OPEN LETTER

By email to Module 3 Solicitors, UK Covid-19 Inquiry

For the personal attention of the Rt Hon. Baroness Hallett DBE, Chair 5 November 2026

Dear Baroness Hallett

Re: Scottish NIPCM — Implementation of Inquiry recommendations and pandemic preparedness

I wrote to you on 28 November 2025, on behalf of the Covid-19 Airborne Transmission Alliance (CATA), expressing our concern that state bodies might not give proper effect to your forthcoming Module 3 recommendations (link). We regret that the revised NHS Scotland National Infection Prevention and Control Manual (NIPCM), published on 3 August 2026, appears to bear out that warning.

At first sight the new guidance appears to respond positively to your findings. It abandons the discredited droplet/airborne dichotomy and removes the traditional list of aerosol-generating procedures (AGPs), recognising that natural physiological processes such as coughing can release more aerosols into the environment around the patient than several of the previously defined AGPs.

However, the practical consequences of the revised guidance are strikingly different from the precautionary approach that you recommended:

- COVID-19 has been classified into the lowest respiratory category 'R1' within their new R1-R3 scale (i.e. the least hazardous, not considered likely to cause severe disease nor cause serious injury to health);
- fluid-resistant surgical masks remain the default for COVID-19 and other 'R1' diseases such as RSV, whooping cough and influenza, all of which may cause serious health effects in the short and long term;
- even procedures which were previously identified as 'high-risk AGPs' do not, in themselves, trigger a requirement for respiratory protective equipment (RPE) when caring for patients with R1 infections.

These moves by ARHAI, the authors of Scottish IPC Manuals risk entrenching, rather than correcting, the shortcomings exposed by the Inquiry, thereby leaving healthcare workers even less protected against serious respiratory infections. We suspect that this may not be the outcome your Ladyship had in mind when publishing the Module 3 report.

We in the Executive Team of CATA stood down shortly after your Module 3 report was published since the brief from our 12 member organisations was to represent them at the Inquiry and that brief had been satisfied. Nevertheless, in the same way as your Ladyship is monitoring State Bodies' progress with your recommendations throughout the life of the Inquiry, so are we – at least insofar as Module 3 is concerned.

We fundamentally disagree with the technical and legal basis upon which ARHAI has developed its revised IPC guidance.

Our accompanying annex examines eight matters in which we consider that the revised Scottish NIPCM, and the arrangements for future pandemic preparedness, fail to give proper effect to the findings and recommendations of your Module 3 report. In particular, we draw your attention to the following:

1. **Clear accountability:** Failure to establish and document a clear structure setting out sign-off procedures, departmental and individual responsibilities and accountabilities ***{Recommendation 1}***
2. **Explaining decisions:** Failing to explain the rationale underpinning IPC precautions. Highly flawed justification for COVID-19 being low-hazard (R1), not requiring respiratory protection ***{Recommendation 1}***
3. **Cautious approach:** Extreme lack of caution, particularly during initial assessment of patients with unidentified respiratory infections. Failure to require precautionary RPE from the outset. ***{Recommendation 1}***
4. **Multidisciplinary expertise:** Unsubstantiated claims of support from subject experts, particularly HSE, for ARHAI's R1–R3 classification and its use of FRSM. ***{Recommendation 1}***
5. **Source control and Personal Protection:** Continued misrepresentation of surgical masks as PPE against inhalable infectious hazards, thereby endangering healthcare workers. HSE have repeatedly stated that surgical masks are not PPE ***{Chapter 1, para 1.10}***
6. **Ventilation and filtration:** Failure to prioritise HEPA air filtration, despite the Inquiry's express conclusion that it should be prioritised throughout healthcare. ***{Chapter 1, para 1.105}***
7. **Potential collapse of healthcare systems:** Flawed IPC guidance risks catastrophic workforce losses during a more severe pandemic, potentially resulting in the collapse of healthcare services. ***{Introduction, pages x-xi}***
8. **Respirator preparedness:** In our view, such a collapse of healthcare systems is likely to be triggered by the lack of arrangements for rapid, large-scale deployment of suitable respirators. ***{Chapter 2, paras 2.104 & 107}***

The implications extend beyond Scotland. Wales has already adopted the Scottish NIPCM and we are concerned that England and Northern Ireland could also follow it. If so, whilst revised guidance across the four nations may give the outward appearance of implementing your recommendations, in reality the fundamental level of protection for healthcare workers is in fact much worse.

Your observations in Module 3 that "***We coped, but only just***" and "***Healthcare systems teetered on the brink of collapse***" deserve particular attention. The next pandemic could involve a more lethal or more transmissible pathogen. Healthcare services cannot cope or function without a workforce that is both able and willing to treat patients. A programme to provide suitable, trusted respiratory protection at scale is therefore an essential matter of national preparedness.

We would go further. Anecdotal evidence suggests that many healthcare workers had already lost confidence in the IPC regimes under which they were expected to work. The publication of your Module 3 report has now provided authoritative confirmation of serious shortcomings in those regimes, reinforcing a sense that they were betrayed by the Government and senior healthcare officials. They have witnessed first-hand the deaths and long-term illness suffered by colleagues, a great many of whom remain unable to work. Without a fundamentally different approach to respiratory protection, there is a real danger that, in a more severe pandemic, substantial numbers of healthcare workers may be unwilling to attend work and expose themselves to potentially lethal infection without demonstrably adequate protection.

Whilst disposable tight-fitting respirators such as FFP3 have an important role, their limitations make them unsuitable as the principal means of providing respiratory protection for prolonged periods across the healthcare workforce. We believe that suitable powered respirators, together with the national arrangements for their manufacture and rapid deployment outlined in item 8 of our annex, offer a practical means of addressing this danger. This is clearly an area needing an update to the EN safety standards and further research.

We respectfully ask you to give careful consideration to the evidence presented as an annex to this letter in which we provide supportive evidence to the 8 areas of concern listed overleaf. We hope these points will be helpful when you review State bodies' progress reports and enable you to keep a watchful eye on whether the measures being taken genuinely give effect to your findings and recommendations, rather than merely giving the appearance of doing so.

When we left Dorland House with your Module 3 report, having heard much of the evidence and followed the Inquiry's work closely, we optimistically believed that its findings and recommendations would lead to the shortcomings of the past being put right. We therefore find it deeply disappointing that the revised Scottish guidance, whilst giving the outward appearance of implementing your recommendations, appears instead to perpetuate many of those same shortcomings.

The sheer scale of the Inquiry's work makes it all the more important that your findings produce a demonstrable improvement, not just in healthcare worker safety but also the nation's preparedness before the next pandemic arrives.

In conclusion, we consider that the revised NIPCM guidance increases the risk to healthcare workers. Furthermore, the nation remains inadequately prepared to provide them with suitable and effective respiratory protection at the outset of the next pandemic.

Yours sincerely,

[redacted]

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ANNEX — NEW NHS SCOTLAND NIPCM AND FUTURE PANDEMIC PREPAREDNESS

ARHAI Scotland has recently published a completely new approach to managing infection control in healthcare settings for respiratory diseases which purports to "***reflect lessons learned from the Covid-19 pandemic***".

In this annex we examine eight matters arising from the findings and recommendations of Baroness Hallett's Inquiry reports. These reports represent a comprehensive and authoritative summary of the lessons learned from the Covid-19 pandemic and detail conclusions and recommendations as to how these lessons should be implemented in practice.

We present evidence which, in our view, demonstrates that the Scottish Government has failed to give adequate effect to these recommendations, both in their implementation and in the wider context of future pandemic preparedness.

The evidence presented below demonstrates that, rather than reflecting the lessons learned from the Covid-19 pandemic, the revised guidance perpetuates fundamental shortcomings identified by the Inquiry which, unless addressed, risk having a serious and prolonged adverse impact on the healthcare workforce for years to come.

1. Scottish Government 6-month response to UK Covid-19 Inquiry Recommendation 1

Recommendation 1 specified: "***Ensure that decision-making on infection prevention and control is underpinned by clear structures and a cautious approach to transmission risk***"

In its response to Recommendation 1, the Scottish Government states ***"this recommendation is not aimed at the Scottish Government"***. This overlooks the subsequent paragraph of Recommendation 1 of the Module 3 report, which unambiguously identifies NHS National Services Scotland as one of the bodies required to review the national IPC manuals and future guidance. In doing so, the Scottish Government gives the misleading impression that it bears no responsibility for ensuring that the recommendation is implemented, thereby deflecting attention from its own obligations.[1, 2]

Although the Inquiry's recommendation specifically names NHS National Services Scotland rather than the Scottish Government itself, it is a statutory public body accountable to Scottish Ministers, who have powers of direction and oversight. The Scottish Government cannot therefore evade responsibility for ensuring that this part of Recommendation 1 is properly addressed which, indeed, it is not – the Government's approach to transmission risk is far from cautious.

A fundamental problem throughout the pandemic was the lack of clarity as to who was ultimately responsible for approving IPC guidance and accountable for its content. This made it extremely difficult for professional bodies and other interested organisations to identify to whom concerns should be addressed. Despite the Inquiry's findings and Recommendation 1, we have been unable to identify any clear, published governance arrangements which resolve this fundamental problem in respect of the revised Scottish NIPCM. We have similarly been unable to identify clear, published governance arrangements for the equivalent IPC guidance in England, Wales and Northern Ireland.

A few days after the Module 3 report was published, NHS National Services Scotland was succeeded by Public Services Delivery Scotland. It is this body which published the revised Scottish NIPCM on 3 August 2026. Ministerial responsibility for oversight of its implementation remains.[3]

Sources:

1. UK Covid-19 Inquiry, Module 3 report, Recommendation 1. (link) (archive)
2. Scottish Government, response to Module 3, Recommendation 1. (link) (archive)
3. Public Services Delivery Scotland, revised IPC guidance published 3 August 2026. (link) (archive)

2. Ensure that guidance clearly explains the rationale for the approach taken.

A key point identified by the Inquiry is that "***any IPC Cell or equivalent body, responsible for formulating the content of IPC guidance, should ensure that guidance clearly explains the rationale for the approach taken. This would aid trust and understanding of decision-making***".[1]

ARHAI Scotland has placed COVID-19 in the lowest R1 category.[2] This classification implies that:

- COVID-19 is not considered to cause severe disease (a criterion used to distinguish R2 and R3);
- It is unlikely to spread to the community†;
- Effective prophylaxis (such as vaccination) or treatment is usually available†.

However, no clear rationale has been documented for the inclusion of COVID-19 as R1, the lowest level of disease severity. Having caused so many deaths and long-term health effects during the past 6 years – and continuing to do so – it is difficult to comprehend ARHAI's assertion that SARS-CoV-2 no longer presents serious health consequences, given that there were over 5,000 Covid deaths in the UK last year.

We are reminded of the Inquiry's finding that "***senior clinical leaders and the IPC Cell were … wedded to the contention of disease transmission being via droplets and contact only, whilst failing to account for alternatives such as the airborne route.***"[3] Acceptance of the airborne route was an inconvenient truth which would require mitigations which the authorities did not seem willing to implement.

We now have a somewhat analogous situation in which ARHAI appears to be similarly 'wedded' to the proposition that COVID-19 is not a severe disease and does not cause serious or prolonged health consequences, thereby avoiding the need to classify it as R2 (which, in our view, is where it belongs).

We have found no evidence that ARHAI took account of the devastating long-term impacts of Long Covid as eloquently described in the Module 3 report: "***For a significant number of people, the range and severity of Long Covid symptoms can be utterly debilitating, forcing them to re-evaluate every aspect of their daily lives***".[4] For these people, ARHAI's downplaying the severity of COVID-19 is an assertion that is likely to cause extreme offence. ARHAI's failure to properly explain its rationale for assigning COVID-19 to R1 can only add to the frustration of those whose lives have been seriously affected by the disease.

Healthcare workers are a particularly vulnerable occupational group due to their close-quarter care of infectious patients, usually without the protection afforded by Respiratory Protective Equipment (RPE). A recent survey found that 40% of healthcare workers worldwide who were infected with SARS-CoV-2 during the pandemic developed Long Covid and a quarter still had symptoms after a year.[5]

† It is important to note that the other two criteria used for placing COVID-19 into R1 are equally flawed:

- **Transmissibility:** COVID-19 spreads extremely efficiently, including from asymptomatic and pre-symptomatic even if vaccinated.
- **Availability of vaccines and treatments:** NHS COVID-19 vaccination in autumn 2026 is restricted to people aged 75 and over, residents of care homes for older adults and those who are immunosuppressed. Access to outpatient antiviral treatments is also restricted to specified higher-risk groups. Consequently, neither measure is generally available to healthcare workers simply by virtue of their occupational exposure.

Sources:

1. UK Covid-19 Inquiry, Module 3 report, paragraph 1.142 (link) (archive)
2. Scottish IPC Manual, Appendix 11, page 14 (link) (archive)
3. UK Covid-19 Inquiry, Module 3 report, paragraphs 1.75 – 1.76 (link) (archive)
4. UK Covid-19 Inquiry, Module 3 report, paragraph 8.24 (link) (archive)
5. NHS Race and Health Observatory : REACH-OUT 4th report (August 2026) (link) (archive)

3. *Decision-making on IPC to be underpinned by a cautious approach to transmission risk*

The Inquiry identified fundamental flaws in IPC guidance, notably that ***"insufficient caution"*** was exercised in its preparation.[1] This led to Recommendation 1, requiring ***"Decision-making on IPC to be underpinned by a cautious approach to transmission risk"***. However, the revised Scottish NIPCM patently fails to reflect this basic requirement.

NIPCM Appendix 15 sets out an algorithm requiring HCWs initially encountering a patient with a suspected transmissible respiratory infection to don a Fluid Resistant Surgical Mask (FRSM).[2]

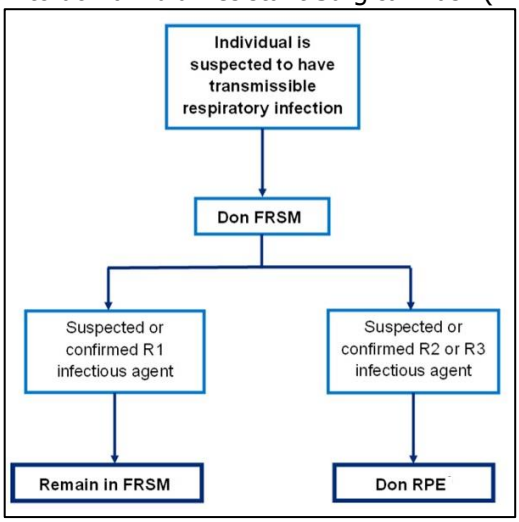


Figure 1. Scottish NIPCM, Appendix 15 – Mask Selection for respiratory infectious agents, flow diagram (explanatory notes omitted).

As per the Inquiry recommendation, the concept of AGPs has now been removed as a determinant of precautions. ARHAI's own document (entitled 'Crib Sheet', at pages 3–4) now acknowledges that natural coughing can generate exposures comparable to those arising from procedures previously classified as AGPs, and that increased particle generation is associated with increased exposure and transmission risks. Nevertheless, the same document (page 8) confirms that ARHAI rejected a precautionary requirement for RPE when caring for coughing patients, relying instead on its new R1-R3 system for classifying respiratory pathogens. [3]

Although ARHAI allows healthcare workers to choose RPE rather than a surgical mask (and has done so for over four years[4]), this places considerable responsibility on individuals who may feel under pressure to conform to the practices of their senior colleagues and peers and remains subject to the agreement of their managers. It also overlooks the interests of patients, particularly those unable to wear masks themselves, who may wish to be protected from infectious aerosols generated by those caring for them. Furthermore, categorising COVID-19 as a disease which does not cause serious illness may mislead healthcare workers when deciding whether additional respiratory protection is necessary. A policy which permits voluntary additional protection is not the same as one which ensures that adequate protection is provided. Such policies are therefore unsatisfactory.

Many serious respiratory infections initially present with similar symptoms, notably 'flu-like symptoms' and coughing, which can generate substantial quantities of potentially infectious aerosols. By the time the pathogen is identified and appropriate RPE prescribed, many HCWs may already have been exposed, become infected and begun to develop the disease. Moreover, FRSM remains the default for infections designated 'R1' including COVID-19, influenza, RSV and whooping cough. It is our contention, shared by experienced respiratory physicians, that this designation is wrong, as is the use of FRSMs for 'protection'.

The Inquiry made clear what a precautionary approach should entail:

"A lack of evidence ought to equate to uncertainty and therefore demand a cautious approach. As a matter of common sense, the assumption should be that a potential risk exists until proven otherwise, rather than requiring evidence that there is such a risk before taking any precautions".[5]

Applying that principle, a genuinely precautionary approach would require effective RPE to be worn from the outset when caring for patients with suspected respiratory infections, only reverting to FRSM once a sufficiently reliable diagnosis establishes that RPE is no longer necessary.

The revised guidance also appears inconsistent with evidence given to the Inquiry by its appointed IPC experts, Dr Warne and Dr Shin. Dr Warne supported the routine use of FFP3 respirators when caring for patients with respiratory viral infections. Dr Shin broadly agreed, specifically including COVID-19 and influenza, whilst recognising that the pathogenicity of different viruses should be taken into account.[6]

Sources

1. UK Covid-19 Inquiry, Module 3 report, paragraphs 1.45, 1.74–1.75 and Recommendation 1. (link) (archive)
2. Scottish NIPCM, Appendix 15: mask selection for respiratory infectious agents. (link) (archive)
3. ARHAI Scotland, TBP definitions guidance changes — Scientific FAQs (*"Crib Sheet"*), pp. 3–4 and 8. (link) (archive)
4. Scottish Government, Health Workforce Directorate – DL (2022) 10, 19 April 2022 (link) (archive)
5. UK Covid-19 Inquiry, Module 3 report, paragraph 1.86. (link) (archive)
6. UK Covid-19 Inquiry, Transcript, 19 September 2024, (link) (archive)

4. Multi-disciplinary membership of IPC decision-making structures

The Inquiry was critical of the lack of formal governance. It was unclear "***which body was ultimately responsible for signing off IPC guidance or where individual responsibility for its contents lay***".[1]

The Inquiry accepted evidence from its appointed IPC expert witnesses that any group responsible for developing IPC guidance needs multidisciplinary input. [1] Although this finding concerned arrangements for a future pandemic, the same principle must surely apply to the development of routine IPC guidance.

ARHAI states that its 25 working groups have engaged with a wide range of stakeholders, including aerosol experts and HSE. In its *Crib Sheet for NHS Boards* (page 10), ARHAI specifically claims that HSE's Biohazards Team supports its R1–R3 categorisation system and its approach to respiratory precautions. Its *Surgical Face Masks – Considered Judgement Forms* (page 61) similarly claims that experts from the HSE's Biohazards Team were "***supportive of the risk assessment approach for mask selection (FRSM and RPE)***".[2, 3] The brackets around the text "**(FRSM and RPE)**" are important. They lead the reader to believe that the HSE Biohazards Team supports not only a risk assessment approach but also the use of fluid resistant surgical masks. However, that is not the case.

A contemporaneous file note of a telephone conversation with an HSE biohazards expert on 27 August 2026 records that discussions about PPE had taken place with HSE's Policy Team, but not with the Biohazards Team. The expert explained that the HSE would not advise on specific healthcare precautions and that its work on the reclassification of SARS-CoV-2 from HG3 to HG2 concerned deliberate work in laboratories.[4]

The distinction is important. Support for the general principle of risk assessment does not amount to endorsement of the resulting selection of FRSM rather than RPE. ARHAI's published statements give the misleading impression that HSE's Biohazards Team endorsed those decisions, when the HSE expert's account does not support that interpretation.

ARHAI's previous misrepresentation of HSE's position, and the subsequent intervention by HSE requiring ARHAI to remove misleading statements from its 2021 Rapid Reviews, were documented in CATA's report submitted to the Inquiry on 6 March 2026 (section 10).[5]

Sources

1. UK Covid-19 Inquiry, Module 3 report, paragraphs 1.106, 1.139, 1.141. (link) (archive)
2. ARHAI Scotland, Scientific FAQs / Crib Sheet, p. 10. (link) (archive)
3. ARHAI Scotland, Surgical Face Masks — Considered Judgement Forms, p. 61. (link) (archive)
4. SHBN contemporaneous file note, telephone conversation with HSE Biohazards expert, 27 August 2026. (link)
5. CATA, An Independent Investigation into the Conduct of the IPC Cell, submitted 6 March 2026, section 10. (link)

5. Surgical Masks, PPE and UK Health and Safety Law

Fluid Resistant Surgical Masks do not provide adequate protection to the wearer against inhalable infectious hazards. Presenting them as suitable PPE for this purpose actually increases the risk to HCWs by giving them a false sense of security.

The Inquiry recognised that IPC guidance which recommended the use of Fluid Resistant Surgical Masks as 'Personal Protective Equipment' was flawed. It confirmed that, according to the Regulatory Authority (HSE), these masks must not be considered as PPE – they are primarily 'source control', intended to protect others rather than the wearer.[1]

This was also confirmed in the oral evidence of HSE's Director of Policy and Engagement, Mr Richard Brunt, on 12 September 2024.[2]

However, the authors of the Scottish NIPCM flout not only the Inquiry's findings and the position of HSE, but also the requirements of the PPE and COSHH Regulations. They state that ***"in their expert opinion surgical face masks may be used for the personal protection of a wearer"*** and persist in using the misnomer '***PPE'*** for surgical masks throughout the IPC Manual.[3]

HSE has expressed concern that wearing a mask which allows ingress of hazardous airborne substances (whether a poorly fitted FFP3 respirator or a surgical mask) may actually increase the risk to the wearer because they believe that they are protected when in fact they are not.

Strangely, despite ARHAI having formed its own 'expert opinion' on the health and safety aspects of PPE, its witness at the Scottish COVID-19 Inquiry, Ms Laura Imrie, stated in oral evidence on 20 October 2026 that ARHAI was not responsible for health and safety matters relating to PPE, which she clearly stated were the responsibility of HSE, whose guidance and legislation ARHAI follows.[4]

ARHAI, however, does not follow HSE guidance, nor does it follow the relevant health and safety legislation. Taking these two points in turn:

(i) Guidance: ARHAI now agree that respiratory diseases such as COVID-19 are 'spread through the air'. They enter the body by inhalation and the only PPE recognised by the HSE to protect against inhalable hazards is RPE. HSE's official guidance on RPE is set out in their document ***"Respiratory Protective Equipment at Work – A practical Guide"*** (HSG53). Surgical masks are not recognised anywhere in this guidance as a form of RPE.[5]

Approved Code of Practice (ACOP): An ACOP has a special legal status, giving its provisions considerably greater weight than ordinary guidance.

The COSHH ACOP requires RPE to provide adequate control of inhalation exposure, using the equipment's Assigned Protection Factor (APF) as a guide to its suitability. Surgical masks have no APF and are therefore not suitable RPE for protecting HCWs against inhalation of infectious aerosols.[6]

(ii) Health and Safety Legislation:

Regulation 7(9) of the Control of Substances Hazardous to Health Regulations 2002 (COSHH) requires PPE to be suitable for its intended purpose.

Regulation 7(9)(b) makes additional provision that, in the absence of alternative legal requirements, RPE shall be of a type approved by HSE or conform to a standard approved by HSE.[7]

Note: The word 'shall' imposes a mandatory duty. Compliance with the applicable requirements of Regulation 7(9) is therefore not optional.

Surgical masks do not conform to any such standard nor have they been approved by the Executive for the purpose of respiratory protection.

Ms Imrie's testimony to the Scottish Inquiry that ARHAI follows HSE guidance and legislation is therefore demonstrably untrue.

The mandatory requirements of COSHH are clear and unambiguous. No ***"considered judgement"*** by ARHAI's expert groups can override the requirements of UK law.

Sources

1. UK Covid-19 Inquiry, Module 3 report, para 1.10. (link) (archive)
2. Richard Brunt, oral evidence, UK Covid-19 Inquiry, 12 September 2024 (link) (archive)
3. ARHAI Scotland, Surgical Face Masks — Considered Judgement Forms, page 15 (link) (archive)

4. Laura Imrie, oral evidence to the Scottish Covid-19 Inquiry, 20 October 2026. Extract transcribed from the hearing recording. (link)
5. HSE, Respiratory protective equipment at work: A practical guide (HSG53). (link) (archive)
6. COSHH Approved Code of Practice, L5 — paragraph 160 (link) (archive)
7. The Control of Substances Hazardous to Health Regulations 2002, regulation 7(9). (link) (archive)

6. **The Role of Ventilation and Filtration Systems in Infection Prevention and Control**

Professor Clive Beggs, in his oral testimony to the Inquiry, described the current hospital ventilation guidelines as "out of date" and "not fit for purpose". These guidelines (known as Health Technical Memoranda) specify six air changes per hour for general and acute wards. He cited measurements at Addenbrooke's Hospital where ventilation rates were less than one air change per hour, illustrating the inadequacy of ventilation in parts of the existing NHS estate.[1]

The Inquiry was unequivocal in its conclusion that: "***in the short term, the use of HEPA filters should be prioritised within healthcare across the UK***".[2]

It is noted that the Scottish IPC Manual contains not one single mention of HEPA filters.[3]

Given the known deficiencies in ventilation across parts of the NHS estate, it is extraordinary that the revised Scottish NIPCM, which purports to provide authoritative guidance on Infection Prevention and Control, fails to advocate the use of HEPA filtration in accordance with the Inquiry's conclusion that it should be prioritised. HEPA air filters can substantially reduce the risk of far-field airborne transmission. Air cleaning should be an integral component of IPC precautions, particularly where existing ventilation is inadequate and patients may be carrying serious respiratory infections.

ARHAI has repeatedly invoked the COSHH hierarchy of controls to emphasise that PPE and RPE occupy the lowest, and therefore least effective, position in the hierarchy.[4] Perversely, however, having placed such emphasis on this principle, ARHAI then fails to adequately advocate the use of 'engineering controls' such as HEPA air filtration units, which occupy a higher position in the hierarchy. ARHAI cannot, on the one hand, rely on the hierarchy to diminish the importance of RPE whilst, on the other hand, neglect the very measures which the hierarchy places above it.

It should be noted, however, that neither general room ventilation nor HEPA filters (nor other air-purification devices) can be relied upon to provide adequate protection in respect of 'near-field' risk such as where healthcare workers are providing direct care to infectious patients at close quarters where the breathing zones of patient and healthcare worker unavoidably overlap.

Source:

1. UK Covid-19 Inquiry, Transcript of oral evidence of Professor Clive Beggs 11 September 2024, page 39 (link) (archive)
2. UK Covid-19 Inquiry, Module 3 report, introduction paragraph 1.105 (link)
3. Scottish National IPC Manual, Print version, last updated 3 August 2026 (link*) (archive)
   * Note: This link will take you to the most recent update of the manual. To visit the version issued 3 August 2026 click the archive link.
4. Scottish National IPC Manual, Appendix 16 'Hierarchy of Controls' : 3 August 2026 (link) (archive)

7. Risk of healthcare workforce collapse during a future pandemic

In the introduction to the Module 3 report (page xi), Baroness Hallett warned that ***"When the next pandemic strikes, there may not be a workforce in the healthcare systems able or willing to work under the conditions that arose during the Covid-19 pandemic."*** We share this grave concern. Indeed, if the next pandemic involves an airborne pathogen substantially more lethal than SARS-CoV-2, the consequences of healthcare workers becoming seriously ill, dying or refusing to work without adequate protection could rapidly overwhelm the NHS, potentially leading to its collapse.[1]

A future pandemic could involve an airborne pathogen arising naturally or through deliberate malevolent biological activity. The emergence of a human-to-human transmissible variant of avian influenza H5N1 is one foreseeable example, given its widespread circulation in UK wild birds, confirmed infections in mammals and its capacity to acquire genetic changes that may increase transmission between mammals.

HCWs cannot reasonably be expected to risk their lives, and potentially those of their families, without confidence that they are adequately protected. Many witnessed the consequences of inadequate respiratory protection during COVID-19, including colleagues left seriously ill and unable to return to work. The written statements provided to the Inquiry by Dr Nathalie MacDermott and Dr Gillian Higgins, together with the moving oral evidence of Professor Kevin Fong on 26 September 2024, bear witness to the devastating consequences for both physical and mental health.[2, 3, 4]

One of the planning assumptions explained in NHS England's framework for managing the response to pandemic disease is that "***it will not be possible to halt the spread of a new pandemic virus, and it would be a waste of public health resources and capacity to attempt to do so***".[5]

The risk of widespread loss of healthcare workers, through illness, death or unwillingness to work without adequate protection, is compounded if pandemic planning proceeds on the assumption that widespread transmission is inevitable, without adequate provision for protecting the workforce against avoidable occupational exposure.

To quote Sir Patrick Vallance, former UK Chief Scientific Adviser; "***Another pandemic is absolutely inevitable***".[6] Ensuring effective respiratory protection from the outset must therefore be regarded as essential to maintaining a functioning health service during the next pandemic, not merely as an occupational health consideration.

Sources

1. UK Covid-19 Inquiry, Module 3 report, introduction p. xi. (link) (archive)
2. Nathalie MacDermott, written witness statement, INQ000492279. (link) (archive)
3. Gillian Higgins, written witness statement, INQ000421873. (link) (archive)
4. Kevin Fong, oral evidence, 26 September 2024. (link) (archive)
5. NHS England, Framework for managing the response to pandemic diseases, Appendix 5 (2024) — (link) (archive)
6. The Guardian, 25 May 2024 (Link)

8. Failure to prepare for rapid, large-scale deployment of suitable powered respirators

The Inquiry recognised the limitations of tight-fitting respirators, particularly for HCWs with facial hair, religious head coverings or difficulties achieving an effective face fit.[1] Recommendation 3 addresses the need for greater fit-testing capacity, but this alone cannot resolve these limitations, nor the difficulties associated with prolonged use of FFP3 respirators.

HSE guidance recognises the advantages of powered respirators with loose-fitting hoods where RPE must be worn continuously for long periods. Such equipment does not require face-fit testing and provides effective protection for HCWs unable to use tight-fitting respirators.[2]

The feasibility of substantial deployment was demonstrated at University Hospital Southampton, where Professor Paul Elkington MBE and colleagues developed the PeRSo powered respirator during the first weeks of the pandemic. Over 3,500 were subsequently in use, with peer-reviewed research reporting strong staff acceptance, favourable costs and an association with reduced staff absence.[3]

Equally important was the confidence that this equipment gave HCWs in their own safety, with published research reporting a strong subjective sense of protection among users. This has implications extending well beyond infection prevention: confidence in the protection provided may be a decisive factor in whether HCWs feel able and willing to continue treating patients during a future pandemic.

In oral evidence to the Scottish Covid-19 Inquiry on 20 October 2026, Laura Imrie stated that respiratory hoods had been considered by CNRG but could not be adequately decontaminated for safe reuse. [4] However, the Southampton PeRSo programme demonstrated that reusable powered respirators could be deployed successfully with appropriate decontamination procedures. These included cleaning with disinfectant wipes, supported by staff training and practical demonstrations made publicly available in April 2020.[5] Professor Elkington has confirmed that the cleaning procedure was tested and proven effective against SARS-CoV-2. [6]

Indeed, section 2.4.5 of the revised Scottish NIPCM itself expressly recognises that powered respirator hoods may be reusable and provides for their maintenance and decontamination in accordance with manufacturers' instructions. [7] This is at odds with Ms Imrie's testimony to the Scottish Inquiry.

Professor Elkington, in a statement prepared for the UK Covid-19 Inquiry, recorded that "***having tried to persuade NHS England that widespread use of powered respirators should be a central strategy, but with no success, was suddenly called on about 20th December 2020 asking if the University had 100,000 of their custom-built 'PeRSo' powered respirators available for immediate deployment. Without advance notice, this was clearly impossible***".[8] The request for so many powered respirators, at a time when thousands of healthcare workers were absent through illness or isolation, demonstrates that their potential value was recognised. However, the absence of advance manufacturing arrangements made it impossible to respond to such a request.

In its formal response to Module 3, Recommendation 3, the Scottish Government has now acknowledged that powered hoods are an essential part of the RPE available where face-fit testing cannot be undertaken or successfully achieved. However, this falls well short of demonstrating preparedness for their rapid deployment across the NHS at the outset of a pandemic.[9]

We believe that an urgent national programme is needed to develop a new BS EN standard, or appropriate additions to existing standards, specifically addressing the requirements of powered respirators for use in healthcare. This must ensure effective protection of both HCWs and patients, whilst overcoming the practical limitations of conventional FFP3 respirators. Any new standard, or extension of BS EN 12941, must also address the filtration of exhaled air to ensure an appropriate level of source control and protection for patients.

Government must also establish arrangements for regulatory approval, advance manufacturing capacity, strategic reserves, training and rapid deployment across the NHS. This should include consideration of guaranteed minimum procurement commitments to encourage manufacturers to invest in production capacity before it is urgently needed.

At the outset of the next pandemic, the number of powered respirators required across the UK could be many times greater than the 100,000 units that were requested of Professor Elkington in December 2020. Whilst maintaining stockpiles on such a scale may be impractical, arrangements need to be established in

advance to ensure that the necessary components can be manufactured, assembled and deployed rapidly when the need arises.

The procurement and supply failures identified by the Inquiry in Module 5 further reinforce the need for these arrangements to be established in advance. [10]

Without such preparations, the UK risks entering the next pandemic with the same fundamental deficiencies in respiratory protection and supply arrangements that were exposed in 2020.

As Baroness Hallett observed in the introduction to the Module 3 report, ***"We coped, but only just."***[11] A future pandemic could involve a pathogen considerably more lethal and/or transmissible than SARS-CoV-2, placing even greater demands on healthcare services, whilst simultaneously threatening the availability of the workforce upon whom the entire UK population depends in time of pandemic.

This raises two fundamental questions:

1) Would our healthcare systems cope next time?

2) Are the UK Government and devolved administrations taking all the necessary steps to ensure that they could?

On the evidence available to us, we remain seriously concerned that they are not.

Sources

1. UK Covid-19 Inquiry, Module 3 report, paras 2.103–2.104 and Recommendation 3. (link) (archive)
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3. Munro et al., Powered Respirators Are Effective, Sustainable, and Cost-Effective PPE for SARS-CoV-2, Frontiers in Medical Technology (2021). (link) (archive)
4. Laura Imrie, oral evidence to the Scottish Covid-19 Inquiry, 20 October 2026. Extract transcribed from the hearing recording. (link)
5. University Hospital Southampton, PeRSo donning, doffing and decontamination video, 23 April 2020. (link) (archive)
6. Professor Paul Elkington, personal correspondence confirming validation of PeRSo decontamination procedures against SARS-CoV-2.
7. Scottish NIPCM, section 2.4.5: Powered respirator hoods. (link) (archive)
8. Professor Paul Elkington, statement prepared for UK Covid-19 Inquiry, 9 December 2024. Page 3 (link)
9. Scottish Government response to Module 3, Recommendation 3, 17 September 2026. (link) (archive)
10. UK Covid-19 Inquiry, Module 5 procurement report, 14 July 2026. (link) (archive)
11. UK Covid-19 Inquiry, Module 3 report, introduction p. x. (link) (archive)