COVID-19 Health Risks Relevant to SDAA Ltd Activities

Background *(last updated 13th August 2020)*

Coronavirus Disease 2019 (COVID-19) is caused by a new virus from the coronavirus family identified as SARS-CoV-2. Coronaviruses are a large family of viruses with some causing less severe disease, such as the common cold, and others causing more severe disease such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

SARS-CoV-2 is primarily transmitted between people through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces. A large number of scientists have proposed airborne transmission is also a route for spreading SARS-CoV-2, as studies have demonstrated that viable virus can be released during exhalation, talking and coughing in micro-droplets small enough to remain aloft in air and pose a risk of exposure at distances well beyond 2m from an infected individual, especially in poorly ventilated environments. SARS-CoV-2 has been detected in the blood, faeces and urine of infected individuals. UK Government advice currently states: "*All secretions (except sweat) and excretions, including diarrhoeal stools from patients with known or possible COVID-19, should be regarded as potentially infectious.*" SARS-CoV-2 is highly infective and the basic reproduction number (R_0) is somewhere in the region of 3 (i.e. on average one infected person will infect 3 people) without the introduction of measures to limit its spread.

Current published scientific evidence suggests there is still no drug cure that will safely kill SARS-CoV-2 and there is currently no vaccine available to prevent infection in the UK. Therefore, governments around the world have relied on good hygiene (e.g. hand washing, sanitising gels, face masks, gloves, etc) and social distancing methods to slow down the spread of the virus amongst the general community (i.e. reduce R_0 to <1). People displaying COVID-19 symptoms are asked to self-isolate, as well as those in the same household. Contact tracing (NHS Test and Trace) identifies those who have been in close contact with someone who has tested positive for COVID-19 and close contacts are also asked to self-isolate. Travellers are now obliged to self-isolate for 14 days when they enter the UK from a non-exempt country to avoid 'importing' the virus (e.g. people entering from France will need to quarantine for 14 days from 15th August, whilst this has been a requirement for people entering from Spain since 25th July).

It is now widely accepted that people can be infective well before they display any symptoms of COVID-19 and that some people who have been infected by SARS-CoV-2 have remained totally asymptomatic. It is likely that a significant proportion of the disease is spread within the community by carriers who do not realise they are infected of SARS-CoV-2. The vast majority of people in the UK have not been tested for the presence of SARS-CoV-2 genetic material and have no idea about their current status. Even those who have been tested only know their status (i.e. positive or negative) at the time of their test.

Antibody tests have been developed to help identify those people who have developed specific antibodies to SARS-CoV-2. However, there is no clear evidence that all people who have tested positive for SARS-CoV-2 have generated antibodies capable of providing any form of long term immunity. Humans only develop short term immunity to the common cold (another coronavirus) and no successful vaccine has been found against the common cold.

Whilst the vast majority of people infected with SARS-CoV-2 appear to display relatively mild symptoms (especially amongst younger generations), a significant number of people develop more severe symptoms, which require hospitalisation and can lead to death. Risk factors for developing symptoms that require hospitalisation include being male, increasing age (especially above 70 years of age), and people with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease, immune compromised status, cancer and obesity.

The overall infection fatality ratio from Covid-19 was thought to be around 1%, based on an argument that many people had mild disease, but this was just an educated guess as most people in the UK exhibiting COVID-19 symptoms have not been tested to confirm the presence of SARS-

CoV-2. A study (REACT-2) of a random population sample of 100,000 adults in England between 20 June to 13 July 2020 found 6% of volunteers tested positive for antibodies to SARS-Cov-2, which suggested 3.4 million adults had been infected with SARS-CoV-2 virus in England to the end of June 2020. Excluding fatalities in care homes, this extrapolated to an infection fatality ratio of 0.9%. One third of antibody positive volunteers reported they had not experienced any COVID-19 symptoms in this study.

An analysis of 17,000 COVID-19 patients hospitalised in England, Wales and Scotland between 6th February and 18th April has shown 49% survived and were discharged, 33% died and 17% were still being treated. Of those admitted to critical care (intensive care/high dependency) 31% were discharged alive, 45% died and 24% continued to receive care. COVID-19 is clearly far worse than 'a bad dose of flu' for those who are hospitalised. The crude fatality rate for people who are admitted to hospital with severe COVID-19 is 35% to 40%, which is comparable to that reported for people admitted to hospital with Ebola in Africa. The researchers also found that after adjusting for other medical problems such as lung, heart and kidney disease that were already known to cause poor outcomes, being male or obese (with a BMI over 30) was a significant factor associated with death in UK hospitals, a feature not seen in China, where it is thought that fewer people are obese.

A clinical trial conducted in the UK showed Dexamethasone reduced the 28-day mortality rate for COVID-19 patients on ventilators by up to 35% and those on oxygen therapy by 20%, but offered no benefit for other hospitalised patients.

ONS data on deaths up to 31 July 2020 showed there were 51,710 deaths registered in England and Wales involving COVID-19. Of these 55% were men and 45% female; the overall ratio of male : female deaths was 1.2:1, whilst the ratio of male : female deaths in the 45-75 age group was 1.9:1. Most female deaths (51%) occurred in those aged 85 and over. The vast majority (99%) of deaths were among people aged 45 years and over; i.e. 0.00% <1; 0.01% 1-14; 1.08% 15-44; 9.56% 45-64; 14.74% 65-74; 32.35% 75-84 and 42.25% ≥85. These data clearly indicate gender and age are risk factors for death from COVID-19.

SDAA Ltd Membership Risk Factors

The vast majority of SDAA members are males. A third of SDAA members purchase a Concessionary membership book, suggesting they are either aged over 65 or have some form of disability (potentially linked to one of the COVID-19 risk factors). Clearly a significant proportion of the SDAA membership have risk factors (gender and age) that puts them at greater risk of developing the more severe COVID-19 symptoms requiring hospitalisation and an increased risk of death from this disease.

The average age of SDAA volunteers is probably higher than the general membership, which means they are potentially at an even greater risk.

In addition to the above, SDAA membership is likely to reflect the distribution of many of the other risk factors amongst the population, e.g. roughly a third of adults in England are obese (BMI>30).

Angling itself poses minimal risks of transmitting SARS-Cov-2, provided anglers remain well distanced, do not share items of equipment and travel separately to and from venues. However, the potential risk of transmitting SARS-CoV-2 via contaminated surfaces does exist at SDAA fisheries, e.g. the locks and gates that are necessary to secure the venues.

Health and Safety Responsibilities

The SDAA committee always seek to minimise the risks that our activities will create for our members, volunteers or rightful users of the land adjoining our fisheries. Therefore, the SDAA committee must minimise the risk of these people becoming infected with SARS-CoV-2 (or having accidents that would require valuable NHS A&E resources) whilst visiting SDAA waters and undertaking volunteer roles.

SDAA members must always respect the laws and guidelines laid out by the Government, including the current social distancing measures, instructions to self-isolate if infected with SARS-Cov-2 (or

identified as a close contact) and the need to quarantine for 14 days if returning to the UK from a country with a high prevalence of SARS-CoV-2. The SDAA committee must also take into account any guidance given by the Angling Trust as we have chosen to be members and they provide our insurance cover. Finally, some land owners may choose to impose their own restrictions on SDAA members entering their land.

The Chairperson is ultimately responsible for H&S issues within SDAA Ltd.

Recommendations

SDAA's principle aim is to provide its members with opportunities to go fishing. A set of additional rules has been put in place to minimise the risk of members becoming infected with SARS-CoV-2 whilst fishing SDAA waters and undertaking volunteer roles. These are based around social distancing (i.e. keeping anglers well apart at all times) and good hygiene (e.g. particularly when touching surfaces that other members have touched such as locks and gates). These addition rules need to be reviewed on a regular basis to ensure they reflect changes in guidance provided by the Government and the Angling Trust, or any relevant changes in our understanding of COVID-19.

It is important that all SDAA members are aware of the existence of these additional rules (e.g. through a covering letter that is issued with every membership book, notices at our major fisheries) and that the latest version can be viewed/downloaded from the SDAA website. Significant changes to the additional rules should also be highlighted to members in a timely manner (e.g. through SDAA's social media pages).

Members who flout any rule designed to reduce the risk of spreading SARS-CoV-2 must be disciplined appropriately and in a timely manner. This will help reinforce the need for members to follow the additional rules at all times if they want to remain members of the club.

Volunteer activities such as committee activities, bailiffing and maintenance work must also ensure that social distancing and good hygiene is observed at all times. Face to face meetings will not be possible unless a suitable venue can be identified that provides >2m social distancing for all participants, or has suitable mitigation measures in place.

Assessment carried out by Richard Bell, SDAA Ltd Chairperson *(last updated 13th August 2020)*