CATA

Covid Airborne
Transmission Alliance

To all CATA organisations and individual members

24 February 2025

Dear Colleagues,

End of CATA's campaign and participation in Module 3 of the UK Covid Public Inquiry

As you know, the hearings of Module 3 of the UK Covid Inquiry ended in November 2024. Baroness Hallett's report for Module 3 is not expected until Spring 2026. You will recall that the metamorphosis from CAPA to CATA in late 2022 led to the appointment of an Executive Team in order to secure legal representation by Saunders Law with the aim of achieving core participant status and financial support in the Inquiry. Initially, 5 of us volunteered to be on the Executive Team but, when one member left his organisation, we soon became 4. We hope we have discharged our responsibilities to your satisfaction and in accordance with the remit given to us. Our journey has not reached its planned destination, but it is in sight. Whilst we may not have resolved all the issues and there are several "loose ends" which we would like to see tied up, the requirement for us to exercise executive functions, until we comment on the report for Module 3, has now come to an end. It is for this reason that we are writing to you now.

The CATA Executive Team has continued to campaign for changes to the 4 nations' National IPC Manuals (NIPCM) citing all of the criticisms we have highlighted to government over the last 4 - 5 years.

We wrote to all 4 Chief Nursing Officers on 27 October 2024 but have received no reply. We requested that IPC guidance be updated in line with evidence heard at the Inquiry in favour of the airborne route and its mitigations. Our letter was formally raised in the House of Lords on 6 January 2025. Reassurances were obtained from the government spokesperson that a response would be forthcoming "shortly", though nothing has yet been received. This has been the subject of much comment on social media platforms. We shall continue to press for a response.

Together with the BMA and a number of Bereaved Family and Long Covid core participants from the Inquiry, we went on to write to the Chair, Baroness Hallett on 20 December 2024. We asked her to consider publishing an interim recommendation to Government advising or mandating an urgent review of the IPC guidance which remains predicated on the now-discredited paradigm of droplet transmission and use of fluid resistant surgical masks (FRSM) for all non AGP care or exposure.

The NIPCM for England still lists FRSMs under the heading of Respiratory Protective Equipment (RPE) which, of course, they are not. It simply perpetuates the myth that FRSM protect the wearer

against airborne respiratory infectious diseases such as Covid-19, RSV and influenza and leads to a false sense of security. The AGP list remains extant despite having no scientific basis whatsoever.

Baroness Hallett wrote back to us on 27 January 2025 rejecting our submissions. The grounds given were worth challenging so we wrote another letter 3 February 2025 which was curtly rebuffed by the Inquiry lawyers within 24 hours, so that avenue is now exhausted.

Another opportunity arose when the former Health Minister, Andrew Gwynne MP wrote a letter to Tim Farron MP in which it was stated that Covid-19 is still droplet-transmitted and surgical masks are therefore fine. Lisa Ritchie was quoted as the source for this advice. As you know, her evidence at the public hearings of Module 3 was thoroughly discredited as she was the only witness to still adhere to the outdated concept of droplets - which are in fact mostly aerosols according to accepted physical science. We wrote to Andrew Gwynne MP 22 January 2025 pointing out how badly he was being advised. Before we could receive a reply, he was sacked. His replacement, Ashley Dalton MP, has not replied to our letter either, but more importantly, it is clear from her answer to a written question in the House of Commons on 17 February 2025 that she also seems to be taking advice from NHSE's IPC leads including Lisa Ritchie. We have pursued various political leads to support our call for action but to no avail thus far.

Meanwhile, Covid-19 continues to cause significant mortality and morbidity. Effective management of other respiratory pathogens also transmitted via the airborne route is impacted by the same flawed IPC guidance. The CATA Executive still feels strongly that this situation is unacceptable morally, ethically, legally and practically in terms of the effect on the NHS of Long Covid, staff deaths, sickness absence, or attrition from the NHS

The CATA Executive, having carried the fight to government on behalf of CATA members, feel there is no more that we can reasonably do to further our cause. Whilst this might sound defeatist, we can be proud of having changed the direction and focus of the inquiry.

Baroness Hallett called upon CATA to submit a Rule 9 witness statement for Module 1 (resilience and preparedness of the UK for pandemics). She accepted the evidence we presented and, in her report, unequivocally stated that "the primary routes of transmission for pandemic influenza and coronaviruses are airborne and respiratory".

We heard more in Module 2, particularly from expert witness Professor Cath Noakes, that it was known that SARS-CoV-2 was potentially airborne in April 2020 and that the desire by the IPC Cell to search for high level evidence (RCTs) whilst producing no evidence in support of their droplet paradigm was at the very least, perplexing. CATA has evidence that the authorities knew from the outset in January 2020 that the novel coronavirus was airborne, defining it as an "airborne High Consequence Infectious Disease" (HCID). The reasons given for its declassification as an HCID in March 2020 were solely concerned with Case Fatality Rate, HCID bed capacity, reliable tests being available and as a vaccine was in sight. These criteria did not alter the 'airborne' descriptor in any way.

As a result of our Module 3 witness statement, appropriate expert witnesses were called to explain the differences between the government bodies and CATA, BMA, RCN, TUC etc. It was clearly demonstrated that the so-called droplets repeatedly referred to by the IPC cell and others were, in fact, aerosols. This has been known since at least 1934! Thus, IPC guidance on the dichotomy between aerosols and droplets is null and void. We believe the Inquiry Chair has taken this on board.

That CATA was called in the first week of the Module 3 proceedings, immediately after the expert witness Professor Clive Beggs, speaks volumes for the direction the Inquiry had decided to take.

HSE's witness, Mr Richard Brunt (Director of Policy, HSE) was subjected to highly effective questioning by our Senior Counsel, Stephen Simblet KC. He admitted that FRSMs are not PPE and do not protect against inhalation of aerosols. He was also forced to admit that HSE knew that Covid-19 was airborne in April 2020, presenting the greatest risk to other people at a distance less than 1 metre. No explanation has ever been provided as to why HSE did not use their statutory powers to enforce appropriate action for the protection of healthcare workers.

Mr Brunt agreed with Counsel that it was not possible for a healthcare worker to undertake a suitable risk assessment for delivery of close contact care to an infectious patient on the basis that the airborne hazard is not detectable by any human sense (sight, smell, taste) and cannot be measured by any instrument (other than in a laboratory). This completely discredits the Government line (as recently stated by the new Health Minister) that healthcare organisations are responsible for conducting "dynamic risk assessments" to determine whether FFP3 respirators need to be worn. It remains the case that when delivering care within a metre of an infectious patient, there is no risk assessment methodology in existence that is suitable for this purpose, which the IPC experts term "near-field exposure". The default therefore has to be that RPE is required for all such care where serious airborne pathogens are involved. Risk assessments can (and should) be carried out for other scenarios ("far-field exposure") where general ventilation, air-purifiers etc are taken into account.

The preliminary hearing for the last Module (Module 10) heard protections against airborne transmission raised again, demonstrating that this has become a cross-cutting topic throughout the Inquiry.

Our Module 3 closing statement is a good summary of our position and achievements. You received this by email from Saunders Law on 20 December 2024. It is frustrating that this document remains confidential until such times as Baroness Hallett authorises its publication on the Inquiry website. We have not been informed why it, and all the other core participants' closing statements, are being held back from public scrutiny. We will send a link once it is released into the public domain.

Other government witnesses were similarly exposed to intense questioning by Inquiry Counsel, Counsel for CATA and others such as BMA, TUC and the Bereaved Family groups. Professor Susan Hopkins, Chief Medical Advisor to the UK-Health Security Agency agreed that Covid-19 is airborne but then denied that RPE in the form of FFP3 respirators is more effective than surgical masks. This is clearly not true, and the expert witness all agreed on this point.

The Chief Executive of UKHSA, Professor Dame Jennie Harries also agreed that Covid-19 was airborne, and the government website does now say this, as does the World Health Organisation. However, the IPC guidance now embodied in the four home nations' IPC manuals is still at odds with the science and evidence presented to the Inquiry.

The persistent transfer of responsibility from central government advisory bodies such as UKHSA and NHS to local Trusts or Boards relies on them being able to perform a "dynamic risk assessment". As I pointed out in my oral evidence at the Inquiry, this is impossible without a clear understanding of the mode of transmission in all settings, not just AGPs and, as mentioned above, there is no credible methodology for doing such assessments.

Despite the flexibility in guidance now claimed by the 4 nations' IPC leads, we know of many examples of our members being denied FFP3 protection when dealing with known respiratory pathogens such as SARS-CoV-2. We appreciate that sessional use of FFP3 masks is uncomfortable but, for short term use to prevent exposure under current prevalence levels, they provide infinitely better protection than FRSMs. Better ventilation and use of HEPA filters and high level UV light offer great prospects but require investment.

For longer term use, we firmly believe that powered hoods provide the answer as demonstrated in Southampton during the pandemic. These must be the default RPE for healthcare workers (HCWs) when the next airborne pandemic disease strikes – as explained in this article. Other foreseeable pandemics (avian flu, other coronaviruses) could have a Case Fatality Rate up to 10 times that of Covid-19. Unless the Government accepts this fact and prepares accordingly, there is a very real risk of healthcare services being overwhelmed and collapsing during the first few months of the next pandemic arriving. One has to question whether, next time around, HCWs will be quite so trusting and willing to expose themselves and their families to mortal risk unless satisfied that they are being equipped with the best possible PPE available.

My personal view is that the medical profession worldwide has failed to follow the science of airborne disease transmission. This is a failure that echoes those of previous generations regarding waterborne diseases such as cholera, or bacterial transfer by dirty hands prior to surgery. As a medical professional, I feel embarrassed by my profession's failure to embrace the science of airborne transmission. This continues to be amplified by a failure to apply current UK law to frontline healthcare worker exposure to pathogens (COSHH Regulations) and the reporting of such exposures and their consequences (RIDDOR Regulations).

The diversionary tactic of claiming that we don't yet know what proportion of Covid-19 infections are caused by airborne transmission is as irrelevant as it is wrong. As already mentioned, the so-called droplets are aerosols up to 100 microns and Health & Safety law requires protection whenever an airborne pathogen is suspected, no matter what other routes of transmission might apply. Finally, the fomite route of transmission which formed the cornerstone of public health guidance at the onset of the pandemic has been refuted. It seems that this route is highly inefficient requiring up to 10,000 contacts for one active infection (CDC and CMOs Technical Report 2022).

I hope this summary of our impact on the Covid Inquiry provides sufficient background for all our members. So many now suffer from Long Covid that we had hoped that our arguments would prevail and underpin new IPC guidance with a chance of preventing infections in the first place. We will have to wait until next spring to find out if the Inquiry reports in our favour. Until then, CATA Executive will go into hibernation and will reassemble to pass comment on the report. As well as individual CATA member organisations, we anticipate that other important healthcare organisations such as the BMA, RCN and the unions, will continue to campaign on behalf of their members. The CATA Executive will write to them accordingly.

Some of our members are involved in the class action seeking redress in the Courts for the life-changing consequences that unprotected occupational exposure to Covid-19 has wrought upon them and their families. My colleague David Osborn is committed to continue his support for the legal teams involved in this action and will direct their attention to the relevant documents as soon as the Inquiry lifts confidentiality constraints.

Once again, I would like to thank all our colleagues in professional and union organisations, and our individual members who have all contributed invaluable evidence and assistance over the last few years. A journey which began for many of us in March 2020 and led to the formation of CATA's predecessors, AGPA and CAPA. Together, we have achieved so much against stubborn opposition from government bodies. Our messages have been clear, the evidence is clear and the actions required to improve IPC guidance and practice are clear.

It has been an honour and a privilege to lead both the Executive Team and our Alliance. However, the time has now come for me to step back until the final report is published.

Finally, my thanks must go to my colleagues in the Executive Team, Kamini Gadhok MBE, Prof Kevin Bampton and David Osborn, without whom CATA could not have achieved much at all. The volume of work and the hours devoted to our cause by them has been truly remarkable.

Yours Sincerely

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Chair CATA and lead for BAPEN

On behalf of the CATA Executive Team:

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