

**Occupational health and safety in Scotland after the Covid-19 pandemic: the case for new principles, policies and practices involving lessons we have forgotten, lessons we have learnt and lessons we should apply in the future**

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**1. EXECUTIVE SUMMARY**

The paper addresses 3 themes:

* The challenges to worker health and safety in Scotland during the pandemic;
* How those challenges relate to past failures and missed opportunities in the UK and Scotland on worker health and safety prior to 2020; and
* The future for worker health and safety in a devolved or independent Scotland.

The analysis in the paper is set within the following framework:

* The neo-liberal forces that have driven de-regulation and ‘better regulation’ on occupational health and safety both within the UK – as currently occupational health and safety is reserved to Westminster – and more specifically within Scotland;
* The related drivers that initially led the Scottish Government to follow the UK Government lead on SARS-CoV-2, but now with more cautious, collaborative and better decision-making. This involves the role of the Health and Safety Executive, Public Health England, Health Protection Scotland and NHS Scotland and how all worker health and safety and not just that of health care workers was repeatedly neglected at each stage of the pandemic so far;
* The role of unions and NGOs in challenging UK and Scottish Government decisions on the pandemic and putting forward alternative or revised proposals to ensure more effective occupational health and safety policies; and
* The requirement to adopt alternative strategies now and in the future to protect and improve worker health and safety in Scotland. This includes specific strategies such as the adoption of the precautionary principle, toxics use reduction approaches relevant to zoonotic diseases and their transmission, and sunsetting hazardous occupations and industries. It also includes linking changes to the major economic alternatives mooted prior to the pandemic for the Scottish economy. This includes Just Transition plans, implementing the Fair Work agenda of the international unions, International Labour Organization, and Scottish Trades Union Congress and last, but not least, the Green New Deal approaches that need to draw on and incorporate plans for healthy and safe working conditions.

**Key recommendations**:

* Scotland needs an independent, properly resourced and staffed occupational health and safety body with effective representation at board level for workers and their unions, employers, local authorities and communities. Safeguarding the workforce also safeguards communities, public health and the economy from the damage done by occupationally illnesses and injuries.
* A Scottish Occupational Health Service should be developed and mainstreamed within NHS Scotland to end the employer driven, free market delivery of occupational health interventions deeply distrusted by workers and unions
* Scottish worker health and safety should be based on effective and coherent principles, policies and practices geared to prevention. This is currently often missing or marginalised in a deregulatory climate that highlights ‘flexibility, proportionate and common-sense action’ which is a code for inaction
* Worker health and safety should never again be neglected in pandemic planning by public health bodies lacking expertise and autonomy and unable to effectively safeguard all workers at risk
* Unlike the UK, the Scottish Government should adopt, in a devolved or independent state, all ILO conventions on occupational health and effective precautionary principles.

**About the author**

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**2. INTRODUCTION**

Occupational health and safety with few exceptions has been of marginal concern to successive UK Government despite the repeated and inaccurate rhetoric about our world leading status in this field. The impacts of poor health and safety tend to hit the ‘marginal’ and vulnerable in our society hardest: often low paid workers, many in the gig economy, in hazardous industries or occupations that affect both physical and mental health. Such workers are frequently not in unions although research has repeatedly shown unions offer the best workplace health and safety protection for workers (Harvard 2012). The value of good health and safety regulation and inspection of workplaces has also been established for many years (Vogel and Van Den Abeele 2010; Levine et al 2012). Yet over decades and well into 2020, the UK Government was attacking workplace health and safety regulations that protect all workers especially the most vulnerable (Whyte 2010; Tombs and Whyte 2010: Tombs and Whyte 2014). Such regulations were viewed as unnecessary red tape and the UK Government promised it would sweep away what was left of health and safety culture and EU health and safety influence when it ‘achieved’ Brexit.

The most vulnerable workers also contain the greatest number of women workers, migrant workers and workers from ethnic minorities and refugee workers who will have the lowest wages, the worst housing and general environment including air quality (Marmot 2010, 2020; Hawkins 2020). These are all factors that may interact adversely with hazardous working conditions. The human and societal costs of what might be termed ‘slow burning’ poor health and safety have been ignored by successive UK governments. Evidence that poor health and safety seriously damages economies too has been made by regulators for decades yet have also been ignored by UK governments although on rare occasions in the past touched upon by the Scottish Government (Matheson 2012). The public good in many economies is often ignored in order to protect private interests (Marks 2019).

In 2014, a group of us wrote a position paper for the Jimmy Reid Foundation on occupational health and safety in Scotland developing an approach we first mooted in 2011 (Watterson 2011; Watterson, O’Neill et al 2011; Watterson, Gorman et al 2011; Watterson and O’Neill 2012; Watterson et al 2013; Watterson et al 2014). The paper advocated a broad-based work environment act, better inter-agency working and more funding for occupational health and safety. It highlighted the need to adopt ‘innovative’ policies and procedures for occupationally-caused and occupationally-related ill-health as well as occupational safety. These included the application of the precautionary principle, greater protection for vulnerable and disadvantaged groups of workers, the use of roving safety representatives, more workplace ‘green’ reps, and an end to deregulation and ‘better regulation’ policies. If just some of these proposals had been adopted in the UK and within Scotland in recent years, the impacts of the COVID-19 pandemic could have been significantly reduced. Instead across the UK there has been a public health and occupational health and safety disaster. Several of our recommendations are now back on the agenda and this paper analyses some of the reasons why they are needed. A more detailed analysis of how the UK and Scottish Government performed on worker health and safety during the early stages of the COVID-19 pandemic is available (see Watterson 2020a).

The pandemic has polarised positions about saving the economy or protecting public and worker health and safety. This is a false position. Damaging public and worker health inevitably damages the economy. The economic and human costs of worker occupational illnesses have in the past been disguised, hidden, offset and externalised in ways that cannot be done so easily now in the pandemic: one unintended but important consequence of recent events.

The pandemic with its immediate, very visible and ‘forest fire effects’ has for the first time ever brought occupational health and safety to the fore in the eyes of the public and within the media. This was triggered initially by the concerns and deaths of health professionals – doctors and nurses – not marginalised workers who are hidden away in the occupational health and safety landscape and exposed to long term risks as well as immediate ones. It has also linked major occupational health and safety failings very clearly with the public health failings in UK Government public sector policies. This is especially so in the NHS and social care sectors linked to pernicious privatisation impacts. These failures have directly and indirectly contributed to worker mortality and morbidity.

The pandemic has exposed how lacking in key powers the Scottish Government has been on worker health and safety and its capacity to ensure the Health and Safety Executive (HSE) and other regulators protect all Scottish workers not just during a pandemic. The UK Government constrains all 3 devolved administrations in terms of laws, funding and control. The first UK patient to contract COVID-19 in the UK was identified in February 2020. At the end of February, the first occupationally-related COVID-19 case in Scotland occurred linked to the Nike Conference in Edinburgh. Yet Scottish workers remained at serious risk from COVID-19 for many weeks afterwards without it seems information being made available to workers potentially exposed at the time. The UK HSE responsible for such workers along with local authority inspectors who enforce health and safety regulations in many shops were either not informed about the cluster or were invisible, if not inactive, in flagging the importance of such an incident to other workers in the area.

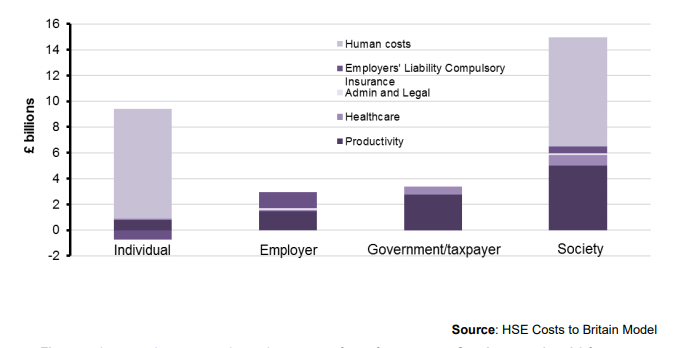
It is very easy to focus on issues in a crisis and then forget them when the crisis has passed. April 28 2020 was International Workers Memorial Day. It was created years ago to commemorate all those across the world who were made ill, injured or died from work hazards. In the mass media, this turned into an event that appeared to recognise only those UK health care and ‘key’ workers who had died during the pandemic and not the tens of thousands of other workers in the UK killed, injured and made ill each and every year by their work. Only BBC Scotland in the mainstream media on the day noted the event was in memory of all these other workers too.

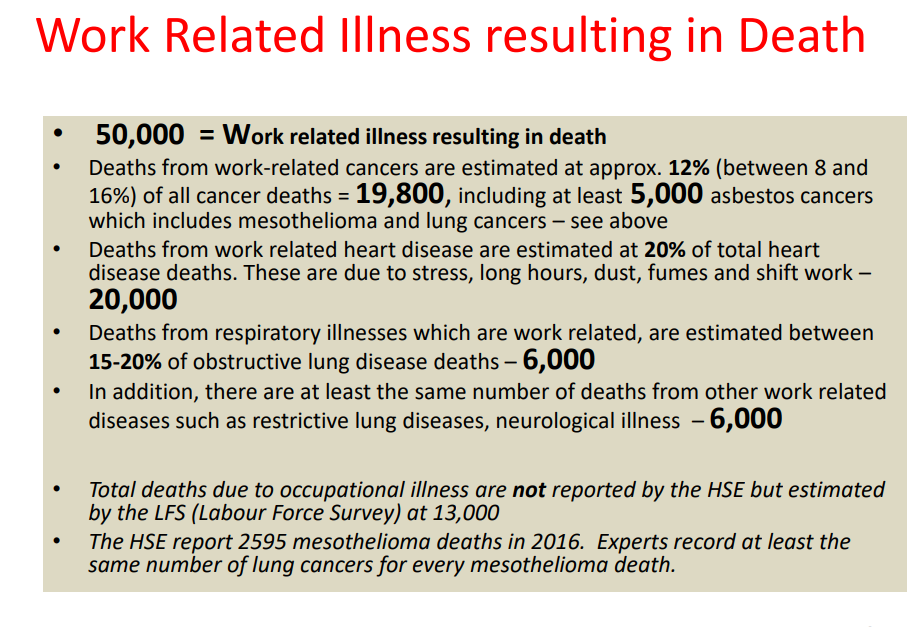
According to the HSE, which acknowledges that many of its official statistics under-report the damage done by work, the following ill-health at work and injury at work estimates for GB including Scotland apply (HSE 2020):

* + 1.4 million work-related ill health cases (new or long-standing) in 2018/19
  + 0.6 million work-related stress, depression or anxiety cases (new or longstanding) in 2018/19
  + 0.5 million work-related musculoskeletal disorder cases (new or longstanding) in 2018/19
  + 28.2 million working days lost due to work-related ill health and non-fatal workplace injuries in 2018/19
  + 12,000 lung disease deaths each year estimated to be linked to past exposures at work
  + 69,208 Non-fatal injuries to employees reported by employers in 2018/19
  + 28. 2 million working days lost due to work-related ill health and non-fatal workplace injuries in 2018/19
  + £15 billion estimated cost of injuries and ill health from current working conditions (2017/18)

HSE estimates of the economic costs of workplace injuries and illnesses in GB make grim reading. Ill- health makes up the greater proportion of total costs, although injuries account for a greater proportion of cases, because ill health cases result in more time off work on average. HSE also found most injury and ill-health economic costs fell on individuals and totalled £8.5 billion a year. For employers, costs were significant but far less at £3.0 billion a year. For government/taxpayers the costs were £3.4 billion (HSE 2019 p2). In Scotland yearly workplace ill-health costs have been estimated by HSE using 2017 prices at £805 million and yearly workplace injury costs at £450 million (HSE 2019:p16) . HSE accepts official figures under-estimate both the numbers of workplace illnesses and injuries that occur so these figures give just an indication of the damage done to the economy and productivity in Scotland by poor health and safety.

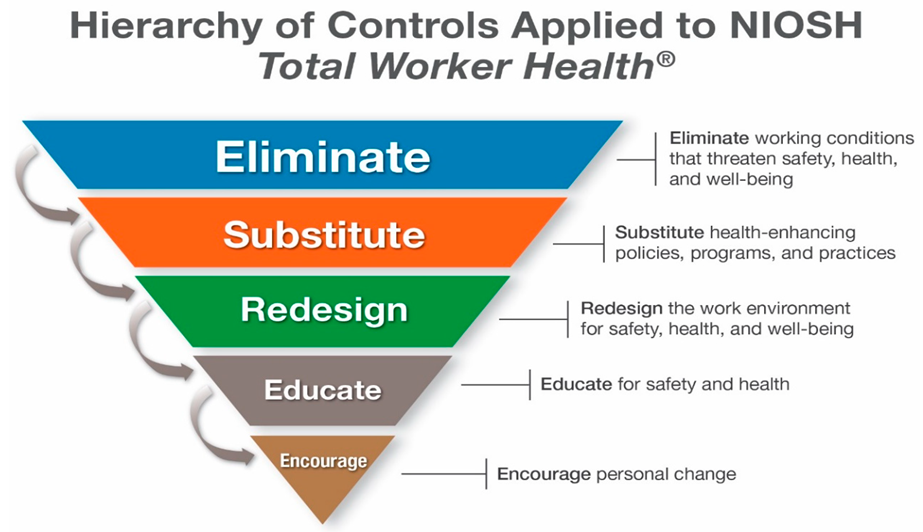
HSE Table of Costs to Britain of workplace injury and new cases of work-related ill health by cost bearer and cost component 2017/18 (in 2017 prices) [HSE 2019:p14]



The UK Hazard Campaign has a very different estimate of the damage done by work in GB. In 2020 for example their yearly estimates for occupational ill-health alone per year were far higher.

Nested within the Hazards figures is a heavy toll of Scottish work-related illnesses, deaths, fatalities and injuries that have prompted efforts to obtain such measures as corporate homicide laws and preventative actions through the STUC and specific unions (Watterson et al 2011,2013,2014).

In some instances, simply adopting the standard global approach to hazards at work built into current UK law and applying the hierarchy would mean real advances could be made in workplace health and safety. Yet steps to eliminate hazardous UK working conditions - such as those in food and textile factories, farms using migrant workers or call centres where SARS-Cov-2 can flourish or preventing worker exposure by design - were slow to emerge or still remain absent.

Now Scotland, wherever and whenever it can, should adopt the best available international principles to underpin occupational health and safety policies that work. Those policies should inform and ensure the implementation of best practice, regulations and laws where needed. This should provide a unified and coherent approach in a properly funded, staffed and supported health and safety structure. These principles, policies and practices are discussed in the rest of the paper along with some of the problems thrown up by the pandemic and failures of existing UK and Scottish agencies to effectively safeguard the Scottish workforce.

For informed observers in early 2020 the pandemic was considered likely to persist exactly ‘because public health was a low priority and workers did not have the sick pay and job protection necessary to survive’ (Hazards Magazine 2020).

**3.CHALLENGES TO WORKER HEALTH AND SAFETY DURING THE PANDEMIC.**

This section briefly examines how the UK and Scottish Government and their agencies have been tackling the pandemic from the perspective of protecting worker health and safety and against the backdrop of a poor UK record on worker health and safety prior to the pandemic. It explores how the UK and Scottish Government and their agencies have been tackling the pandemic from the perspective of protecting worker health and safety and against the backdrop of a poor UK record on worker health and safety prior to the pandemic. UK Government policy has been driven by a neo-liberal agenda that stretches back to Margaret Thatcher and through the Blair and Brown Labour Governments to May and Johnson. Part and parcel of that agenda was to deregulate, or soften regulation through ‘better regulation’, occupational health and safety. This has had some significant effects on various Scottish Governments and their agencies (Watterson and O’Neill 2012; Watterson et al 2013,2014) although not embraced so fully nor so openly as the British Government which continues to retain control over occupational health and safety as a reserved matter but not in Northern Ireland.

Occupational health and safety is too often viewed as a cost and a burden on industry not an investment because the human and economic costs of failures to protect workers can be offloaded on the victims, their communities and the NHS. The costs are externalised and so we all pay for bad employer and bad business practices. Health and safety is frequently hidden away or sometimes used by governments to mount ideological and not evidence-based attacks on so-called red tape – ‘elf and safety’ parodies. It can be considered marginal, primarily affecting industrial and construction workers. Ignoring workplace health and safety and cutting budgets of those agencies who deal with workplace health and safety has ironically been frequently viewed as a ‘safe’ option because few people would be affected by such cuts. This was never the case because poor occupational health and safety through disease and injury adds significantly to NHS treatment costs and patient numbers.

COVID-19 has brutally exposed the failures. COVID-19 transmission may occur by multiple routes. Early research from China showed the virus could be transmitted through the touching of contaminated surfaces, viral aerosolization in a confined space, and contact with infected people who had no symptoms (University of Minnesota 2020). While the particular properties of the SARS-CoV2 virus that causes COVID-19 may not have been known in 2019 and early 2020, the international pandemic planning for that period included preparations not just for influenza pandemics but also SARS, MERS and Ebola. Effective health and safety planning and risk assessments should also have required stockpiling of gowns, gloves and face shields generally appropriate for use in whatever was the pandemic cause.

**3a UK Government policy**

Knowledge of the virus routes should have informed decisions in the UK about occupational health and safety precautions, risk assessments, availability of sanitisers, what PPE was needed, by whom and in what settings. Information from China, South Korea, Hong Kong, Taiwan, Vietnam and then Italy provided early and further information about the occupational health and safety risks. These risks were run not just by health and care workers but many other key workers such as the police, security, transport, shop workers, cleaners and support workers in a range of different settings. In the USA, researchers noted that pre-pandemic training and occupational health capacity in nursing facilities, long term care, prisons and home care where transmission will occur was abysmal. It looks like similar failings occurred in parts of the UK but perhaps not at the same scale.

UK readiness has been claimed but not evidenced. If the UK had conducted a proper occupational health and safety impact assessment for all workers faced with exposure to the SARS-CoV-2, many illnesses and deaths could have been avoided.

It was entirely predictable that multiple work locations would be hit by the pandemic and it is important the pandemic planning currently in place should now be re-assessed as well as reviewed after the pandemic has ended. A containment policy with effective track, trace and isolate steps and resources was visible in several countries prior to the pandemic entering the UK. So if foresight had been used, the pandemic would have been controlled far better. The ineffective delay and mitigate phases of the UK response undoubtedly jeopardised the health and safety of health workers, social care workers and many other groups of workers across the UK (Watterson 2020d)

The UK Government determines the national health, social care and workplace health and safety policies and related infrastructure and other spending. Its priorities and projects provide both the frame and main engine within which we need to assess the impact of COVID-19 on our society. The Government determines what health and safety laws and regulations we have in Scotland and hence the policies and practices, funding and direction of the regulators who deal with occupational health and safety. It is difficult to escape the conclusion that such policies are ideologically driven and are neither evidence-based nor evidence-informed yet have had enormous adverse consequences in dealing with the COVID-19 pandemic. Successive UK governments have run down the budget of regulators and implemented a deregulatory and reduced regulation approaches to workplace health and safety openly and also covertly (Watterson and O’Neill 2012).

The HSE has responsibility for regulating most workplace health and safety in England, Wales and Scotland including hospitals and many other workplaces where COVID-19 may be a threat to health and safety directly and indirectly through staffing levels, stress and fatigue. Local authority inspectors cover smaller workplaces such as shops, warehouses and offices. There is a separate body for workplace health and safety in Northern Ireland - HSENI. All the general provisions of health and safety legislation would apply to identifying, monitoring and controlling the risks that flow from any pandemic hazards in the workplace. HSE also produces extensive information on the web and standard guides to managing health and safety and carrying out risk assessments which are easy to follow although they may be harder for some employers to implement (HSE 2013: HSE 2014/2019).

These laws and guidance should have ensured many of the easily remedied health and safety problems of reducing COVID-19 exposures that have been so visible every night on UK TV were addressed but they were not. For example, pictures of call centre, food factory workers, farm harvest workers and production workers in close proximity or health workers without any or any effective PPE were shown. What HSE has been doing, could do, should do and will be doing to protect workers from COVID-19 during the epidemic merits urgent investigation now. The mantra of the senior managers in HSE, taking their lead from the Government, was that HSE should be ‘business-friendly’ and all its actions should be ‘flexible and proportionate’ in dealing with COVID-19.

HSE senior managers during the pandemic were quiescent in their response to Government ministers’ propaganda. HSE’s performance was woefully inadequate and never proportionate to the scale of the problem it faced.

HSE did input various documents produced by the DHSS, PHE and other departments linked to preparing for pandemic flu in the 2010s. For example, in 2014 HSE flagged a Cabinet Office four-page checklist for business on pandemic flu preparedness (Cabinet Office 2014). The checklist was sparse in detail and had less than a quarter of a page on planning with the rest geared primarily to what to do in a pandemic. HSE produced its own more useful pandemic material on its web page at least from 2014 onwards prior to the emergence of the SARS-CoV-2 virus. This was its ‘Pandemic Flu - Workplace Guidance’, the latest version of which was apparently put on the web on 26th November 2019 (HSE 2014/2019). PHE material is again referenced but in addition HSE flagged risk assessments under COSHH for a range of workers who might foreseeably be in contact with ‘droplets from coughs and sneezes on surfaces, used tissues/clothing’. The workers listed as examples of those who could be exposed included cleaners, prison staff or residential care workers in direct contact with sick people. This begs the question about what employers did in their pandemic risk assessments and planning, if any, for these and other groups of workers and if HSE ever monitored employer actions.

However, HSE stated early on in the pandemic that COSHH did not cover employees who were exposed to a disease which is in general circulation and so may happen to be in the workplace (Hazards Campaign 2020). HSE did recognise there could be ‘indirect health and safety consequences of such a pandemic which do impinge on Health and Safety legislation (Health and Safety at Work etc Act 1974 and the Management of Health and Safety at Work Regulations 1999 in particular) for example the redeployment of workers to unfamiliar tasks or to lone or remote working as a consequence of a depleted staff resource due to sickness absence’.

HSE provided limited information on COVID-19 itself in the early stages and frequently referred workers to Public Health England guidance and guidance from the various health departments across the UK for detailed information on health worker PPE (HSE nd). The major early action of HSE during the pandemic appeared to be an exemption permitting the manufacture and supply of biocidal hand sanitiser products in the UK using various chemicals. This was due to the great demand for biocidal hand sanitiser product.

What else HSE did specifically at that stage to protect workers from COVID-19 is unclear. It has certainly not been widely publicized by June 2020. HSE remarkably appeared to have ‘gone missing’ during the start of the COVID-19 pandemic beyond a little information on hours of to drivers and a little information on health surveillance. It was guided it would seem by PHE. Yet interventions by the regulator to ensure suitable PPE was available to staff and that health and safety standards and good practice were being observed for COVID-19 in all workplaces could not have been more critical for health and other workers, patients and the public.

In a different political climate, health and safety laws and regulations would have reduced the morbidity and mortality of workers during the pandemic through controlling the risks better. This would have been through the rigorous checks on pandemic planning and the effective application of the 1974 Health and Safety at Work Act, the Control of Substances Hazardous Health Regulations (COSHH) revised and amended over the years and risk assessment, risk management requirements, Working Time controls only partially implemented, and Work Equipment Regulations dealing specifically with PPE. These measures came from European Union directives. In addition, the 1974 Act also contains provisions under section 7 and 8 that require employers, so far as is reasonably practicable, to protect individuals other than their own employees at workplaces. This covers members of the public and other workers in various settings and has particular relevance during a pandemic.

Specific UK regulations, if properly and widely implemented could also have contributed to stronger action during the pandemic to protect workers. These are ones giving union safety representatives in unions or as employee representatives rights to information and training, time off for inspections and investigating workplace incidents, injuries and diseases Such regulations have been under attack for several years by the UK Government. Safety representatives have rights to be consulted about risks and hazards at work and rights to sit on safety committees although obstacles may be put in their way to exercise those rights. The committees are the place where pandemic plans by employers should have been brought for scrutiny by workers.

Employment law under the Employment Act 1996 section 44 also gives employees the right to leave work where there is a serious and imminent danger and depending on specific circumstances. Concerns that might include for example lack of or deficiencies in PPE and risk assessments should be raised first with the employer and then the HSE if not resolved. Workers in libraries, the postal services and waste collection have walked off the job because of worries about COVID-19 exposure (Asquith 2020). However, HSE has not effectively enforced action against employers who have not followed the COVID health and safety guidance anywhere in the UK. Redress under the Employment Act has to be sought at a tribunal and outcomes may be limited and inadequate. Nevertheless, unions report they have used section 44 with some success during COVID-19 usually as part of collective bargaining and not through one individual. Whistle blowers in this context need more effective statutory protection. Cases during COVID-19 have shown the best defence for individual vulnerable employees, when raising health and safety concerns, has been membership of a union.

These and other regulations, codes and guidance notes provide a framework for the HSE and local authority inspectors in Great Britain to inform and advise employers and employees and enforce GB health and safety laws. They can inspect and, if necessary, issue improvement and prohibition notices and prosecute employers who breach the law. Yet there appears to have been minimal and often no action by the health and safety regulators against employers in hospitals, factories, care homes, warehouses, offices and other workplaces who breached COVID-19 related health and safety regulations and laws during the pandemic.

There is likely to be considerable debate and scrutiny after the pandemic has ended about HSE ceding effective oversight to PHE of COVID-19 occupational health and safety for health professionals through PHE publications and also apparently for food workers and farm workers when clusters emerged and the consequences of that action. This is also remarkable because HSE did apparently advising some employers and workers about PPE needed to work safely yet its own staff felt so unsafe they did not apparently visit any key workplaces during the height of the pandemic (Watterson 2020e). This follows the reports from clinicians early in the pandemic that ‘Doctors are angry about PHE’s new advice issued last week which reduces the level of the PPE that staff need to wear. Doctors believe the change in advice was driven by the lack of equipment rather than a change in the clinical evidence about the risks from the virus’ (Campbell and Busby 2020).

The HSE should have had an active role at that time in disseminating authoritative COVID-19 PPE information and wider health and safety material to all workers in all sectors across the UK. This would have allowed them to check that all was well and hence re-assure workers or address any problems raised so complementing and not delaying positive actions on COVID-19. However, the HSE went missing at the peak of the pandemic’s first wave on both information supply and inspections unlike inspectors from the Care Quality Commission, police officers and other emergency services who were all in the field.

Public Health England (PHE) and the English Department of Health and Social Care (DHSC). PHE have had the de facto lead for COVID-19 (PHE 2020, PHE ndi &11). Bizarrely this appeared to include the health and safety of all health care workers. During the UK Government press briefings on COVID-19, when there were crises about the health and safety of health care and social care workers and major PPE issues, it was PHE and the HSE who appeared alongside Government ministers to defend the indefensible failures of Government to protect these workers. HSE referred to PHE material and links on its early COVID-19 web page (PHE 2020). PHE produced guidance for health professionals in January 2020. In addition, it has produced a series of guides on PPE including fitting and use (PHE nd). The advice has at times been queried by clinicians in the field and revised for reasons that have not yet fully emerged but changes were viewed by health professionals as lowering PPE standards below WHO guidelines. PHE did not appear to adopt the same precautionary public health strategies to COVD-19 applied in those Asian and European countries that successfully controlled the early stages of the pandemic. PHE in public certainly bolstered the line taken by the UK Government ministers in England on late lockdown, delayed test and trace and fast movement out of lockdown.

The senior managers and medical and scientific staff of the NHS central administration frequently appeared with government ministers at press briefings. They explained and defended their policies and decisions and those of ministers on the pandemic and the planning prior to March. Questions about NHS preparedness to deal with UK health needs generally and a pandemic in particular have long been raised and deficiencies widely publicized throughout March, April and May (Watterson 2020b). Failures including provision of PPE, pandemic planning and risk assessments have occurred over the last four or five years (Merrick 2020, Sridhar 2020). These failures created significant problems relating to health and safety as well as public health protection. Cuts in NHS funding, privatisation and the state of the HSE from the 2000s and 2010s to 2020 resulted in a perfect but deadly storm for workers, patients and those in care homes. The SARS-CoV-2 pandemic that has led to the estimated 60,000 UK deaths by early June 2020 then triggered a range of belated and inadequate responses to the occupational health and safety threats that had already emerged and revealed further serious failures.

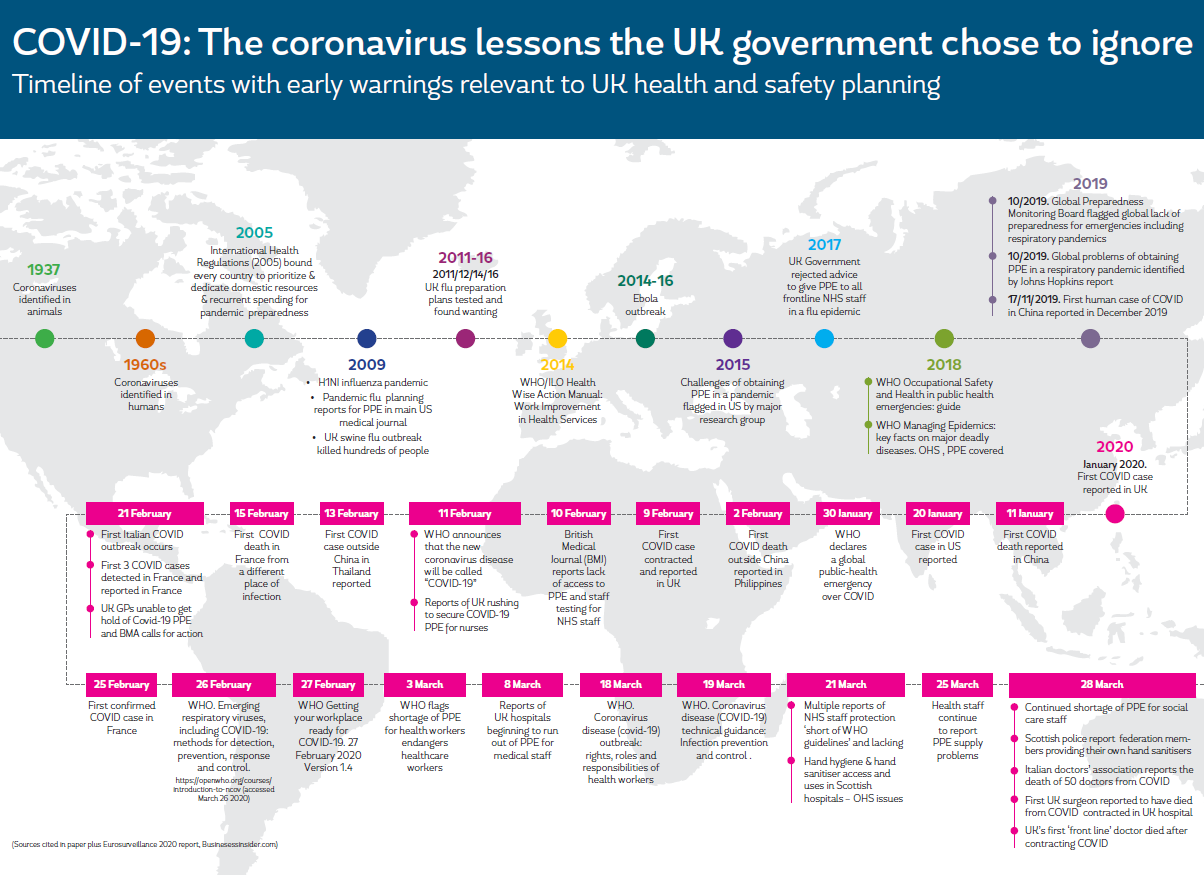
Despite protestations to the contrary by all UK governments, the pandemic was both foreseeable and at various stages foreseen, managed and mitigated far better for instance in in the early stages by China, South Korea, Hong Kong, Taiwan, Singapore, Vietnam, Norway, Denmark and Germany. These countries used foresight, containment and speed in the first wave and not ‘delay’ and they now appear to be acting quickly in China and South Korea in June 2020 to contain new clusters that have emerged. The mortality from COVID-19 both in the population at large and in the labour force was therefore generally much lower in these countries than in the UK.

**‘Based on other countries’ experiences, health care workers have been among the bulk of positive COVID-19 cases. We need to protect all of our health care workers, especially those at the frontline, because losing any of them means many COVID-19 patients will not receive the care they critically need. Protecting our health care workers means giving them the tools and gear they need to fight the virus. Losing any lives to the pandemic is devastating and society will be put at greater risk of losing more if we unnecessarily sacrifice health care workers lives by not given them the protection they need’. (Dr Bianca Frogner 2020 in USA)**

The UK Government did not draw on and use the global empirical data and WHO advice available from January 2020 onwards about both virulence, spread and control of COVID-19 and information about best practice on PPE and other health and safety issues. This does not of course mean that all the COVID-19 answers were available early in 2020. At the same time, there was no consensus in the UK scientific community about the best approach to the pandemic. UK and NHS policy and occupational health and safety practice changed regularly in March, April and May 2020 depending it would seem on these different scientific approaches, the pressure from health and emergency staff faced with the realities of failing government policy, and public and media pressure. On occasions the UK Government bowed to this pressure.

The timeline infograph below identifies the extent of the UK delays on early warnings. German researchers had already developed a test to identify the virus within weeks in January 2020, and publicized at that stage by WHO, and tested, traced and isolated many before the UK even started to get its act together.

The Chinese Government had apparently also worked out a very effective strategy to contain the virus. Testing and containment of course are also highly effective mechanisms for preventing occupational health and safety problems as well as protecting public health: the two things go hand in hand. The link between worker health and public health should now be inescapable for all governments after COVID-19 (Berkowitz 2020).



[from Watterson May 2020]

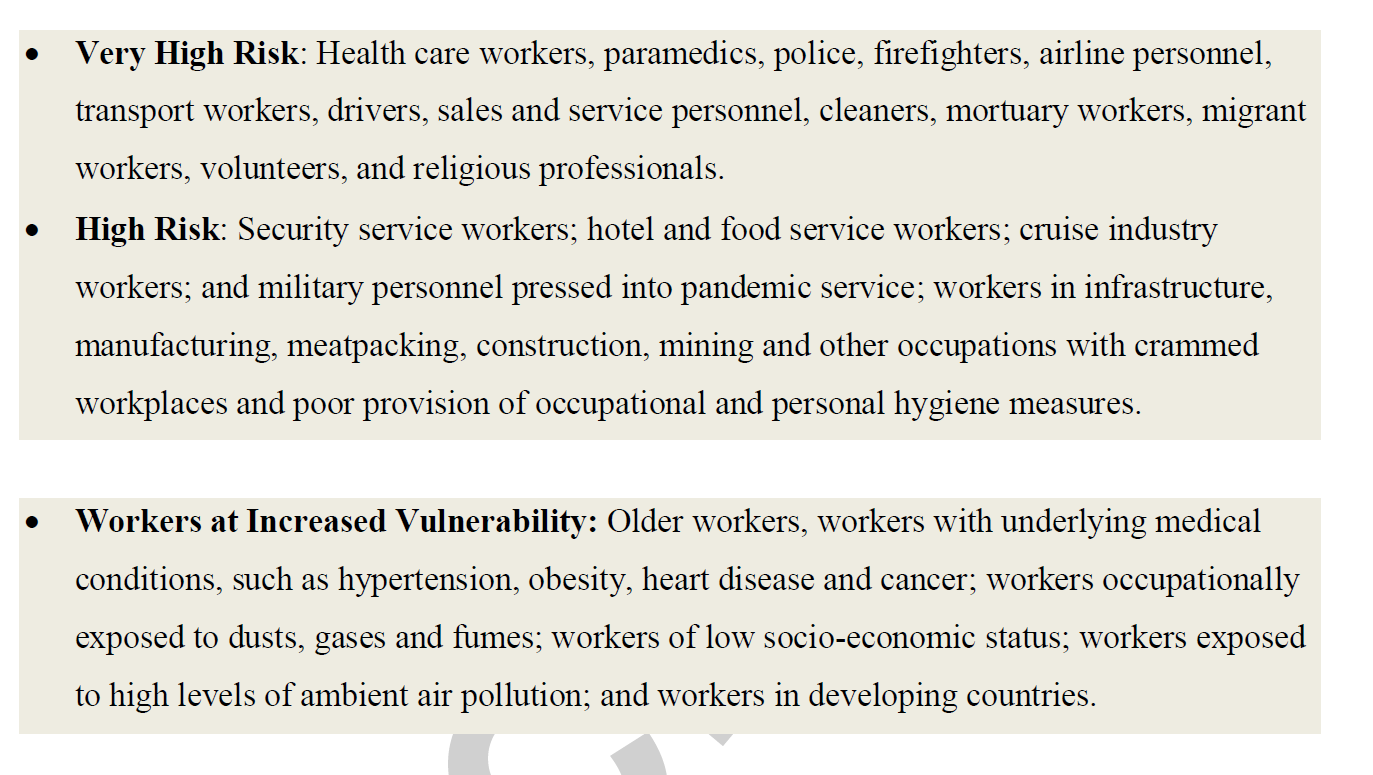
The first wave of the virus will have affected a wide range of UK workers but the recognition of the disease as occupational effectively only occurred for health and social care workers in the first instance. Good data on COVID-19 occupational morbidity as well as mortality is still lacking across the UK. Even that may be contested in terms of failures to protect workers and may in some instances be ignored in England by coroners. Scotland has established its own legal group to investigate COVID-19 deaths and looks likely to produce better data because of this. Recognition of the waves of occupational disease for all groups of workers beyond those on health and social care settings will prove even harder (Watterson 2020d). Nevertheless, the pandemic has undoubtedly increased awareness of the UK’s failures to prescribe diseases, something not within the power of the Scottish Government to deal with at present.

In North America diseases are assumed to be occupational in the first instance – the rebuttal presumption approach – and on paper this would be the fairest way to deal with COVID cases for all groups of workers. Many employees most vulnerable to COVID-19 outwith the health and social care sector are in exactly those groups that generally have the poorest health and safety record. This is compounded by multiple deprivation linked to underlying ill-health conditions and poor air quality that further increases their risk. A comorbidity or syndemic approach to workers who may have contracted COVID-19 would be the most equitable. A syndemic is a set of linked health problems involving two or more factors, interacting synergistically, and contributing to excess burden of disease in a population. Hence diabetes and COD-19 or other illnesses linked to deprivation and/or ethnicity and COVID-19 would produce a syndemic. COVID-19 occupationally-caused and occupationally-related illnesses are part of the syndemic and may have gone under the radar in large numbers but should form part of the later assessment picture just as occupational mortality does and inform future occupational health and safety policies in Scotland (Watterson May 2020).

The most extensive study of work-related COVID-19 cases has been done in 6 Asian countries with risk existing from both early and late transmission. It should inform the UK and Scottish understanding of occupational risks although there may be some significant differences between countries. In addition to health care workers, construction workers, shop workers, receptionists and transport workers, the following at risk occupations were found:



What is now concerning is that in the June 2020 relaxation of the lockdown in England, evidence had already emerged that some employers were not carrying out and making available risk assessments to workers. So, more groups of workers in England may already be at increased risk from COVD-19. On June 18 and June 19 2020, details of workplace clusters of COVID-19 in a Yorkshire meat packing plant emerged along with reports of other workplace clusters elsewhere in the county and in Wales (Drury 2020). Since then, there have been reports of clusters in textile plants and farms often employing migrant workers and BAME workers. It is difficult to avoid the conclusion that yet again workers health and safety is being neglected in the relaxation of thee lockdown. These at risks groups have been clearly identified globally and are shown in the table below.



[Landrigan 2020: Collegium Ramazzini statement on COVID-19]

**3b. Scottish Government policy and practice affecting workers during the pandemic – successes and failures often due to working within the UK**

This section explores some of the response in Scotland to the pandemic against the backdrop of UK control over worker health and safety law and government structures. Occupational health and safety, a reserved matter for the UK government to deal with, has been a Cinderella in the funding and staffing policies and practices of successive UK governments over decades. Neither Scottish workers nor the Scottish Government have control over either the HSE regulator or health and safety laws but may be able to progress some occupational health and linked public health plans at the moment. Scottish local authorities will enforce some UK health and safety laws mainly in smaller workplaces including shops, stores, warehouses and some nursing homes.

UK ‘better regulation’ policies will have damaged and reduced inspections, monitoring, information and advice and enforcement on workplace risks in Scotland. This probably meant that HSE checks on the health and safety aspects of pandemic planning in hospitals and local authority social care settings either did not occur or at best were limited. Pre-COVID-19, many workers in Scotland were already dying from occupational diseases and large numbers had been made ill by work each year (Watterson 2015, Watterson et al 2015; HSE 2019, HSE 2020).

Several Scottish-specific initiatives prior to 2020 did exist supposedly addressing workplace health and safety. They were largely but not exclusively based on health promotion and lifestyle approaches to public health rather than hazard and risk prevention. These had relatively little to offer in terms of effective occupational health and safety interventions but used resources that could have been far better deployed elsewhere.

At various times throughout the 2000s repeated calls were made to strengthen Scottish Government policies and practices on occupational health and safety and to focus on prevention where it was possible to do so (Watterson et al. 2011, 2012, 2013, 2014, 2015). It did not happen. If these approaches had been adopted it seems highly unlikely that the COVID-19 risks to health care workers, social care workers, transport workers, public utility workers and other groups of workers would not have been recognized and acted upon much earlier.

Action on occupational diseases and injuries through inter-agency working has been lacking. Repeated opportunities to adopt policies and innovative methods linked to worker and community initiatives appear to have been missed due to bureaucratic inertia or possibly ignorance. It does not seem that a fully joined up approach to date between HSE, the NHS in Scotland, local authorities, a range of Scottish Government departments dealing with the economy and employment, employers and unions has emerged and worked on occupational health and safety.

There appears to have been reluctance in the Scottish Government over two decades to engage with the progressive developments and analysis occurring elsewhere in the world on worker health and safety. Perhaps this is because control for worker health and safety, but not health and the environment and some social policies, has remained at Westminster with serious consequences. In 2019, a review was produced of the Scottish Government’s Health and Work Strategy (Bell and Reece 2019). Scattered among 23 recommendations relating to health and employability, recruitment to work and skills were a number that reflected the earlier calls for action in the 2000s and 2010s made in JRF publications and ignored by the Scottish Government. They included the need to ensure a robust regulatory, inspection and enforcement environment and to establish a single, integrated National Occupational Health body for Scotland.

The establishment of properly funded worker and community health and safety centres across Scotland is needed to advise employees, unionised or not, about prevention and detection of disease and injury and support for victims. Voluntary groups and unions are already doing important work in this area on COVID-19 health and safety and measures needed to ease the lockdown safely.

A Scottish Occupational Health Service is needed as part of the NHS. Scotland’s Social Justice and Fairness Commission which has much promise looking at income security, housing and wellbeing and how respondents would like to see changes in an independent Scotland is also being urged to support an NHS occupational health service too.[[1]](#footnote-1)

Some of the worst mistakes of the Scottish Government in planning for and dealing with the pandemic came in the early stages and will have affected the mortality and morbidity of a range of Scottish workers. These errors apparently related to an early reliance on UK Government policy and its advisory groups and specific scientific advisors. Assessments of the likely speed, spread and overall impact of the virus based on evidence from China, South Korea and Italy were seriously flawed in January, February and well into March 2020 across the UK. UK pandemic preparedness and identification of ‘at risk’ populations over at least the last ten to fifteen years were inadequate and the capacity to carry out effective contact tracing of travellers from Italy, France and Spain as well as Asia happened in countries like South Korea and Vietnam. It may have been compounded by the ‘group think’ that appeared to have operated in the early stages across all four countries of the UK with regard to the scientific and medical advisors within PHE, HPS, Public Health Scotland, NHS England and NHS Scotland.

There have, however, been some later problems that have affected worker health and safety in Scotland since the start of the pandemic especially for health care workers and care homes staff and for emergency and support workers. These relate to legal, structural, knowledge and resource issues and with testing and tracing in the Nike case that had ramifications for workers but now look to have been corrected.

There have too been some Scottish-specific pandemic planning problems linked to NHS Scotland. For example, the Silver Swan training exercise conducted in 2015 across NHS Scotland health boards, and with ambulance and police staff, to check preparedness for a flu pandemic revealed serious potential difficulties. These included occupational health and safety concerns about inadequate supplies of PPE for workers and the threat posed by health service staff falling ill during the pandemic. Following the exercise, reviews of the distribution of PPE were to be conducted but it now seems the Scottish PPE problems were not fully resolved by March 2020.

Not all workers at immediate risk from COVID-19 spanning very high risk, high risk and vulnerable risk groups can have been fully recognised during pandemic planning and operationalisation in terms of risk assessment, risk management, PPE and training needs. Specific often relatively localised problems emerged relating to access to and use of sanitisers in hospitals, suitable and sufficient PPE supply in hospitals, GP practices, residential homes, social care, transport and other service and emergency settings services. Some basic requirements such as hand sanitisers were not being met. In April, over three months after COVID19 was confirmed in China, RCN Scotland still expressed concerns about whether staff had the PPE they needed not just in the NHS but in the communities, in the care homes, in the hospices, wherever care is being provided. BMA raised similar PPE concerns for medical staff. Nevertheless, the Scottish PPE supply problems have been far less than those encountered by NHS England.

Many Scottish workers also face the double jeopardy of either losing their jobs or carrying on working in what might hazardous employment. The ILO and international unions in their pandemic planning publications in the 2000s indicated the need to protect all workers economically during a pandemic especially those in precarious employment and in the gig economy. The Scottish Government lobbying for UK Government economic support for these workers is therefore important. It will help to ensure employees are not forced back prematurely into dangerous work environments without proper ‘COVID-safe’ measures in place, risk assessed and checked. The broader Scottish Government initiatives on fair work through the Fair Work Convention in 2016 and the Fair Work Action Plan of 2019 are welcome in the context of improving health and safety after the pandemic and look important developments to underpin a more joined up approach to work.

As the pandemic progressed the Scottish Government policies and leadership proved more decisive and at the same time more cautious than that of the UK Government. This undoubtedly ensured better worker health and safety and fewer workers at risk from COVID-19. Scottish Government policies in June 2020 look likely to maintain that position. It is now clear that the Scottish Government has done significantly better than England in managing the COVID-19 crisis after the easing of lockdown. Its policies look likely to maintain that position. In April the unions for example welcomed the stronger guidance issued by the Scottish Government to construction firms during the COVID-19 pandemic, which clarified what was essential works and, in the event of construction sites ceasing work, indicated workers’ pay must be protected (Unite 2020a &b).

By early March the Scottish Government and STUC had agreed a joint statement on ‘Fair Work during the COVID-19’ crisis that had begun to address broad-based health and safety issues (STUC nd; Scottish Government 2020a). By the end of May and early June 2020, there were clear indications that the Scottish Government was still engaging constructively, if under pressure to act at times, with the unions on COVID-19 lockdown health and safety issues. Scotland produced its route map through and out the crisis towards the end of May (Scottish Government 2020a). Unions and employers were consulted on health and safety plans when easing lockdown. The picture in England was rather different and consultation by the UK Government and HSE with the unions there appeared very limited if not non-existent.

The Scottish Government described its approach as a mixture of regulation and guidance. It drew on the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020 that came into force on 26 March, imposing the 2- metre ‘rule ‘on all businesses and service providers that remained open. By July 2020, the 2-metre guidance had changed. Further discussions about health and safety guidance in Scotland after lockdown then took place in some employment sectors between government, employers, regulators, unions and their advisors on social distancing and mitigation measures at work.

As HSE was not the lead on COVID, it was possible for Scotland to formulate its own policies on health and safety in some of these sectors. The Scottish Government believed the HSE were treating COVID-19 as a workplace health issue. Evidence in the House of Commons DWP committee in June 2020, however, indicated HSE had taken very little enforcement action on COVID-19 anywhere in the UK (Watterson 2020e). There is therefore little evidence at the moment to support the view that HSE is able or willing to act where necessary to ensure rigorous compliance with the relevant public health guidance to control COVID-19 health risks to workers.

The Scottish Government continues to engage with employers, unions, researchers and regulators to produce sector-specific general principles, guidance notes and checklists. This is a welcome contribution to protecting worker health and safety in any return to work during the lockdown and in addressing any changes needed after it is completely phased out. In addition, regular reviews are promised of any guidance so produced. The Scottish Government plans have been described in a variety of documents (Scottish Government 2020 b,c,d). The devil will be in the detail in terms of how government and employers really do engage with proposals put forward by workers and unions and how effective HSE and local authorities prove to be in monitoring, inspecting and, where necessary enforcing regulations and law.

On 19 July 2020 the Fair Work Convention set up by the Scottish Government produced a major statement highlighting the significant differences that then existed in COVID-19 return to work policies and practice across the UK. The joint statement with the STUC on fair work expectations during the transition out of lockdown is in some respects ground-breaking (Scottish Government 2020c). It advocated the adoption of effective worker engagement, supporting workers to follow public health guidance, paying workers while they were sick or self-isolating or absent from work following medical advice relating to COVID-19. It also supported flexible working arrangements including homeworking which is currently the default position of the Scottish Government. This Fair Work policy provides one of the best templates for securing safe returns to work across the UK if it is fully implemented.

Teasing out the exact detail of the occupationally-caused and occupationally-related mortality and morbidity due to COVID-19 in Scottish workers will be difficult with many contributory factors and influences at play. These have been described earlier in this report and may make workers more susceptible to COVID. In this context, occupation whether employees were at work or not may well have been a factor in both illnesses and death from COVID-19. National Records of Scotland has provided data on deaths from COVID-19 for the first 24 weeks of 2020 (National Records of Scotland 2020). For the major occupation groups with people aged 20 to 64 years old, the highest number of deaths occurred among ‘process, plant and machine operatives’, ‘transport and mobile machine drivers and operatives’ had the highest rate. Health care workers had a lower death rate and social care workers had a higher rate. These were the occupations stated on the death certificate and NRS note it did not necessarily mean the individuals contracted the virus while at work, only that this was their occupation at the time of their death (NRS 2020). Another interpretation of the Scottish COVID mortality figures is that occupation could be viewed as a contributory factor, if not a direct cause of death from exposure to SARS-CoV-2.

Health Protection Scotland (HPS) appears to have followed closely or even mirrored the assessments of PHE and the UK scientific and medical advisors on COVID-19 in lockdown and test and trace ways that initially proved disastrous across the UK. However, HPS and Public Health Scotland have worked effectively in test, trace and isolate work when the system in England has struggled to cope checking clusters linked to workplaces. HPS has also issued a range of guidance on COVID-19. This includes general information and specific guidance covering health protection teams, primary and secondary care workers, those employed in pharmacies, working as opticians and optometrists. Some specific PPE information and references to aerosol generating procedures are also included (Health Protection Scotland nd; HPS2020).

It is a critical time and a great opportunity to seize the momentum generated on occupational health and safety to get significant changes in Scotland. The danger will be that nothing alters after the pandemic and the rhetoric for change does not translate into action. So, producing a programme for action on worker health and safety now that is an integral part of a wider Scottish progressive social and economic programme of reform will not only be very timely but critical.

**3c. The global context: WHO, ILO and a non-governmental organization on occupational health**

The WHO has had a mixed record with regard to the pandemic and more generally on occupational health (Ladou et al 2018). It produced a series of important and relevant guides to pandemic planning and the health and safety of health care workers in pandemics throughout the 2000s. Prior to 2019, it produced a manual, the Health Wise Action Manual: Work Improvement in Health Services, to guide health workers on a range of topics including the control of occupational hazards and improving workplace safety (WHO 2014). Reports from a number of UK workplaces in 2020 would seem to indicate UK COVID-19 practices fell short of this WHO guidance.

In 2018, the WHO with the ILO, produced a manual specifically addressing occupational safety and health in public health emergencies and the steps needed to protect health workers and responders (WHO 2018). It included guidance for employers on their rights and duties and information for workers on their rights. One chapter was devoted to occupational health and safety in communicable disease outbreaks including Ebola and contained information about hand hygiene, risk assessment for the appropriate use of PPE; cleaning and disinfection of the patient environment and patient-care equipment; laundry and waste management; and respiratory hygiene.

In the same year WHO produced key facts on ‘Managing epidemics’ including information on worker health and safety planning and PPE (WHO 2018; Watterson 2020a). By January 2020 the WHO had published documentation and checklists for all countries on risk communication and community engagement readiness and response to the 2019 COVID-19 pandemic. This was relevant to ensuring the health and safety of communities and health workers. In February 2020 WHO produced guidance on getting workplaces ready for COVID-19. As WHO indicated ‘Employers should start doing these things now, even if COVID-19 has not arrived in the communities where they operate. They can already reduce working days lost due to illness and stop or slow the spread of COVID-19 if it arrives at one of your workplaces’ (WHO n.d.; Watterson 2020a).

Basic information about ensuring workplaces were clean and hygienic, promoting regular and thorough hand-washing by employees, contractors and customers and pitting sanitizing hand rub dispensers in prominent places around the workplace was listed. In the UK in March 2020 it was clear that in many workplaces including hospitals, these basic steps had not been taken and there appeared to be little sign of inspection and action by regulators to improve conditions to protect workers faced with COVID-19 threats. Accounts from UK health professionals, paramedics and emergency workers dealing with known and suspect COVID-19 patients through much of March 2020 unfortunately still revealed many of these WHO-listed workers’ rights were not observed and are still not being observed by some health and social care employers.

The WHO/World Bank Global Preparedness Monitoring Board reports (GPMB 2019; Johns Hopkins 2019) identified the lack of global preparedness for a respiratory global pandemic. Issues around PPE for health workers were specifically touched up. The 2019 report was widely covered in the UK press. These WHO reports and earlier ones were therefore less a case of showing the writing was on the wall about pandemic threats, rather they revealed they were on multiple big screens everywhere illuminated not for months but years. Yet the UK Government still did not act upon them appropriately.

WHO circulated details in 2020 of the German test for COViD-19 that were ignored in the UK but used to real effect in Germany. WHO argued rightly for a ‘test, test, test’ approach to dealing with the pandemic. On the negative side, it was slow to make the call for the COVID-19 pandemic but, even so, if the UK had acted when the WHO call did come then the lives of many UK workers would have been saved. WHO has also not supported the precautionary approach to social distancing and appears unable to evidence exactly why it thinks a one metre and not two metre standard should apply when research shows the public health benefits of two metres.

In the 1980s, WHO Europe produced a Charter on Environment and Health and the principles and duties it developed for governments and employers are highly relevant to occupational health and safety (WHO 1989). They also link in with a wider public health and environment agenda and would be a valuable addition to Green New Deal programmes in Scotland. The Charter ideas should underpin future Scottish health and safety developments.

The WHO principles include acknowledging the benefits to health and wellbeing from a clean and harmonious work environment. This has not been recognised by the UK Government. Prevention not cure was advocated as the best approach: another idea alien to the UK Government. The UK failures to plan effectively for a pandemic to prevent the worst impacts, to institute an early lockdown and to test, trace and isolate and to require face coverings be worn have proved catastrophic and put a great many workers in Scotland at risk.

The health of every individual, especially those in vulnerable and high-risk groups, must be protected and special attention should be paid to disadvantaged groups. This was patently neglected prior to the epidemic in UK occupational health and safety policy and practice. During the epidemic the consequences of these UK failures became clear for vulnerable, low paid workers, migrant workers and BAME workers disadvantaged by their work, general health status, socio-economic deprivation, previous exposure to workplace air pollutants and community air pollution.

New policies, technologies and developments were to be introduced with prudence and not before appropriate prior assessment of potential environmental and health impacts. The failures in pandemic planning and the reluctance if not inability of the UK Government to act on WHO, ILO and other countries’ guides, advice and experience of the new virus and its impacts was exposed.

WHO also indicated the health and safety of individual workers should take clear precedence over considerations of economy and trade. Healthy and safe workers are productive workers in productive workplaces. Governments, public authorities and private bodies should aim at preventing and reducing adverse effects caused by potentially hazardous agents. In so many sectors, from hospitals, primary care, social care and emergency work through to transport workers, security guards, mortuary workers, food store and service workers with regard to safe systems of work and provision of suitable and sufficient PPE, this did not happen across the UK.

The ILO, a tripartite body of employers, employees and governments, has the global lead to produce conventions on working conditions including occupational health and safety and to produce reports on these topics. As the UK retains powers over workplace health and safety, it failed to adopt several ILOs key occupational health conventions because it is ideologically opposed to such proposals and guided by deregulatory principles. This has seriously disadvantaged UK workers. If Scotland was either independent or given jurisdiction over health and safety, it could have adopted these conventions which would have been of benefit during the pandemic.

The ILO Decent Work and Fair work agendas argue for both effective health and safety standards for workers and decent wages and conditions including sick pay and social welfare support. In the UK, the top down economic measures initially produced by the Government in response to COVID-19 neglected the most vulnerable low paid workers, the precariat, on zero hours contracts in the gig economy. These workers, without an economic safety net, are forced to continue working often in hazardous conditions and without proper protection in a COVID-19 pandemic.

The ILO has a bottom up approach and has been developing social welfare proposals to help exactly these most vulnerable workers during the pandemic. In 2019, the ILO published guidelines on decent work in public emergency services (ILO 2019). For the ILO ensuring decent work for these employees meant addressing PPE needs properly along with reducing such factors as occupational stress. Yet in March 2020, there have been a swathe of reports from UK emergency workers indicating these types of guidelines have not been fully met to their detriment.

By March 18 2020, ILO was assessing the effects of COVID-19 on global labour markets again especially for more vulnerable workers (ILO 2020). They noted: ‘unprotected workers, including the self-employed, casual and gig workers, are likely to be disproportionately hit by the virus as they do not have access to paid or sick leave mechanisms, and are less protected by conventional social protection mechanisms and other forms of income smoothing. Migrant workers are particularly vulnerable to the impact of the COVID-19 crisis, which will constrain both their ability to access their places of work in destination countries and return to their families’. In the UK significant numbers of workers still fall into these groups.

The ILO was unequivocal in calling for policy responses that firstly made sure: ‘workers and employers and their families should be protected from the health risks of COVID-19. Protective measures at the workplace and across communities should be introduced and strengthened, requiring large-scale public support and investment’ (ILO 2020). There is some considerable way to go before the UK can be said to have achieved this first policy objective. The second objective of effective economic support for workers affected by COVID-19 is even further away

Other international non-governmental bodies working in the field of occupational health and safety have identified some of the key governmental failures to COVID-19 and proposed best practice policies to address those shortcomings. Their approaches could be used in Scotland as a framework for employers, the NHS and unions to adapt and apply in a wide range of workplaces. Such measures would not necessarily be contingent upon the creation of new agencies or new regulations.

The Collegium Ramazzini COVID-19 statement offers a very good template or set of benchmarks against which progress in the UK and specifically Scotland could be measured. Ramazzini is viewed as the founder of modern occupational medicine (Landrigan 2020).

The statement outlines the responsibilities of Governments. These include the maintenance and strengthening of public health systems. Governments have responsibility to protect workers’ health and the health of populations by (1) maintaining disease surveillance systems that track the spread of disease and obtain information on the industry and occupation of each sick and injured worker; (2) supporting epidemic intelligence services and laboratories that warn of impending pandemics; (3) organizing and leading responses to prevent disease and death; and (4) communicating accurate, evidence-based information to the public that openly acknowledges limits and uncertainties in current knowledge.

Governments have a responsibility to protect the health of workers by sustaining comprehensive social insurance systems that include health insurance; unemployment insurance; contributions to the pension system; and provision of wages and benefits during illness and isolation. Workers must be permitted to report sick and enter quarantine without fear of losing wages or benefits. All workers must be covered by such systems, including those in precarious working conditions such as migrant workers, volunteers and the self-employed.

Governments, it notes, have a responsibility to regularly inspect workplaces and to ensure that all employers fulfil their legal and moral duty to care for their workers. Governments can further protect the health of workers and the population by officially defining COVID-19 infection as an occupational disease and establishing the presumption that any COVID-19 infection in a worker in a high-risk occupation or industry is work-related. Governments must prepare for future pandemics by investing in public health and occupational health programs, maintaining disease surveillance systems, and maintaining adequate stockpiles of emergency medicines and critical supplies.

The cuts in UK budgets that affect the NHS and HSE in England, Wales, Northern Ireland and Scotland along with the lack of rebuttal presumptions for occupational disease listings currently indicate none of the governments in the four UK countries could fulfil all or many of the above responsibilities.

As numbers of new cases decline in the late stages of a pandemic, the Collegium observed governments must develop protocols for systematically relaxing infection control procedures and reopening schools and businesses, beginning with lower-risk activities. During this phase, governments must continue to sustain comprehensive social insurance systems that protect workers from unemployment, job instability and stress caused by the pandemic. The UK Government has only partially fulfilled these requirements but the Scottish Government’s protocols on relaxing the lockdown indicate a greater understanding of the public health threat posed by the pandemic.

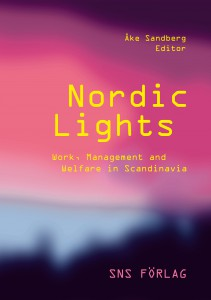
The Collegium also developed a list of responsibilities relating to employers who should, in all at-risk industries, develop Infectious Disease Preparedness and Response Plans. The plans would include designation of an infection control officer; provision of training to all at-risk workers; eliminating adverse working conditions that predispose to spread of infection, such as crowding and extreme work hours; and development of pandemic contingency plans for staggered work shifts, provision of meals and teleworking. Pandemic preparation by employers parallels pandemic planning by governments and the two must link. In the UK it is difficult to easily identify how such ‘good practice’ duties had been comprehensively implemented prior to the pandemic in many workplaces.

Additional targets were mooted to reduce hazardous occupational exposures, reduce occupational exposures to dusts, gases and fumes that increase risk and severity of infection because of the impact of SARS-CoV-2 on those affected by air pollution and occupational lung diseases. Again, the extent to which this has influenced or will influence UK employers is unknown at this stage.

The Collegium stressed the need for appropriate exposure controls. Engineering and administrative controls were to be given highest priority. PPE and behavioural controls to be used only when and if there is no other feasible option. In July 2020, detailed information about how employers have used exposure controls is unavailable but we do know that across many sectors there has been a shortage of any or suitable or sufficient PPE at various times.

**3d Health and Safety and Pandemic Controls in other European countries**

There have been widespread attacks on occupational health and safety standards, regulation and enforcement across Europe in the last decade. However, some countries have resisted these attacks more effectively than others. They have been able to defend public services and social welfare to a greater extent than in the UK and have shown a far greater commitment to worker health and safety (Sandberg 2013). It is noticeable that these countries have done much better than the UK in controlling the COVID-19 epidemic and hence protecting their health care and wider workforce from exposure to SARS-CoV-2

The Nordic model provides the best example for occupational and public health action as Norway and Denmark but not Sweden have been able to demonstrate so far. Even Germany and Greece have significantly out-performed the UK on the pandemic public health front.

**3e What the pandemic tells us about policies and practices within the UK and Scotland: unions, non-governmental organisations and professional bodies**

There have been suggestions that we are ‘all in this, the pandemic, together’ and that no one is responsible for the pandemic impacts and related health and safety failings. Both statements are untrue. The distribution of risks from COVID-19 is not equal across UK society although unusually health professionals have been heavily affected and this may explain why for the first time so much attention has been focussed on occupational health and safety. In addition to the high risks faced by health and social care professionals especially BAME workers in acute, primary care and community settings, substantial evidence is emerging that low-paid women in the UK are also at high risk of COVID-19 exposure (Booth 2020) along with low paid workers elsewhere in our gig economy. The UK Government has called for all its citizens to act responsibly to stem the mortality from the pandemic but of course governments and government advisors have not done so and have been irresponsible with the UKs public health and occupational health and safety. That has not happened. In the UK and within Scotland there have also been recent calls to go back to those economic policies that created the unequal society within which the disadvantaged, low paid and vulnerable workers - so critical to combatting the pandemic and caring for those affected - were hit hardest by COVID-19.

**3e.i Unions**

Unions continue to frame many of their responses to workplace hazards in terms of the need for employees to have decent work and fair work. The hazards of COVID-19 and the risks it presents are viewed as preventable. Where workers are affected, their employment rights, job security and access to sick pay and support should be protected and applied. Some of the information and advice available on COVID-19 occupational health. In contrast to the UK Government, government agency and sometimes employer pandemic planning and action failures, the Scottish unions and their representatives along with NGOs like the UK Hazards Campaign and Scottish Hazards Campaign acted quickly. They identified hitherto neglected ‘at risk’ workers and pressed for effective policing of workplace social distancing, closure of non-essential work, early lockdowns – topics on which the Scottish Government led the UK Government - and PPE.

There were some positive signs in June 2020 that unions would be fully involved in health and safety developments with the Scottish Government. Some of these initiatives have already been outlined in the earlier section on the Scottish Government role and are not repeated here. Joint consultations are underway in some sectors on the details of guidance relating to a wide range of subjects including risk assessments, planning, preparation, PPE, travel arrangements, home working, piloting and using dynamic risk assessments in COVID returns to work. These guidelines also include information about the approach and procedures for test and protect.

The TUC, the STUC, hazards groups, a cluster of unions including the GMB, Unite, Unison, FBU, USDAW, POA, Police Federation RCN, BMA and professional bodies all provided good health and safety information on COVID-19. They proposed immediate solutions for their members along with the need for economic support and job security for workers affected by the pandemic. The unions used a precautionary approach to risks from hazards. It is difficult to envisage a public health threat that could have warranted a more precautionary approach than a pandemic. Yet the UK Government did not act.

Unions and some professional bodies in both Scotland and across other parts of the UK have been very influential in countering the flawed occupational health and safety policies and practices of governments and government agencies (USDAW 2020). They have developed their own strategies and built up expertise linking in with international union groups to produce charters, information, education and advice programmes to better protect their members from the hazards and risks of COVID-19 both during the lockdown and also in the ‘return to work’ stages. Unions like GMB, Unite, EIS, FBU and NUT along with STUC and TUC have played a major part in assessing return to work plans by government and employers from a health and safety and public safety perspective.

The Scottish Trades Union Congress (STUC) approach to COVID-19 has been to work constructively with Government where it can press for measures which will protect public health and occupational health. It supports unions and non-unionised workers to avoid unnecessary risk and unfair detriment. It tries to ensure employers face up to their responsibilities by pressing for measures to be put in place by the Scottish Government on pay, sick pay, hours, and paid care for those affected by COVID-19 (STUC 2020). The organisation has consistently flagged the occupational health and safety threats that Scottish workers continue to face when dealing with COVID-19 especially PPE issues, problems relating to employees forced to continue working during lockdown, and the hazards and risks of relaxing lockdown. In this respect the STUC has supported important health and safety research in recent months on vulnerable groups exposed to risks from COVID-19 such as those in call centres (Taylor 2020). The Scottish Government agreed for example to set up a COVID-19 - Call Centre Sector Workplace Guidance Group with the unions, regulators and employers following the recommendations from that research.

The Trades Union Congress (TUC) has produced a range of information on COVID-19 including planning advice, health and safety information, employment rights and links to resources including standard government advice (TUC 2020). Case studies on workplace hygiene were developed at an early stage along with detailed information on PPE. The TUC noted ‘Workers in public-facing roles will also be on the front-line of responding to COVID-19 and helping to limit its public health impact. Specific risk assessments under Control of Substances Hazardous to Health Regulations 2002 (COSHH) should be performed in such workplaces’.

The General, Municipal and Boilermakers Union (GMB) has produced a detailed briefing for members on COVID-19 (GMB 2020). This provides information on the law and worker rights, on symptoms, transmission, precautions and risks. There is specific information about what PPE should be supplied, what face masks in addition to other actions their employer should take to protect their health and safety. GMB has catalogued some of the many wholly avoidable health and safety problems that workers have faced when dealing with possible coronavirus exposure. These have included access to PPE for hospital porters, lack of protective clothing and sanitisers for hospital workers, ambulance workers left with no hand sanitisers, wipes and masks and faulty testing gear, airport staff with no gloves or sanitisers and gig workers abandoned and penniless when faced with coronavirus threats.

Unite has produced some of the most detailed COVID-19 guidance and checklists for trade unionists, open to all on its web pages. It covers for example those in clinical and non-clinical settings, and a wider workforce. There are sections on PPE, cleaning, canteens and welfare facilities, home working, lone working, transport working, international working

The Fire Brigades Union (FBU) like other emergency services has had a critical role to play during the pandemic. The FBU has produced generic guidance on COVID-19 for its members (FBU 2020) and has also flagged the problems of the lack of testing which is needed to determine which of their members who are or have been self-isolating have COVID-19. Failure to test people for COVID-19 has seriously affected staffing levels in the brigades. This jeopardises the health and safety of its members in operational settings (FBU 2020). Similar problems will exist in the other emergency services. The issues faced by the police service and raised by the various police federations are discussed elsewhere in this paper.

Unions that also function as ‘professional bodies’ have not been inactive. The British Medical Association (BMA), BMA Scotland and its leadership have raised numerous health and safety issues relating to COVID-19 that their members have faced during March 2020. These have often focussed on serious PPE problems in terms of supply and suitability (BMA 2020) but have also included risk management, health and safety procedures, staffing, wider resource issues and stress and fatigue. Some of these are immediate and direct health and safety issues, others affect health and safety indirectly. Many BMA members have echoed or pre-empted the concerns raised by Richard Horton in the Lancet (Horton 2020; Lancet 2020) about COVID-19 policies, procedures, resources and delayed and ineffective actions at national level in England and Scotland. The editor in chief of the BMJ, Fiona Godlee, weighed into the debate on April 2nd 2020 with an urgent and telling plea to protect all healthcare workers based on some personal experiences and published evidence of failures (Godlee 2020). The Royal College of General Practitioners has also expressed similar concerns (RCGP 2020i and 2020ii).

The Royal College of Nursing (RCN) has argued for ‘priority COVID-19 testing for all health care professionals, access to adequate supplies of personal protective equipment and hand sanitiser for all nursing, midwifery, social care and student nurse staff for use at the point of care, full occupational sick pay paid from day 1 for all our members, with no detriment, regardless of where they work, Provision from government and employers to ensure all nursing staff can care for their children without a loss of income. Clarity on the measures taken to protect pregnant and vulnerable nursing staff. Stringent measures in place to ensure the health, safety and wellbeing of staff by addressing fatigue, hydration and issues of abuse towards staff’ (RCN 2020).

The Society of Occupational Medicine (SOM), British Occupational Hygiene Society (BOHS), Faculty of Occupational Medicine of Royal College of Physicians (FOM) have contributed to the debate too (SOM 2020; RCP 2020). FOM has produced various guidance on COVID-19 sometimes with other professional bodies and societies such as the British Occupational Hygiene Society (BOHS) and the SOM, BOHS and other groups have pressed for COVID-19 testing of all key workers and have called for an investigation of the supply of suitable PPE for health professionals (SOM 2020). By April 6th 2020, SOM spoke out further in a telling intervention on COVID-19 with an unequivocal statement exposing failures in UK occupational health and safety policy on COVID-19. It did not believe: - ‘work related fatalities due to COVID-19 exposure is a given. The UK should have aimed for a target of zero work caused fatalities in this pandemic within the NHS, essential services and UK business. With proper application of controls, no worker should die of work acquired COVID-19’ (SOM 2020).

Occupational hygienists are a key group in working out what is the best form of PPE to use for COVID-19 in various settings and in assessing effectiveness. One of the most useful and up to date guides to PPE for COVID, also a source of other more detailed information on the topic, has been produced in a journal editorial by occupational hygienists. They filled a gap that HSE did not seem to have addressed (Semple and Cherrie 2020). The Institution of Occupational Safety and Health (IOSH) is the professional body for health and safety practitioners who function in the public and private sectors as advisors on health and safety matters. They have produced an information sheet and have web links to a range of other sources on COVD-19. The organisation draws on WHO as well as UK sources and covers preventive measures, emergency planning, managing occupational safety resources and occupational risks to workers (IOSH 2020 nd). Bodies such as ROSPA, CIEH and CIPD have also produced information and advice on COVID-19 occupational health and safety topics.

**3.e.ii Non-Governmental Organizations**

The role of NGOs in campaigning for worker health and safety is well-established. The need for better environmental justice is equally strong (Schlosberg 2007). The role of workers and their unions in pressing for the green New Deal post-COVID-19 which should build in much higher health and safety standards and ‘better regulation’ and oversight is also growing (Hoff et al 2020). The recognition by some environmental campaigners at a global level to recognise the role of the unions in pushing for such a new deal is at times less powerful (Klein 2019; Pettifor 2019). The COVID-19 pandemic should now be a means of strengthening the link between unions and environmental groups and building on an analysis of the immediate health and safety problems that address the wider but associated issues of ill-health due to socio-economic and environmental factors. There has never have been such a good opportunity to make the connections.

NGOs with a campaign role have been most active in raising problems about the UK response to the occupational health and safety threats presented by SARS-CoV-2. The UK Hazards, Campaign, with the Hazard Magazine, has a long history of campaigning, informing unions especially safety reps and workers on the shop floor on hazards and analysing hazards in depth. It has drawn attention to the cuts in occupational health and safety regulation, monitoring, inspection and enforcement over several decades and advocated precautionary and preventative policies and procedures. Such cuts caused several of the problems emerging with worker health and safety during the pandemic.

The Campaign has provided excellent, accessible, detailed and clear information, guides and advice on COVID-19 frequently more detailed than those available from some employers (Hazards Campaign 2020). It has tracked and documented cases and clusters of the disease. Risk assessment, risk management, healthy and safe working practices and procedures, occupational health surveillance, provision of suitable and sufficient PPE etc have all been highlighted. The campaign focus has been on what employers should do to prevent transmission in workplaces and how employees can get employers to act. The group raised major concerns with HSE at an early stage about contradictory and flawed COVID-19 advice provided by the UK government to workers. In addition, the Campaign has been defending the 2-metre social distance for workers connected to evidence about the airborne spread of the virus and helping those with the greatest health and safety concerns who would be in workplaces on precarious contracts.

The Scottish Hazards campaign shares many of the same policy objectives and programmes on COVID-19 as the UK Hazards Campaign but works closely with the STUC and unions in Scotland. It also provides its own additional information and advice. This includes offering COVID-19 advice and support linked to returns to work after the lockdown. It runs its own national workshops and conferences and reaches both union shop floor reps and workers in non-organised workplace. In addition it has been monitoring health and safety compliance and regulatory action by both HSE and local authorities on COVID-19 in unionised and unorganised workplaces.

Employers should play a major part both of the debate about relaxing the lockdown and about occupational health and safety more generally. Large and medium-sized employers have their own health and safety advisors as do bodies like the CBI and will have worked out plans for dealing with COVID-19. Much of the bespoke employer information available has focussed on economic and financial impacts of COVID-19 and not on the occupational health and safety threats to employees. How successful employer plans have been in protecting employees will be a matter for careful scrutiny after the pandemic has ended. It is already clear there have been major failings by some employers in protecting their staff from exposure to the virus There has been extensive media footage available for months of workplaces showing employees closely packed and lacking suitable protection and PPE. Evidence in March 2020 in the UK revealed a number of companies had failed to develop and implement effective health and safety procedures and provide appropriate equipment to protect staff. The CBI in UK had little specific information relevant to occupational health and safety on its COVID-19 web page early on although it has working groups looking at people redeployment, keeping the nation healthy and supporting families in hardship which may impact on health and safety (CBI 2020)

By June 2020 the lobbying by some companies but not the public sector to ease the lockdown and re-open business in Scotland and England grew very loud. Small and medium sized enterprises and their employees have inevitably been hard hit by the pandemic. However, some of the greatest noise for relaxing health and safety controls such as the 2-metre social distancing guidance has come from big business, bankers and their lobbyists. They juxtaposition the potential health damage from the virus with the damage to the economy and hence to employee health but this risk balancing exercise is distinctly wonky. The main difficulties with their arguments on 2 metres are twofold. Firstly, those running the greatest risk of returning to work are rarely, with the exception of SMEs, if ever those take the decisions for employees to run the risks. Hence there is no informed consent. Secondly the relaxation of the 2-metre rule is not currently supported by medical and scientific advisors in either Scotland or England. So, if 1 metre is introduced and more COVID-19 clusters and waves emerge as a result, this could cause even more damage to the local, regional or national economies than a more gradual relaxation of social distancing. The debate about the 2-metre rule in many ways reflects the much bigger debate about health and safety in the UK. ‘You run the risks and we’ll take the decisions from a distance much greater than 2 metres’ (Watterson 2020f).

**4. HOW THOSE CHALLENGES RELATE TO PAST FAILURES AND MISSED OPPORTUNITIES IN THE UK AND SCOTLAND ON WORKER HEALTH AND SAFETY PRIOR TO 2020**

Before the pandemic hit, despite protestations to the contrary by the UK government, worker health and safety and the regulations, agencies and resources available across Great Britain to protect those workers were seriously deficient. GB had never topped the table of countries with the best occupational health records. With occupational health and safety being a reserved matter for the UK parliament to deal with, the Scottish Government has always been constrained in what it could do about occupational health and safety even if it wished to make radical changes. In 2018/9, fatal injuries in Scotland were running at the highest rate in GB with 1.07 cases per 100,000 workers. Ill-health in Scotland was occurring at 3,280 cases per 100,000 workers. There was no effective health and safety oversight although toothless talking shops were set up to provide a façade of respectability and consensus to defend failed UK policies.

HSE itself contains dedicated and skilled field and technical staff but their staffing and funding levels were stretched and their inspection and enforcement activity very constrained. In addition. UK Government policy on ‘better regulation’ has damaged both the effectiveness and credibility of all UK regulatory agencies. The most effective analysis prior to the pandemic of health and safety policies and programmes for action in Scotland came from NGOs like the UK Hazards Campaign and the Scottish Hazards Campaign, with very limited resources, along with unions based in Scotland.

**5. THE FUTURE FOR WORKER HEALTH AND SAFETY IN A DEVOLVED OR INDEPENDENT SCOTLAND.**

Occupational health and safety, post-COVID-19, needs to be located within a society that values its workforce and protects the vulnerable, low paid and marginal employees effectively as well as other groups of workers. It needs to be based on ‘Decent Work’ principles and build in sunsetting hazardous work, and the application of just transitions to healthier, safer and more socially useful jobs in Scotland. Such approaches are central to a Green New Deal in Scotland not a rehashing of failed economic and social policies and practice coated with the rhetoric of change that has emerged in some Scottish Government documents in recent years. These approaches are both reasonable and realistic. They resonate with the policies of the STUC, many unions, the Fair Work agenda which is being supported by the Scottish Government, the Scottish Hazards Campaign and the UK Hazards Campaign and will ensure both a greatly improved occupational health and safety record and contribute to a sustainable economy capable of addressing wider issues around pollution and climate change.

COVID-19 has already produced a major development in Scottish Government approaches to occupational health and safety. It is now actively involved in examining how the pandemic, measures to control the pandemic and lockdown release steps will affect worker health and safety in a whole range of employment sectors. There should be no reason why such positive engagement with health and safety at work cannot continue post-pandemic. The engagement provides strong strategic and practical reasons why the UK Government should now hand over health and safety regulation to the Scottish Government because it is so strongly intertwined with public health and, when neglected, manifestly has very serious consequences.

Bodies such as the Jimmy Reid Foundation (JRF) have important roles in generating ideas about how to ensure better working conditions and more effective workplace health and safety structures and policies can be achieved. JRF has addressed occupational health and safety issues and the role of unions directly in its work in the past unlike many other NGOs and think tanks. Commonweal has also produced an increasing number of important analyses and proposals for the Scottish economy including a Green New Deal. Yet its latest publication, ‘Resilient Scotland: post-lockdown’ does not mention unions or such ideas as just transition (Commonweal 2020).

Reports from other organisations that purport to address the economic problems of Scotland do not engage in any meaningful way with debates about working conditions. They usually do not mention the role of improved occupational health and safety in benefiting the Scottish economy apart from the human, moral and social reasons for reducing illness and injury in the workforce. These deficiencies sit very uneasily with documents that supposedly moot a ‘sustainable growth’ model for the economy. Decent Work rarely figures and only superficial mention is made of workers and unions if any at all appear. The approach appears to be a throwback in several respects to old economic thinking based exclusively on financial and banking interests and ideas of corporate lobbyists for deregulation and ‘better regulation’ policies that contributed to some of the pandemic and many of the earlier worker health and safety problems.

The Sustainable Growth Commission 2018 report, 354 pages long, for example has only token references to the role of unions - unions are mentioned just 8 times – and links them in a very superficial way to ‘partnership’ (Sustainable Growth Commission 2018). There are no mentions of ‘working conditions’ or ‘just transition’ or ‘sunsetting’ or even pollution, central to developing a sustainable Green New Deal and moving out of polluting and hazardous industries and work. The economy envisaged in such a proposal would not seem at all well equipped to address the world post-COVID-19 that many would wish to see. Indeed, the chair of the Commission in June 2020 has been reported as calling for measures to end lockdown that appear geared heavily to capital and business and not at all to labour. The proposals seem based on workers and the public taking risks that many of those often unlikely to run such risks determine are quite acceptable for others.

The Scottish Advisory Group Report on Economic Recovery post-COVID, ‘Towards a Robust, Resilient Wellbeing Economy for Scotland’ had a brief to look at immediate economic recovery issues. It stressed the importance of making the most of opportunities to move towards a greener, net-zero society (Scottish Government 2020d). However, the report fails to indicate any deep understanding of the need for effective workplace health and safety that will support a sustainable economy. Nor does it recognise that if the advice of the ILO and WHO had been taken by the UK in the decades prior to COVID-19, then the public health and adverse occupational health and safety impacts of the pandemic would have been greatly reduced as countries as far apart as Norway – totally ignored in the report - and Vietnam revealed. Not only does the report see New Zealand as an economic model for Scotland to follow when evidence shows that from a health and social policy perspective it is not, but there is little if any mention of working conditions and the work environment anywhere in the document. What is touched upon relating to worker health and safety looks very ambiguous and potentially worrying. Under labour supply, workplace health and safety is cited, during COVID-19 as ‘restricting working practices, e.g. manufacturing’ that will ease over time’ (p24). There is also a reference to the crisis ‘ exposing the lack of resilience and the instability of the UK’s ‘flexible labour’ market’ which ‘calls for a reconsideration of the approach to labour market regulation and enforcement, not least in relation to workplace health and safety; the definition of a ‘worker’; working hours; minimum wages; flexible working; and collective rights. These are complex issues that push at the boundaries of currently devolved powers’ (p56). No further explanation is offered about what is meant by this, intended or desired in the future. Vague references to a well-being economy do not suffice.

Policy should be upstream, practical and pragmatic but based on principles and values that reflect the changed world we live in and build on the best solutions mooted for Scottish society, working life and economy now being floated by bodies like the Jimmy Reid Foundation, Commonweal and others. The success of European countries like Norway in tackling COVID-19 is also reflected to some extent in their occupational health and safety, labour and social policies and values prior to the pandemic. Germany and Denmark along with South Korea and Hong Kong also performed far better than the UK on controlling SARS-CoV-2 and frequently did much better on occupational health safety hazard and risk controls. The recommendations for action on health and safety in Scotland put forward in 2014 in a JRF briefing paper (Watterson et al. 2014), with some fine tuning in 2020, therefore still apply.

There would be large economic and sustainability as well as health benefits flowing from these new priorities and structures but this would be a secondary although welcome effect of the changes.

**6. RECOMMENDATIONS**

**Principles**

The principles based on the WHO Europe charter and similar documents should include:

* acknowledging the benefits to health and wellbeing from a clean and harmonious work environment.
* promoting the principle of ‘prevention is better than cure ‘in workplace health and safety: an approach that was sadly missing in early UK pandemic planning.
* addressing the still neglected issues and lack of research on the health and safety of women flagged in the pandemic again on PPE and work equipment design, chemical and biological risks, welfare provision and the need for sex sensitive risk assessments.
* confronting the issue of gender stereotypes that leave women doubly and triply exposed to some hazards such as cleaning chemicals at work and home, more housework, childcare, sexual harassment and abuse.
* the health of every individual, especially those in vulnerable and high-risk groups, to be protected - missing in the pandemic for care home workers, ‘key’ workers especially those in service, food and support roles in the gig economy, transport and utility workers and beyond.
* special attention for disadvantaged groups – hazards and risks were neglected prior to and during the epidemic the consequences for vulnerable , low paid workers, migrant workers and BAME workers multiply disadvantaged by their work, general health status, socio-economic deprivation, previous exposure to workplace air pollutants and community air pollution.
* new policies, technologies and developments introduced with prudence and not before appropriate prior assessment of potential health, safety and environmental impacts.
* the health and safety of individual workers taking clear precedence over considerations of economy and trade. The pandemic has shown us that doing this also protects public health and the economy. Healthy and safe workers are productive workers in productive workplaces.
* governments, public authorities and private bodies should aim at preventing and reducing adverse effects caused by potentially hazardous agents and processes. In so many sectors, from hospitals, primary care, social care and emergency work through to transport workers, security guards, mortuary workers, food store and service workers with regard to safe systems of work and provision of suitable and sufficient PPE, this did not happen with SARS-CoV-2.

**Policies**

* Introduce a Work Environment Act or facilitate measures to ensure actions wider than the UK 1974 Health and Safety at Work Act that will establish a properly funded and staffed Scottish Occupational Health and Safety Agency (SOHSA). This will necessitate the ending of workplace health and safety as a matter reserved to Westminster. Responsibility for health and safety should in the future be given solely and completely to the Scottish Government in either a devolved or independent Scotland.
* SOHSA would have similar powers to the HSE to institute and bring prosecutions, and issue improvement and prohibition notices. These powers would be protected from political interference.
* SOHSA to be geared to prevention policies and practice, located within the Scottish Government health department, with oversight from the Minister of Public Health (linked to work and environment bodies) and accountable to a fully representative board of employers, employees, unions and citizens groups.
* SOHSA would apply ILO Decent Work and WHO 1988 Charter on Environment and Health principles and adopt the Fair Work agenda advocated by the STUC and largely accepted by the Scottish Government.
* SOHSA would apply the precautionary principle in policies linked to the needs of a sustainable society, develop strategies and best practice: for example using the most internationally up to date prescribed occupational disease lists based on a rebuttal presumption approach to listing such diseases, toxics use reduction approaches, control of job-related stress and establishing whistle-blower hotlines, support and protection.
* SOHSA would reflect key and progressive Scottish Government policies, where appropriate, and its work would be facilitated by for example the by for example the recommendations of the Scottish Just Transition Commission and he work of the Social Justice and Fairness Commission and developments of a Green New Deal approach.
* A Scottish Occupational Health Service should be developed and mainstreamed into NHS Scotland ending the employer driven, free market delivery of occupational health intervention deeply distrusted by workers and unions.
* ‘Better’, ‘smart’, ‘soft’ or ‘responsive’ regimes that fail to protect public health and - for a SOHSA occupational health and safety as the first priority - should be dropped and replaced by effective enforcement based on principles, policies and practices flowing from social justice, environmental justice and workplace health and safety justice.
* The pandemic exposed major failures in Public Health England, UK government medical and scientific advisors and the HSE. Their action did not protect health care and other workers effectively in Scotland. HPS Scotland appeared to follow or perhaps reflect the line taken by PHE with serious consequences. HSE also went missing at a critical time for all workers. In the future, Scotland should not rely on UK bodies to protect either public health or worker health and safety. Scotland should have fully accountable agencies that demonstrate rigour and autonomy and link in with effective Scottish health and safety agencies.
* The Scottish Government, if able to do so constitutionally, should adopt all the ILO Conventions on occupational health and safety. If not constitutionally possible to adopt them, it should publicly state its strong support for them.

**Practices and structures**

* SOHSA should operate with a well-resourced inspectorate and adequate powers, along the lines of the Nordic model, that would advise, inform, inspect and regulate workplaces on worker health, safety and welfare. The inspectorate would have legal rights of entry to all workplaces
* Meaningful inter-agency working should be enhanced to ensure effective policy and practice not talking shops and tick box exercises. Resources should be used to effectively reconnect health, work and environment with social policies and ensure effective advice and information especially for SMEs and employers. This would again be facilitated by the work following for example the Scottish Just Transition Commission recommendations and the Social Justice and Fairness Commission and developments of a Green New Deal approach.
* Bodies such as the proposed SOHSA, SEPA and the Health Protection (Scotland) or their successors should be far more transparent and accountable to the communities they cover than has been the case in the past. There are currently major democratic deficits in practice. Improved governance at national and regional level of all work environments and wider environments is needed with appropriate employer, worker and community input.
* Union safety representatives should be more widely supported with rights to enter workplaces to investigate health and safety matters, rights to issue provisional improvement notices, rights to appoint union ‘roving safety reps’, rights to use ‘employment rights’ representatives with a regional role. These representatives could link with community environmental monitors and citizen science projects, initiated and run by communities and not simply acting as data collectors for government. This would cement the link between investigations of work environments and wider environments.
* Worker and union safety representatives require easy and rapid access to enforcement authorities to report health and safety problems and such authorities should have a duty to react to unsafe and unhealthy workplaces and work environments.
* The Scottish Government should support innovative methods of workplace and community participation like Participatory Action Research on workplace hazards and risks investigation. These could also be linked to community safety, pollution and public health and could be developed to harness local skills and knowledge
* The establishment of worker and community health and safety centres across Scotland is needed to advise employees, unionised or not, about prevention and detection of disease and injury and support for victims. These could be funded in part by monies at present used for health promotion and initiatives would then be geared to preventing workplace health and safety hazards. Unions and the STUC have demonstrated during the pandemic that they have a central role in safeguarding worker health and safety and hence public health through information, education, critical but constructive advice and support. The STUC and NGOs like the Scottish Hazards Campaign have played a significant role during the COVID-19 pandemic lockdown, easing and return to work preparations through these activities that have not been taken up or performed by other bodies in the same way

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1. See <https://www.socialjustice.scot/> [↑](#footnote-ref-1)