



PNiS/CC

16th April 2020

Mr Paul Reid
Chief Executive Officer
Dr Steevens Hospital
Dublin 8

By email to: ceo.office@hse.ie

Dear Paul

I refer to ongoing public reported HCW infection rates from Covid-19. The figures appear to be increasing at a significant rate and we have sought and obtained the following breakdown of figures from the office of the HSE's Chief Clinical Officer this afternoon.

Table 1: Number and proportion of HCW COVID-19 cases by week

Week (Calendar date)	Number of HCWs	Total number of cases	Proportion of HCWs
10 (1 – 7, March)	2	16	13%
11 (8 – 14, March)	23	129	18%
12 (15 – 21, March)	202	691	29%
13 (22 – 28, March)	427	1645	26%
14 (29 March – 4 April)	824	2471	33%
15 (5 – 11, April)	1023	4647	22%
Total	2501	9599	26%

Table 2: Number and proportion of HCW COVID-19 Cases by role

HCW Role	Number	Percentage
Nurse	883	35.3%
Other allied HCW	639	25.5%

Healthcare assistant	445	17.8%
Doctor	287	11.5%
Porter	37	1.5%
Unknown	210	8.4%
Total	2501	100.0%

On March 31, the Chief Medical officer reported the total figures as 3,235 and advised that ¼ were HCW and that of those ¼ had non-work acquired Covid-19.

Even generously assuming that the proportion has remained constant due to travel restrictions in place since that report, the 2,501 figures in the table above could mean that over 2,200 healthcare workers have acquired this infection at work.

By any standard that is a high number and proportion. The European Centre for Disease Prevention and Control found on 8th of April that across Europe, “between 9% and 26% of all diagnosed COVID-19 cases are in healthcare workers.”

As set out previously by this organisation, the safety, health and welfare of employees is the responsibility of the HSE, and these figures indicate that immediate review of two main issues need to take place.

Firstly, and as a matter of priority, a review of Occupational health advice on derogating essential workers who are suspected positive, or close contacts with Covid-19 when asymptomatic to work within the 14-day period. There is no evidence that despite being asymptomatic that they are not a vector for this virus, and there is WHO evidence of pre-symptomatic transmission.

Secondly, we have several reports from members that they have been able to procure and supply PPE from domestic suppliers. One example is this afternoon: a large acute hospital was told that their supplies of PPE would not last the night shift. One nurse then contacted a local supplier and secured 2000 masks which were delivered to the hospital. It is simply not acceptable that staff in the frontline have to secure their own protective equipment.

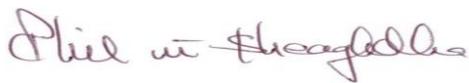
There must now be an immediate investigation into the PPE procurement function of the HSE, and a full audit of available domestic supplies from all possible sources and the distribution of same must be undertaken as a matter of urgency.

The expectation we hold is that no stone will be left unturned in seeking all available supplies of PPE domestically, as well as internationally, to protect our members when they are at work. If our members can source supplies at short notice domestically there are serious questions to be asked. This is a matter of extreme urgency as shortages are being reported to us at an increasing rate. There cannot be an expectation that staff will work without adequate PPE.

We have circulated the figures you have sent us so far to our membership. However, we believe that these figures should be published regularly, in line with HSPC's daily epidemiology reports. Not only are infection rates among healthcare workers a matter of legitimate public and professional interest, but clarity and transparency on this issue will prevent unhelpful, runaway speculation which has caused great fears amongst our members and their colleagues in other professions.

Looking forward to your reply,

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A handwritten signature in purple ink, reading "Phil ní Sheaghdha".

PHIL NÍ SHEAGHDHA
General Secretary

cc: Dr Colm Henry, Chief Clinical Officer, HSE