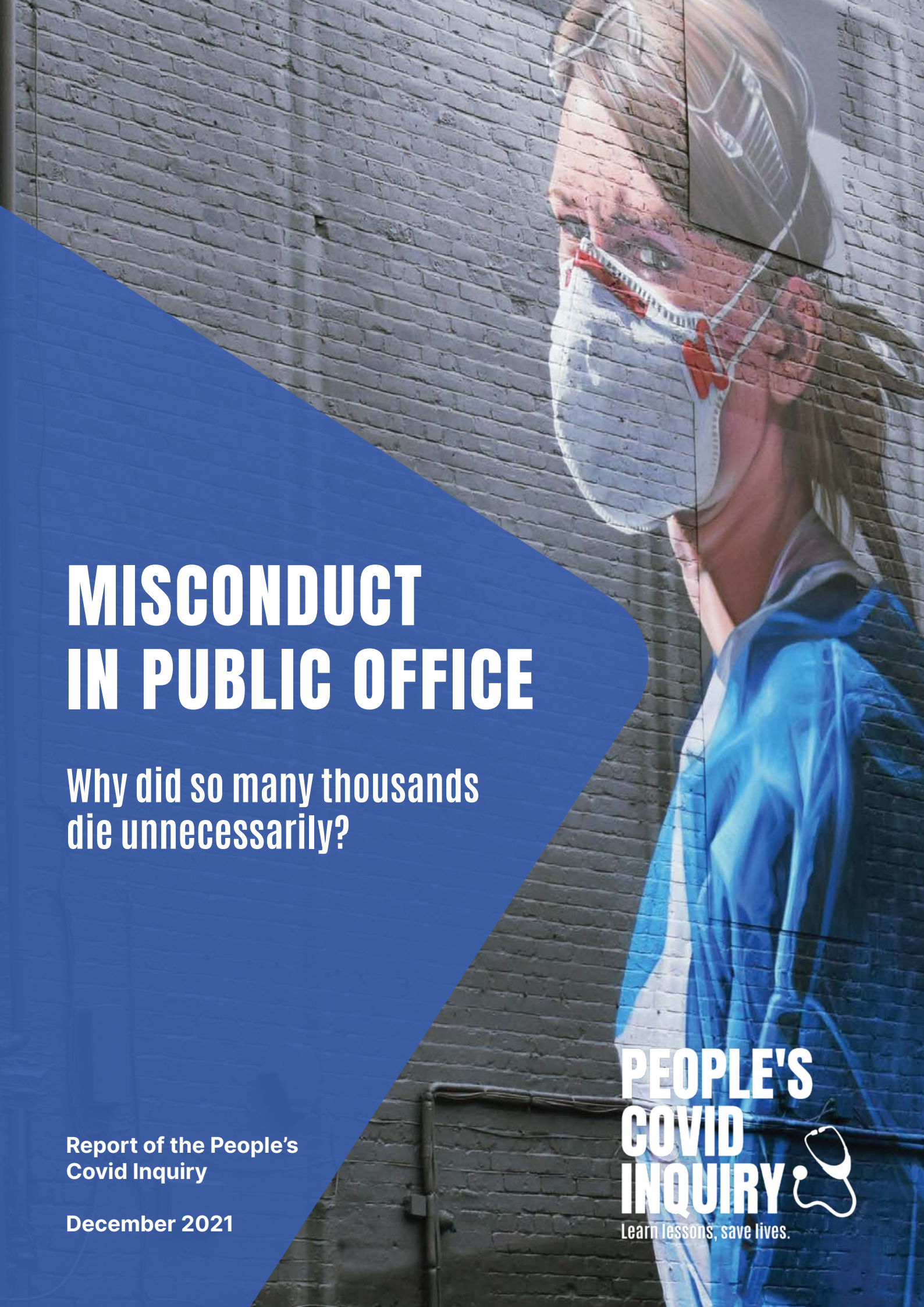


MISCONDUCT IN PUBLIC OFFICE

Why did so many thousands die unnecessarily?

Report of the People's Covid Inquiry

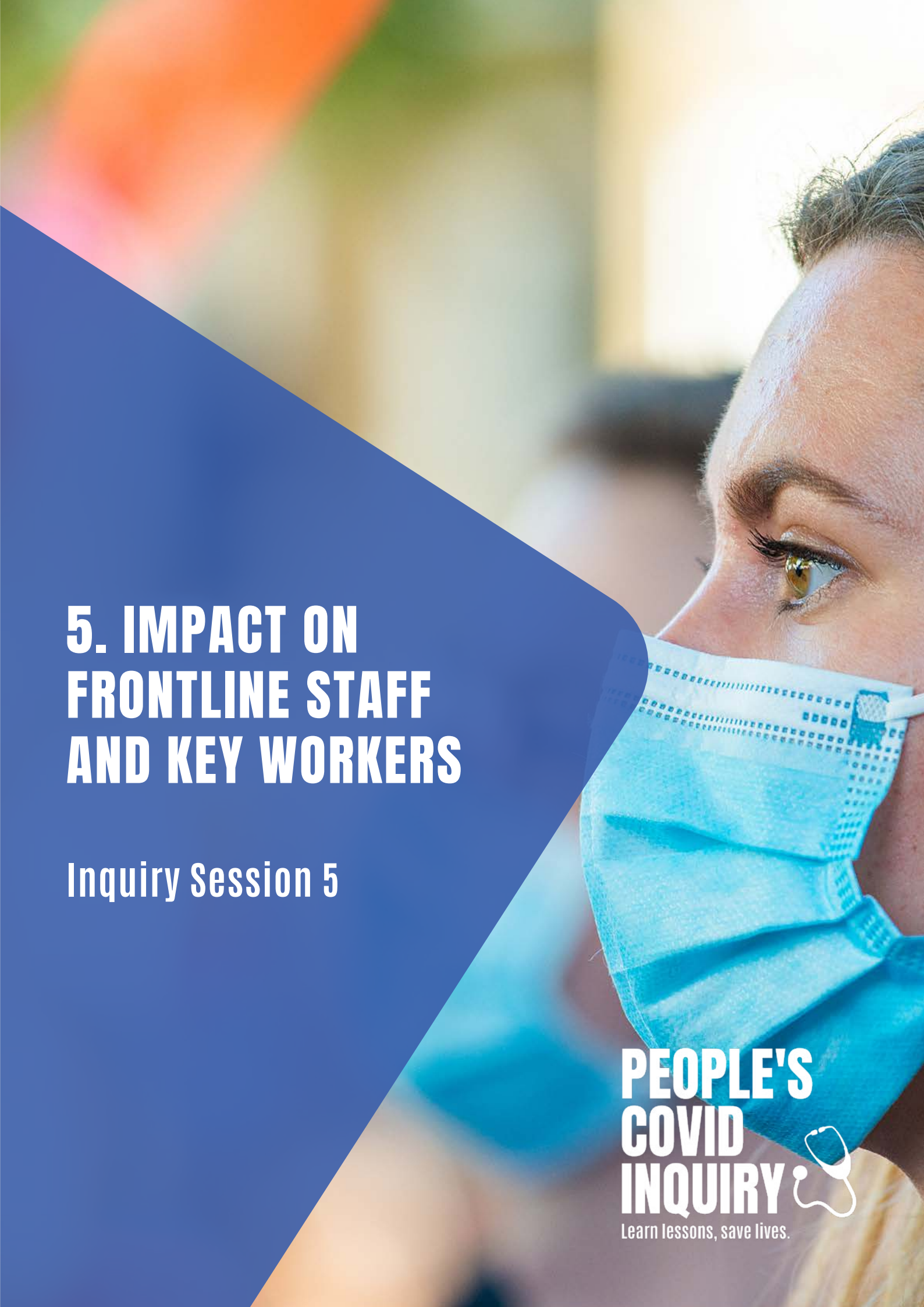
December 2021

PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

5. IMPACT ON FRONTLINE STAFF AND KEY WORKERS

Inquiry Session 5



PEOPLE'S COVID INQUIRY

Learn lessons, save lives.

5.0 INTRODUCTION

5.0.1 In lockdown and beyond, large numbers of workers – often low-paid, frequently in insecure employment on zero-hour contracts and with a high proportion from BAME communities – served the public alongside NHS and care staff. It appeared to catch the Government unawares (despite Operation Cygnus in 2016/17, conducted during Jeremy Hunt's tenure as Secretary of State for Health) that high-quality PPE was essential not only for NHS staff – but also for the over one million care staff, transport workers, taxi drivers, supermarket and food store staff, delivery drivers, school and nursery staff, etc.

5.0.2 By the start of the Inquiry, nearly 900 NHS and care staff had died and many bus and train transport workers had also succumbed to Covid. Schools, shops and delivery staff had suffered too; all are part of the community, with individuals both becoming infected and passing on infection. Unable to work from home, and often living in homes with high occupancy and low space, many faced increased risk without access to support necessary for self-isolation.

5.0.3 Cases related to possible exposure to the virus at work were not sufficiently reported or investigated so that valuable lessons could be learned and findings applied. Psychological trauma was clearly leading to long-term mental health problems and around 10% of those infected were found to be suffering long term symptoms ('long Covid'). These will require considerable investment in health service infrastructure to provide assessment and ongoing treatment.

5.1 PROTECTING WORKERS FROM RISK OF INFECTION?

> *'I had little doubt at the onset of the pandemic that thousands of workers were not being adequately protected from serious risk to their health.'* (Agius)

5.1.1 It is clear that neglect of health and safety at work by Government and employers resulted in the needless deaths of many workers as well as care home residents, with a disproportionate effect on those from BAME communities. After the initial lockdown, the public came to appreciate the work of many employees to be of key importance in keeping society functioning, with a new insight into how jobs and roles interconnected. High income/status occupations such as stockbroker were now compared unfavourably with the social value provided by, among others, cleaners, public transport staff, and distribution and shop workers in addition to those in the health and care service.

5.1.2 We heard, however, that those working in social care remained invisible, forgotten and undervalued. Of around 1.5 million working in the care sector, 840,000 general care workers were looking after 420,000 vulnerable people in care homes. Government's poor support for this sector was reflected in deaths of 11,186 care home residents up to 2 June 2020, and 131 social care workers up to 20 April 2020, with more deaths predicted.[5.1] Data from the Office of National Statistics showed a twofold higher risk of death from Covid for social care staff compared with the general population, with five times the chance of having a positive test result for the SARS-CoV-2 virus.

5.1.3 Vulnerability in the social care sector is likely to be connected to 50% cuts in local authority funding over the past 15 years adding to existing financial pressures. Other factors were the precipitate discharge of elderly hospital patients into care homes without testing, and subsequent spread of virus to other residents and care home staff. The national shortage of PPE meant the care sector lost out to the NHS. The pandemic highlighted that social care was 'broken' through lack of funding and resources.

5.1.4 Early in the pandemic NHS England recognised the disproportionate mortality and morbidity in BAME people. NHS Employers published guidance on 30 April 2020 for NHS organisations to take appropriate measures to mitigate the risk of Covid, including taking age, gender, underlying health conditions and ethnicity into account. However,

> *'Viral exposure and inadequate protection at work as the principal determinants of risk were not given adequate recognition.'* (Agius)

5.1.5 Neither the 'Risk reduction framework' for NHS staff (used in conjunction with NHS employers guidance) nor PHE advice took sufficient account of relevant past research which had generated precautionary guidance on how to reduce risk of viral exposure. Pre-pandemic work from the HSE had demonstrated that the FFP3 type of facemask was much better than fluid resistant surgical masks (FRSM) in protecting against inhalation of airborne virus:

> *'There is a common misperception amongst workers and employers that surgical masks will protect against aerosols ... Live viruses could be detected in the air behind all surgical masks tested. By contrast, properly fitted respirators could provide at least a 100-fold reduction.'*[5.2]

This led to the recommendations that these be used for workers exposed to risk from aerosolised virus.

5.2 PRECAUTIONARY APPROACH TO GUARD AGAINST COVID INFECTION ABANDONED

5.2.1 During the pandemic, HSE abandoned this precautionary approach, and accepted less stringent requirements for PPE thereby exposing workers to greater risk of infection. While the reasons for this are not fully clear, it seems probable to have been related to the inadequate, rundown and neglected state of the national PPE stockpile.[5.3] Pre-pandemic, not only had emergency stockpiles of PPE been allowed to dwindle, but also training for key workers in how to deal with a pandemic had been put on hold. In addition, early attempts to source PPE were weak and opportunities for collaborative procurement missed.[5.4] As far back as 2008, HSE had warned that in anticipation of a pandemic, stockpiling of facemasks ('respirators') would be essential:

> *'The widespread use of respirators might be difficult to sustain during a pandemic unless provision is made for their use in advance.'*[5.2]

5.3 UNDERESTIMATION OF AIRBORNE SPREAD OF VIRUS

> *'A huge concern in relation to preventing spread of Covid-19 at work has been the persistent underestimation of the risk of airborne spread and hence the*

inadequacy of precautionary protection, in spite of past lessons.' (Agius)

5.3.1 The risk of airborne spread of virus was consistently played down despite mounting evidence, and with disastrous consequences. Lessons that had been learned during other viral epidemics and outbreaks (SARS-CoV and MERS-CoV – also betacoronaviruses like SARS-CoV-2) were not applied in the current pandemic. During the spread of SARS (SARS-CoV) in Hong Kong in 2002/03 it was learned that health and care workers had to be provided with FFP masks as minimum respiratory protective equipment.[5.5]

5.3.2 This should have made it essential for use of FFP3 type facemasks for health and social care workers likely to be coming into contact with Covid infected patients. As awareness developed of people without symptoms being able to spread the virus, such masks should also have been used in other occupations involving close contact with the public.

5.4 RATIONALISING THE RATIONING OF PPE

5.4.1 Consistently understating the role of airborne transmission was used to justify recommending less effective facemasks. We heard that the misplaced insistence that airborne transmission of virus came only from specific 'Aerosol Generating Procedures' (such as intubation of a patient immediately prior to mechanical ventilation) and seems likely to have been influenced by a need to justify rationing of equipment.

5.4.2 For example, PHE guidance did not advocate wearing the higher grade FFP3 masks for workers involved with routine face-to-face care of infected patients, despite the fact that breathing, coughing, and talking generate aerosols carrying the virus. Although aerosol generation was much debated, PHE advice ignored the earlier precautionary guidance from HSE and was contrary to the principle that

'All workers encountering such exposure must have a sufficient workplace assessment and appropriate risk reduction such as through better ventilation and filtering face piece respirators.'[5.6] (Agius)

5.4.3 The PHE guidance on PPE was weaker than that from the European Centre for Disease Prevention and Control which, in February 2020, stated that the minimal composition of a set of PPE for the management of suspected or confirmed cases of Covid should include an FFP2 or FFP3 respirator, with FRSM only to be used 'in case of shortage'.

5.4.4 PHE guidance in respect of PPE was similar to that of WHO, with the proviso that WHO advice was designed for lower and middle income countries with constrained resources.[5.7] However, in December 2020 WHO updated guidance to say that health workers caring for Covid patients should use FFP2/3 masks providing they were widely available and cost was not an issue.[5.7]

5.4.5 Despite overwhelming evidence supporting airborne transmission, the DHSC failed to upgrade recommendations during the second wave of infection even though there was now more than enough PPE stockpiled. Regrettably, the HSE failed to step up, show independence of political influence, and firmly enforce occupational hygiene measures for infection control, including regular staff testing, segregation, and improved ventilation. It should also have argued for application of precautionary principles given the mass of accumulated evidence for aerosol

transmission of coronavirus, advocating the use of FFP2/3 masks in particular.

5.5 HEALTH AND CARE WORKERS WERE AT INCREASED RISK OF INFECTION

5.5.1 Failures of risk assessment and provision of appropriate PPE led to many unnecessary deaths. There is clear evidence that health and care workers are at increased risk of contracting Covid. Compared to nonessential workers, health and care workers have a seven-fold increase in risk of severe Covid (testing positive in hospital or death). Frontline, or patient-facing health and care workers have a three-fold increase in risk of testing positive for Covid compared to the general population. Compared to non-patient-facing health and care workers they have a three-fold risk, and their household members have a two-fold risk of hospital admission with Covid. Covid risk is also specialty dependent with Accident and Emergency departments, medical specialties including general, acute, and geriatric medicine, and infectious diseases all being at increased risk compared to intensive care health and care workers, who in some studies had a lower risk than other health and care workers.[5.7]

5.5.2 The striking finding of lower risk of Covid among intensive care staff (the most exposed to allegedly high risk 'Aerosol Generating Procedures') may be due to higher grade of PPE, and better training and facilities for changing PPE than other staff. Opportunities were missed to protect the primary care workforce, with PPE shortages persisting for months. BMA surveys in April 2020 found over one-third of GPs did not have eye protection, while in May, 69% of GPs had sourced their own PPE or relied on donations, and in June ongoing problems with supply of masks to GPs were reported.[5.7]

5.6 LONG-TERM EFFECTS OF INFECTION AND DEALING WITH THE PANDEMIC WORKLOAD

5.6.1 Covid-induced serious multi-organ damage causing lasting ill health and work pressure producing psychological distress are among the profound long-term effects of the pandemic. A precautionary approach to infection control from the start, and provision of support and mentoring for staff could have saved many lives and greatly reduced the burden of disease. An estimated 10% of people infected with Covid may have significant post-acute or chronic symptoms persisting beyond 12 weeks. Moreover frontline work during the pandemic has had significant psychological consequences with exhaustion, depression, PTSD and 'burnout' adding to sickness absence and long-term ill health.

5.7 INADEQUATE RISK ASSESSMENT

> *'Workers are legally entitled to be consulted about the risks to their health at work and the risk assessments and control measures which are consequently envisaged. This is particularly important to give a voice to, and empower workers. In many workplaces such consultation with workers was conspicuous by its absence.'* [5.6] (Agius)

5.7.1 Workers' concerns about risk and safety at work were often unheeded by managers, putting the onus on workers' safety representatives to do their own assessments and argue for protective measures to be implemented. Poor understanding and lack of

engagement by management contributed to unnecessary deaths and sickness. In fact, all employers have a legal responsibility to make a 'suitable and sufficient' risk assessment in respect of all employees.

5.7.2 The level of detail in the risk assessment must be proportionate to the level of risk and appropriate to the nature of the work. Risks in the pandemic were clearly high and the nature of frontline work so critical that detailed assessments should have been carried out. The common occurrence of an employer simply stating they were 'following PHE guidance' did not constitute a risk assessment. In any case, as set out above, PHE guidance provided inadequate protection relative both to pre-pandemic guidance and later professional consensus.[5.8]

5.7.3 Frontline staff continued to have risk assessments and protective measures that were inadequate. The pressures on occupational health services during the pandemic were unprecedented and the evidence from trade unions would have been of value as regards the extent to which their members perceived themselves to be adequately protected.

5.8 THE CASE OF LONDON TRANSPORT STAFF

> *'... the view of union members was that the management were going to try and run this on "a wing and a prayer", where we do the praying, and they do the winging.'* (Mirza)

5.8.1 Transport staff with unavoidable close contact with the public were tragically unprotected at the start of the pandemic. With regard to transport workers, the Inquiry heard that London Underground simply announced it would follow Government and PHE advice, prompting union members to rapidly establish networks for information-sharing among themselves in order to promote worker and passenger safety.

5.8.2 London bus drivers were initially left to their own devices regarding implementation of safety measures and suffered from being a more fragmented workforce. Attempts to implement social distancing by cordoning off the front two bus seats led to threats of disciplinary action by managers; over 50 drivers died.

5.8.3 Government messaging was often confused, contradictory and unreliable. Risk assessments were primarily paper exercises that did not reflect the seriousness of the situation and were not proportionate to the risks involved. The union had had to push for a robust and consistent cleaning regimen; members fought for masks, hand gel and gloves (basic fundamentals that should have been on hand from the start), threatening to refuse to work on grounds of safety and invoking relevant legislation. Drivers also had to push for information about testing and access to test kits.

5.8.4 Low pay and insufficient financial support (including the low level of statutory sick pay) continually hindered people's capacity to isolate. As a consequence, overcrowding on London Underground trains and platforms frequently featured in national news coverage. A cursory glance of the images suggest many of those travelling were poor and from BAME communities, many no doubt working in privatised industries characterised by zero-hour contracts and weak or non-existent trade union or workplace representation.

5.8.5 Staff struggled with anxiety over developing infection, having seen friends

and colleagues dying and adding to the national statistics. This was coupled with fears that the pandemic was being used as a pretext to drive down terms and conditions of work. Increasing numbers of work place outbreaks by January 2021 pointed both to inadequate risk assessment and implementation of safety measures by managers.

5.9 REPORTING CASES OF COVID IN WORKERS: MISSED OPPORTUNITIES TO LEARN LESSONS

5.9.1 Reporting infection in the workforce should lead to investigation, lesson learning and application of knowledge gained to improve safety. Tragically, this was often not the case. Employers have a legal obligation to report cases of Covid in workers for whom a 'reasonable judgement' can be made 'on the balance of probability' that they contracted the disease from work.

5.9.2 The legal provision for this arises from the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. The report is made to the enforcing authority, usually the HSE, which should investigate in order to explore what lessons can be learned. Coroners may also investigate work-related deaths but compared with the HSE have very limited experience of inquiry into occupational disease caused by biological agents.

5.9.3 It is a matter of grave concern that Mr Hancock, the Secretary of State for Health and Social Care, when questioned at a House of Commons Select Committee sitting, apparently considered employers to be the appropriate investigators of the deaths of NHS staff, appearing to discount the key role of the HSE.

5.9.4 From 10 April 2020 to 13 March 2021, 31,380 occupational disease notifications of Covid in workers were reported to the HSE, including 367 death notifications. Out of these, 9,947 cases (including 139 deaths) were in 'human health activities', with similar numbers in social care. However, it is recognised that there is widespread under-reporting by employers[5.9] and that HSE guidance for reporting work-related Covid may result in many thousands of cases being missed:[5.10]

> *'HSE has investigated only a small fraction of the Covid RIDDOR reports. In my opinion this, on top of the already limited HSE reporting guidance, constitutes a very serious failing in investigating Covid contracted from work, and has missed opportunities to learn lessons and save lives.'* (Agius)

5.9.5 The ONS statistical bulletins have shown that SMR for male security guards and related occupations were nearly four times higher than those for all men of working age, while for taxi cab, bus, and coach drivers the SMR were well over double.[5.9]

5.9.6 This is consistent with the conclusion that jobs with frequent and close public exposure (besides health and social care) carry a higher risk of Covid. Such jobs did not fall within the remit of HSE reporting and were not therefore subject to investigation. Furthermore, HSE also considered that PHE guidance constituted 'effective control measures' and intimated that Covid cases among employees did not need to be reported if such guidance had been followed.

5.9.7 PHE has collected data on hundreds of workplace outbreaks. However, it is not clear whether PHE has pursued these to the extent necessary to learn lessons about specific measures to prevent further

outbreaks, for example through work practice, engineering controls (notably ventilation) or standard of respiratory protective equipment.

5.9.8 The Secretary of State for Health had steered the HSE away from the need to investigate deaths from Covid among health and care workers when presumed to have been contracted at work. During the pandemic the HSE did not assert the relevance of their own prior research findings and their precautionary guidance for worker protection against biological agents, but simply endorsed 'PHE guidance'.

5.9.9 The response by HSE in investigating occupational Covid has been lacking, with only a minuscule proportion of reported cases being investigated. It should also be noted that the additional funding allocated to the HSE to meet the pandemic challenge bore no relationship to the scale of the task at hand.

5.10 VACCINATION TO PROTECT WORKERS

5.10.1 Delay in vaccinating health and care staff and other high risk occupational groups has contributed to infections and sickness absence. One month after vaccinations with the Pfizer/BioNTech vaccine commenced, NHSE wrote to Trusts and clinical commissioning groups requiring immediate vaccination of frontline staff, including those working in primary care, to 'Protect the NHS'. However, health and care workers' second vaccine doses were delayed up to 12 weeks after the first dose.

5.10.2 While there was good evidence for the Oxford/AstraZeneca vaccine, in contrast, the Pfizer/BioNTech vaccine dose delay occurred despite the Medicines and Healthcare products Regulatory Agency approval, and WHO and Centers for Disease Control and Prevention advice, to use the original shorter dosing schedule.

5.10.3 Other high-risk groups (e.g. public transport drivers and teachers) were not given priority as a more comprehensive evidence-based account of occupational risk would have indicated they should have been. Had frontline healthcare workers been prioritized when immunization roll out commenced at the beginning of December 2020, this may have better maintained the functioning of the NHS in the face of soaring admissions and staff sickness or isolation.

5.11 EFFECTS ON HOSPITAL STAFF

> *'We cannot look after people to the standard we trained to – that is a devastating fact. The pandemic only exacerbated an already existing problem, we were on our knees long before COVID hit.'* (Brewerton)

5.11.1 Stress at work has had a major impact on the mental health and wellbeing of staff with limited recognition and provision of support. The Inquiry heard from a nursing sister who had previously worked in an Accident and Emergency Department where difficulties from short staffing and lack of investment had created enormous pressures on staff.

5.11.2 The moral injury of feeling unable to give patients the care they deserved caused stress that had personally resulted in a period of time off work. The potential for work to impact negatively on the mental health of staff was often unrecognised, and support services, when available were very variable.

5.11.3 Routine exposure to infected patients and unavailability of testing for staff added to stress. Despite some staff developing chronic symptoms ('long covid') and having to give up work, there seemed to be few that were reported under RIDDOR, with managers happily making the assumption that infection was always community acquired and not contracted at work.

5.11.4 This may have contributed to the Industrial Injuries Advisory Council decision that Covid should not come under the Industrial Injuries Disablement Benefit Scheme.[5.11]

5.11.5 Worries about the inadequacy of PPE were compounded by the advent of more transmissible newer variants but with no change to existing guidelines:

> *'Where it became a case of real moral hazard was when we totally ran out of resources. And yet you had patients who you knew, within ordinary times, if we'd had the resources or places to send them, the odds were that they would survive. So you were now having patients who rather than going to the Intensive Therapy Unit were going to High Dependency Unit, rather than going to High Dependency Unit were going to wards ...'* (Ejimofo)

5.11.6 The initial positive approach by staff in a busy emergency department to managing the demands raised by the pandemic was tempered by having to cope with a huge increase in demand. This was seen as a direct consequence of Government strategy side-lining primary care with patients being told to go to hospital and not to their GP.

5.11.7 Staff faced additional pressure from having to cover sickness absence, and were worried about the adequacy of available PPE and the validity of national guidance, such that they sourced their own supplies.

5.11.8 Additional concern related to the fact that a high proportion of the workforce were from BAME communities, who had been identified as being more vulnerable to Covid.

5.11.9 Trying to prevent spread of infection among patients and staff in the department was challenging because of its physical layout and constraints on space. Increasing evidence of airborne viral spread added to anxiety, knowing that in a crowded environment with mixing of patients cross-infection was extremely likely. By the second wave of infection staff were simply exhausted as well as demoralised having predicted Government strategy was likely to lead to a resurgence of hospital admissions.

5.11.10 Deaths among colleagues, and more widely among health and care workers and key workers heightened a sense of grievance that appropriate risk assessments were not being performed. Senior staff were having to work long hours to provide supervision, particularly for staff reassigned to unfamiliar roles. Problems were superimposed on those already created by chronic underfunding (such as pre-pandemic short-staffing) and also brought the lack of preparation for a pandemic into focus.

5.11.11 The Nightingale hospitals were a disappointment because frontline staff had not been consulted and would have highlighted the fact that valuable and intensive care staff would have to be taken away from hospitals where they were required and were already in short supply.

5.11.12 Finally, when resources were running out, difficult decisions had to be

made about prioritising patients, knowing that some who in normal circumstance had the potential to recover, would now die.

5.11.13 In terms of support for staff from employers and professional and regulatory bodies, a need for a robust and independent way of feeding back or reporting when staff feel they are being constrained from being able to carry out their duties by factors beyond their control was emphasised:

> *'The Covid-19 pandemic has highlighted a system that is broken, through lack of funding and resources. In order to avoid the same tragedy in another pandemic, lessons must not only be learned, but must also be acted on.'* (Agius)

5.12 EFFECTS OF THE PANDEMIC ON WELLBEING OF FRONTLINE WORKERS

> *'It's been a roller coaster – my immediate team are absolutely amazing. But I lack confidence in my Trust; and feel hugely let down by the Government – cannon fodder absolutely nails it.'* (quoted by Sumner)

5.12.1 The pandemic has had huge negative consequences for staff well-being across a wide range of sectors, worsening as time has gone on. The Inquiry heard from two psychologists about their research into the response of health workers in both the United Kingdom (UK) and the Republic of Ireland (ROI) to the handling of the pandemic by Government. The project started in March 2020 to track the well-being of frontline workers across different sectors using survey and interview data. It included health and care workers, social workers, education, civil defence, emergency services, supermarkets, and supply chain logistics staff.

5.12.2 The strategy for the pandemic adopted by the Government of the ROI involved a suppression and elimination approach, moving quickly to impose restrictions. In contrast, the UK delayed 'lockdown', allowing huge sporting events like the Cheltenham Festival and Champions League football games to go ahead, even as numbers of infections were rising.

5.12.3 The study explored whether or not these different strategy approaches were reflected in different effects on well-being in frontline workers. Participants were asked how they felt about their Government's response, whether they considered it to be timely, effective, or appropriate. For each of those metrics, those in the UK rated lower, in terms of their perception of the Government's actions.

5.12.4 There were statistically significant differences between the ROI and the UK in terms of worker well-being including resilience and burnout, with UK workers suffering more adverse outcomes particularly in the initial period from March to May 2020. The gap then decreased over time, with frontline workers in the ROI showing a decrease in well-being associated with change in government strategy, and those in the UK remaining at a low level

5.12.5 Workers described the UK Government advice as chaotic, and the overall response indefensible. There was particular criticism of unclear and ambiguous messaging; schools and universities being open at certain stages; the failure to lockdown soon enough before Christmas 2020 (which effectively undid all their good work); rule-breaking (especially the very notable rule-breaking by some prominent figures

that took place) was not dealt with consistently. Social solidarity, compliance, 'incredible' generosity to those in need and appreciation for health and care workers were undermined by Government demonstrating that in practice, rules only applied to some.

5.12.6 This was 'devastating' for frontline workers, many of whom expressed a great sense of pride in their work and tried to stay positive even though feeling really overwhelmed – not having been provided with adequate PPE, testing or support. Health and care workers began to think about leaving their posts, particularly when early popular support (e.g. the 'clap for carers') was not followed up by compensation or support.

5.12.7 Well-being continued to deteriorate, with indicators of burnout and even PTSD in some, including in those with resilient coping styles. Little help was available for staff feeling under stress from having to deal with a mixture of very strong emotions.

5.12.8 A consistent finding from frontline workers was that they wanted timely and decisive action from the Government. Insofar as making sure their own voices were heard, many of the research participants said their focus was entirely on trying to get from one day to the next as well as keeping family life going at home.

5.12.9 Burnout involving physical and mental exhaustion, and feelings of inadequacy and futility, was found to have increased at six months with a further rise by 12 months. A worrying trend, given the likelihood of continuing high workload demands for a long period, was that recognisable levels of PTSD were beginning to emerge. Overall, the research showed that after 12 months, participants were starting to feel hopeless and losing the drive to keep working:

> *'And so much of this vital work is about that personal drive, because it's hard work, all of it is hard work. It's hard work, and it's dangerous. And for people to leave their door every day to go into that hard and dangerous work, they need to know that it's worth it, and that it means something...'* (Kinsella)

THE PEOPLE'S COVID INQUIRY

The People's Covid Inquiry took place from 24 February to 16 June 2021.

A panel of four, chaired by Michael Mansfield QC, heard evidence from over 40 witnesses including bereaved families, frontline NHS and key workers, national and international experts, trade union and council leaders, and representatives from disabled people's and pensioners' organisations.

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