Module 3 Week One

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Opening Statement of CTI

Stay at Home, Protect the NHS, Save Lives

Why did we need to save the NHS?

IPC Cell

This cell that made the infection prevention and control recommendations that underpinned the UK IPC Covid-19 guidance. It was chaired by Lisa Ritchie. It was not technically a decision-making body. However, you will want to consider the extent to which, if at all, the UK IPC cell's recommendations were altered and/or overturned. Was the IPC cell the de facto decision-making body for IPC guidance?

ICU and Dilution of Care:

Figures provided by the intensive care society indicate the UK entered the pandemic with just 7.3 critical care beds per 100,000. By contrast, Germany had 28.2 beds per 100,000, and the Czech Republic had 43.2 critical care beds per 100,000.

The experts will tell you patients were looked after in ways that were stretched and diluted care compared to usual critical care, sometimes in makeshift ICUs. Ordinarily ICUs have one nurse with specialist critical care training per patient. During the pandemic in some places the ratios were stretched to one critical care nurse to four or even six patients.

Clinical Prioritisation Tool

During the pandemic, there was great concern amongst the medical profession that frontline doctors would be called upon to make ethically and legally challenging decisions about which patients should be escalated to critical care in the event there was no more critical care capacity.

For a brief period, a working group was convened to consider and develop a clinical prioritisation tool to be used if saturation of critical care resources was reached. In fact the tool was stopped very shortly after it was asked to be worked on, because it was considered that critical care resources would not in fact be so stretched that the tool was needed.

There is evidence that suggests that the pandemic resulted in a rationing of care and/or poorer outcomes.

DNACPR

During the course of the pandemic, there were reports of blanket DNACPRs being imposed, for example the BMA heard reports of GP practices sending blank DNACPR forms to patients over 65 or to those with a disability. There are also reports of DNACPRs being used inappropriately.

Pete Weatherby KC on behalf of CBFFJ UK

Boris Johnson, Matt Hancock and others, have brazenly asserted that one of the key successes of the Covid response was that the NHS was never overwhelmed. The fact that hospitals and healthcare facilities continued to operate at some level must not be allowed to point to a dangerously misleading conclusion that things went reasonably well. Where acute demand for emergency and critical care services outstripped supply, those services were indeed overwhelmed and unable to function as they should. Overwhelmed services cost lives.

Protocol 36

Change made to the patient prioritisation: Individuals triaged as Category 1 should receive an ambulance within 7 minutes and those in Category 2 should receive one within 18 minutes. If a person called for an ambulance saying they were struggling to breathe they were assessed as category 1. However, this was changed during the pandemic so that if a person called for an ambulance saying they were struggling to breath, and they have covid symptoms, they would be classified as category 2.

Sarah Hannett KC on behalf of Long Covid

The healthcare system has not committed even now to preventing Long Covid, there is no treatment for Long Covid, the only way to avoid contracting it is to prevent Covid 19 yet practitioners, patients and the public were not and are not adequately warned about the risk of Long Covid. Further there was no communication of the risk of Long Covid as part of the drive to encourage vaccine take-up.

Mr Wagner on behalf of CVF

The clinically vulnerable and clinically extremely vulnerable were given the strictest precautionary advice at home. However those same people were most likely to have to spend time at GP practices and in hospitals, and there they were exposed to a serious risk of contracting Covid-19. The clinically vulnerable

were told to take personal responsibility. Patients cannot be responsible for environments in healthcare settings – that is the responsibility of the institutions.

Mr Simblett obo CATA

Conflicts between the instructions given to the wider public with the instructions and procedures in work. They were instructed to suspend common sense and follow flawed instructions and without necessary equipment. they were not told these decisions were based on lack of equipment and was expected to believe that such equipment was not required.

The response was never about following the science at all, all of this was compromised for economic and pragmatic reasons.

The IPC cell workings will need to be scrutinised carefully. CATA suggests that the IPC cell towed the line of political expedience rather than following the science. The precautionary principle and common sense should always prevail in the face of scientific uncertainty.

Prof Leslie Thomas KC obo FEMHO

The disparate impact arising from the pandemic of this nature was foreseeable. It did not have to be, however, inevitable. 95% of doctors and 64% of nurses who succumbed to the virus in the early stages of the pandemic were from ethnic minority backgrounds.

Brian Stanton obo BMA

The UK entered the pandemic with too few doctors, hospital beds, critical care beds, alongside high staff vacancies. The consequences of entering the pandemic significantly under-resourced and of the severe disruption that followed are still impacting healthcare systems today with millions on waiting lists for treatment.

The supply of PPE was woefully inadequate, and during the early months of the pandemic PPE shortages meant that staff had to go without PPE, re-use single use items, use items that were out of date, with multiple expiry stickers visibly layered on top of each other, or use home-made and donated items.

In addition to these severe shortages, the inadequacies of the IPC guidance meant that any items that staff did have often failed to provide adequate protection from an airborne virus.

It was well known at the start of the pandemic that there was the potential for aerosol spread. It was also known that FFP3 respirators provided far greater protection against an airborne virus than a fluid-resistant surgical mask. Based on these two pieces of knowledge, the IPC guidance should have taken a precautionary approach to protecting the lives of staff and patients, by recommending that all staff working with Covid-19 patients use FFP3 respirators to protect them from infection. Shockingly, despite

the growing weight of evidence of aerosol transmission as the pandemic progressed, the IPC guidance continued to put staff and patients at risk of infection and of spreading that infection by recommending surgical masks for routine care of patients with Covid-19.

It is the BMA's view that lives could have been saved if those responsible for producing the IPC guidance as well as Britain's national regulator for workplace health, the Health and Safety Executive, had taken a precautionary approach to protecting healthcare workers and patients.

Mr Burton obo Disabilities Charities Consortium

Three in five Covid deaths were experienced by one fifth of the population. clinical as opposed to social factors cannot possibly explain these massive disparities in mortality rates. But the DCC does not accept that (a) the disproportionate impacts on disabled people were in some way inevitable or (b) merely by being aware of the disproportionate impacts at the time was sufficient. Handwringing is no replacement for positive action.

All too often the needs of disabled people were an afterthought, and disadvantage was only corrected if at all after interventions by amongst others DCC members. Because government was not properly and systemically addressing potential disability discrimination many more disabled people died or were negatively impacted by Covid-19 than ought to have been. Leaving disabled people feeling expendable as if their lives were valued less.

Witness Evidence

John Sullivan from CBFFJ UK

John gave evidence about the tragic death of his daughter Susan. Susan was taken into hospital by ambulance after waiting many hours, with one ambulance even being diverted. Because SUsan had Down Syndrome and would not have understood important matters, the hospital initially allowed her Mum in with her however this was only for a short period. Susan did not like anything on her face so was not able to keep her oxygen mask on. The hoospital did not make a reasomable adjustment to allow either a family member or someone from the Disability Support Team to be with Susan who would have been able to explain in a way that Susan could understand, why the mask was important.

Susan deteriorated however the hospital notes record “"ITU declined in view of Down's Syndrome and cardiac comorbidities." The only co-morbidity Susan had was a pacemaker. Neither Down Syndrome or a pacemaker are reasons to decline ITU care. Susan died within 28 hours of being in hospital. John said “they gave her a bed to die in.”

John said of Susan *“240 people attended her memorial. Susan didn't matter maybe to them doctors, but she mattered to all them hundreds of people that took the day off to attend her memorial. She was one of life's special people.”*

Paul Jones from CBFJ Cymru

Paul lost his 25 year old daughter Lauren during December 2020. Medical medical staff have thought that Laurens age may have masked how sick she was and she may have been suffering from silent hypoxia.

Lauren was admitted to a covid specific ward and the next day messaged to say she was doing ok. At this point there was nothing to suggest she was seriously ill. They thought she would be discharged the evening or the next day however this was their last conversation with her.

They received a call around 11pm by a consultant who explained that as Lauren was overweight, there would be difficulty placing a line in her groin and after discussion with other consultants it was decided she wasn't a candidate for treatment. Consultant told us Lauren was unlikely to survive the night. I was shocked and left with the impression that Laurens weight formed part of the decision to deny her treatment.

Carole Steel from SCB

Carole lost her son Andrew who was 28 years old. After calling for assistance he was told to wait another day because it was only his ninth day. The next day he deteriorated. We called the ambulance and during that call he became unresponsive. HIs girlfriend was talked through how to give CPR. The Ambulance arrived and they worked on Andrew for around 20 minutes

They told us that he'd had a blood clot, a pulmonary embolism, and that it had been caused by Covid, and the damage that it had done was irreversible, and I just couldn't understand how that was possible, he was young. I remember the advice at the time was that we were to look out for the elderly and the vulnerable, those that are most at risk, and I couldn't understand why someone at 28 years old, this could happen to. The doctor said they were seeing this in younger people. Nobody else was aware of that as far as I knew. It didn't seem to be in the public domain that younger people were at risk.

Catherine Todd from CBFFJ NI

Catherine lost her newborn baby Ziggy. Catherine started to feel unwell with Covid and noticed reduced movement in her baby. She called for advice and was told to lie on her side, take paracetamol and drink fizzy drinks.

I asked for Ziggy to be checked and the said they wouldn't bring me in to reduce the risk of Covid spreading. I think I would have been checked earlier if I had not had Covid.

On 16th July I decided to go to hospital because I just kept getting the same advice every time I called. I was 27 weeks and 6 days. Because of this they would only give me the basic scan, they would not give

me the advanced scan because I was not yet 28 weeks. They said me and Ziggy were fine and sent me home. it felt rushed.

3 days later started to struggle to breathe. An ambulance came out and checked me but didn't check Ziggy. They said I was fine. The next day I called my GP and they told me to go to hospital straight away and they would tell the hospital to expect me. After waiting for more than 15 hours I was told I needed an emergency C-section. My partner was only allowed in after Ziggy had been born. We were told we were being taken to see Ziggy, I thought he was doing ok. They did not tell us Ziggy was on palliative care. They handed Ziggy over to me and left us. Ziggy passed away and they didn't come back for 2 hours. We had to wear full PPE. There was no compassion.

Prof Clive Beggs - IPC Expert

Bioengineer and a physiologist. Particular expertise in ventilation and the behaviour of aerosols in the air, biophysics and the application of engineering interventions to mitigate the transmission of infection.

- Droplets are above 100 microns. It behaves ballistically. It has mass and weight and has trajectory and velocity. They will fall rapidly to the floor and cant go more than a metre to a metre and a half.
- Aerosol particles are below 100 microns. They float in the air and wherever the air goes, the particles go.

In 2024 my opinion is C19 is transmitted predominantly by an airborne route but not excluding other routes such as droplets and contact

In 2020 my opinion was that it was likely to be airborne, that was a strong component but not exclusively so also droplet and contact. Those who were advising and preparing IPC guidance did not have the same opinion as me. The clinicians say anything above 5 microns is a droplet. As far as I'm concerned that has no basis in physics, it's completely arbitrary.

The size of the particle is relevant to how far it can travel but also the type of IPC measures that might be required. Lisa Ritchie's view is that the distinction between a respiratory aerosol and a droplet in terms of size is an academic consideration that cannot usefully be applied in national guidance.

It is not academic. It's really important to understand how infection is transmitted, so that you can take steps to mitigate the transmission.

The longer you spend in a space, even if the concentration is not that high, you're at risk. Where the viral load is allowed to accumulate in a poorly ventilated room, even short exposure times can result in significant risk.

<u>PPE</u>

FRSM protect the wearer and other people from droplets, not from aerosols

FFP3 Respirator masks are tight fitting and are designed to protect the wearer from inhaling aerosols. They also protect from pushing particles out into the environment.

Assessing how effective masks are in a lab setting is straightforward. Assessing the effectiveness in the real world is more difficult.

A study found that masks were effective in mitigating and reducing transmission and that respirators were more effective than FRSMs.

If there is a high viral load in a room one way of preventing infection is wearing masks, the other is ventilation. Ventilation flushes out the particles and reduces the concentration.

Dr Barry Jones from the Covid-19 Airborne Transmission Alliance (CATA)

I do not disagree with Prof Beggs about anything. We absolutely concur with Professor Beggs' expert opinion, particularly on the definition of aerosols and droplets, which we regard as absolutely critical. There are thousands of healthcare workers who disagree with the IPC guidance which is based on bad science, a bad interpretation of the science. Nevertheless, we had to follow the IPC guidance during the pandemic

The Environmental Modelling Group set up by SAGE advised SAGE on 14 April 2020 that Covid-19 was likely to be transmitted by the aerosol route, and that the particle size was 100 between aerosols and droplets, not 5. That was ignored. Public Health England pushed back against the IPC Cell a number of times in December 2020 and 2021 and said they wanted to broaden the use of respiratory protection and invoke the precautionary principle, and they were ignored somehow. All of us who tried to push back were rebuffed and managed so that we weren't a nuisance.

The the guidance did not address the natural activities such as coughing, sneezing, even breathing. They all generate significant aerosols which posed a hazard if sufficient protection is not provided. Those who were making the IPC guidance didn't take a sufficiently cautious or precautionary approach to the risk of aerosols and we don't understand why they did that.

If it wasn't clear to them that Covid-19 was airborne, that comes under the heading of scientific uncertainty. The precautionary principle should be invoked when there is scientific uncertainty. Taht is the failsafe but they didn't do that.

The reason why that mattered is because the wrong PPE was being advised. The fluid-resistant surgical face masks don't prevent the aerosols from reaching the nose and the mouth and therefore initiating the disease and therefore healthcare workers weren't as protected as they could have been.

All the correspondence we had from HSE made it clear that so long as trusts, hospitals were following, the guidance, that was fine by them, it didn't matter that they were the wrong masks. We have regarded the response of the Health and Safety Executive as entirely unsatisfactory throughout the whole pandemic.

Richard Brunt from the Health and Safety Executive (HSE)

HSE is responsible for workplace safety. It has a role in enforcing workplace health and safety law.

PPE

IPC guidance will set the benchmark, the minimum standard to be achieved. We accepted the IPC guidance as the appropriate level of compliance.

HSE regulates the provision of PPE. PPE is designed to protect the individual and nobody else, it's personal. The fluid-resistant mask (FRSM) is classed as a medical device, not as PPE. Although it may offer some protection, it's not what we would consider PPE. FRSMs offer a limited amount of protection for droplets. They're not the same as an FFP3.

The recommended PPE table included fluid-resistant surgical masks which are not considered by HSE to be PPE. I had conversations with PHE and DHSC throughout the pandemic, we were always going back to that, that fluid-resistant masks are not PPE.

Chair: If you know as the HSE, that it is airborne, and if you know that surgical masks aren't sufficient, you surely can't, in accordance with your statutory duties, say, we'll just follow whatever the IPC cell says? The HSE has statutory duty to protect three-quarters of a million healthcare workers, shouldn't you step in?

What we knew about routes of transmission was reflected in the IPC guidance. Had we thought that that was falling short of what we thought was going to be the exposure routes, we would have advised accordingly and stepped in

We were aware of the concerns about the labelling issues and whether the PPE was appropriate. We worked very closely with DHSC and others through the supply chain and gave advice.

For FFP3 masks you must do a fit test – a fit check is no substitute.

RIDDOR

Making a report under RIDDOR is not an acceptance of blame or that a breach has occurred, it's just a statement that an event has taken place. RIDDOR was not intended to be used in a pandemic involving thousands of instances of infection, it was really designed to capture single one-off unexpected events, distant and incidents.

HSE took the view that the reporting relates to the work activity. If you're exposed by meeting a colleague coincidentally in the corridor, that's not the work activity. We were looking specifically at those people

who were directly interacting with patients known to have Covid. It is a judgment by the employer as to how likely it was that an infection was caused by that work related exposure.

Trades Union Congress, the Royal College of Nursing, the British Medical Association and the Covid-19 Airborne Transmission Alliance, and all those core participants have taken the view that the Health and Safety Executive set the bar too high for reporting occupational Covid-19

We think that that bar was the correct one.

We regulate work activities. We need to understand if work has led to a death and take appropriate action but it is still the judgment of that workplace to determine whether that work activity was contributory.

Inspections

Our inspection activities continued on hospitals. We extrapolated information from that to be able to help those healthcare settings to identify where the challenges were. There comes a point at which there is nothing left to learn and we can say that we understand what is expected.

HSE categorises harm from Covid-19 as Significant rather than Serious.

- Health and Safety Executive defines serious harm as harm that has an effect which is progressive or irreversible, permanently disabling, a lifelong restriction of work capability or a major reduction in the quality of life.
- Significant harm is one rung below, is non-permanent or reversible, non-progressive and any disability that is temporary.

BMA wrote to the HSE on 21st Jan expressing concern that the FRSMs did not offer sufficient protection and asked the HSE to undertake a review of the guidance. HSE responded saying it will not be undertaking a review, as this has already been done by those responsible for the guidance.

We were looking to the Public Health England and DHSC as the leads on the pandemic and making sure that guidance is suitable based on what we knew at the time. We'd taken account of the advice we're getting from our chief scientific advisers.

Chair: Given that you've always accepted that certain kind of masks weren't suitable why doesn't something change? This looks a bit like a fobbing off.

HSE lessons learned document

"Aerosol transmission was underestimated significantly at the outset and for some months thereafter. Controls were therefore less effective than they could have been, notably in settings like health and social care."

"All plausible routes of transmission for a novel biological agent should be considered and an initial precautionary approach to risk management should be adopted."

Sara Gorton from the Trade Union Congress and UNISON's head of Health

There were signs going into the pandemic for the few years in the run-up that the healthcare workforce had been largely overlooked and neglected in favour of a government and policymakers who seemed to be obsessed with structure, system architecture, rather than addressing the needs of the workforce.

The survey paints a picture of people at breaking point. Not having enough staff, not having access to the breaks they need in order to work the shifts, the pressures they feel under to accept more work in order to cover the gaps, the personal impact they felt from not having what they needed to deliver the services to the standards they wanted to deliver them to patients. That's not a description of a resilient workforce ahead of a major crisis.

The particular issue of the airborne nature was a gap that lots of professional bodies had been raising.