated from their loved ones.

They did this in full awareness of the potential dangers involved to themselves. As such, they were (and continue to be) very brave. Many of them paid the ultimate sacrifice and died. Even more of them paid the price with their health and endure serious long-term consequences which may be with them for the rest of their lives. It is on account of these brave people and the bereaved families that I am writing you this letter and making similar representations to the Health and Safety Executive.

I am certain that the thousands of people across the country who, like me (and probably like you), stood on our doorsteps and 'clapped for carers' would agree that those brave people carers who have been severely harmed by the disease which they contracted whilst helping sick patients should, themselves be supported. The nation supports its military veterans who have been wounded in service in war. We should do no different for those who fought the pandemic at the front line.

Yours sincerely

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QSHCR Registered Consultant

Director
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