

THOUGHTS ON VENTILATION DESIGN AND OPERATION POST COVID-19

Supplementary material and bibliography

Wells–Riley risk assessment model

The Wells–Riley model has been used extensively for the quantitative risk assessment of infection with respiratory diseases in indoor premises. It has also been used extensively to analyse ventilation strategies and their association with airborne infections in clinical environments.

Airborne concentrations can be related to infection risk using the Wells–Riley model for specific ventilation rates:¹

$$N = S[1 - \exp(-\lambda t)]$$

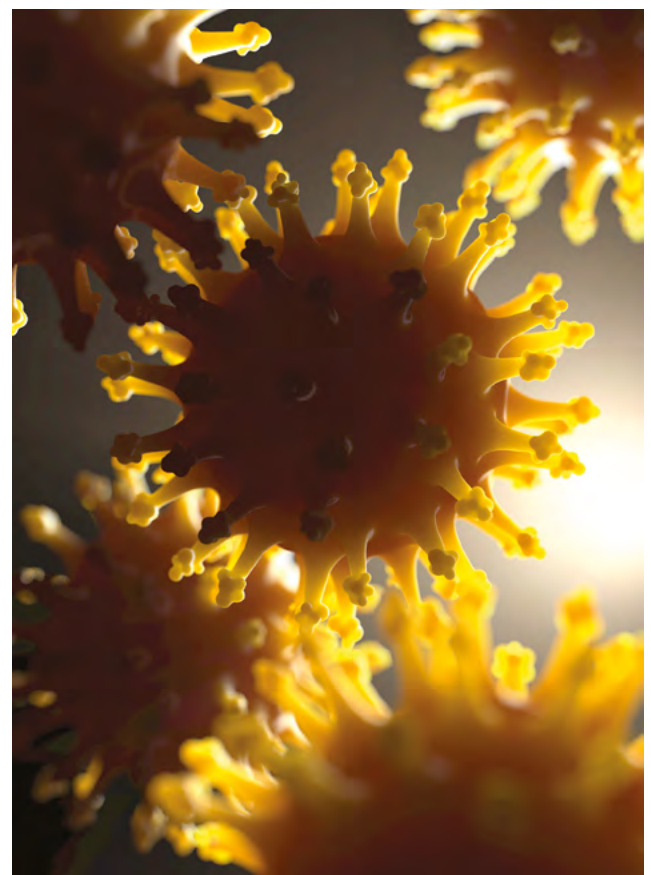
where N is the number of cases affected over time t , S is the number of susceptible people in the space supplied with air at Q m³/s, and

$$\lambda = Iqp/Q$$

where I is the number of infectious people, p is the pulmonary ventilation or breathing rate of susceptible individuals (m³/h) and q is a unit of infection (a quantum) that represents the response of susceptible individuals to inhaling infectious droplets (expressed as the number of viral particles per hour).

Elovitz and Elovitz² used influenza data to calculate values of p and q . They proposed a value for p of 0.5 m³/h for adults, and values for q of 10 (sitting and breathing normally), 34 (standing or walking and breathing normally), 320 (sitting and talking) and 1030 (standing or walking and talking) viral particles per hour. While these are not absolute values, and are not based on COVID-19, they can be used to obtain an indication of the rate of infection and the role of ventilation in this process.

The same study also looked at the probability of infection with various air supply rates expressed as the number of air changes per hour (see Table 1 in Elovitz and Elovitz²). Besides the airflow rate (Q), the volume of the space (V) is important, because V/Q gives the age of the air. A high value of V/Q indicates stagnant and stuffy conditions, which would mean that the virus remains in the space for



Source: Allan Swart | Alamy Stock Photo

longer. The inverse of this ratio (Q/V) gives the air change rate (the number of air changes per hour).

Values of the air-change rate are specified in various guides to ventilation for a variety of spaces, but it should be remembered that these values do not take into account the impacts on the rate of transmission of infection. Elovitz and Elovitz² and the Federation of European Heating, Ventilation and Air Conditioning Associations (REHVA)³ have attempted to do this in the results they have reported.

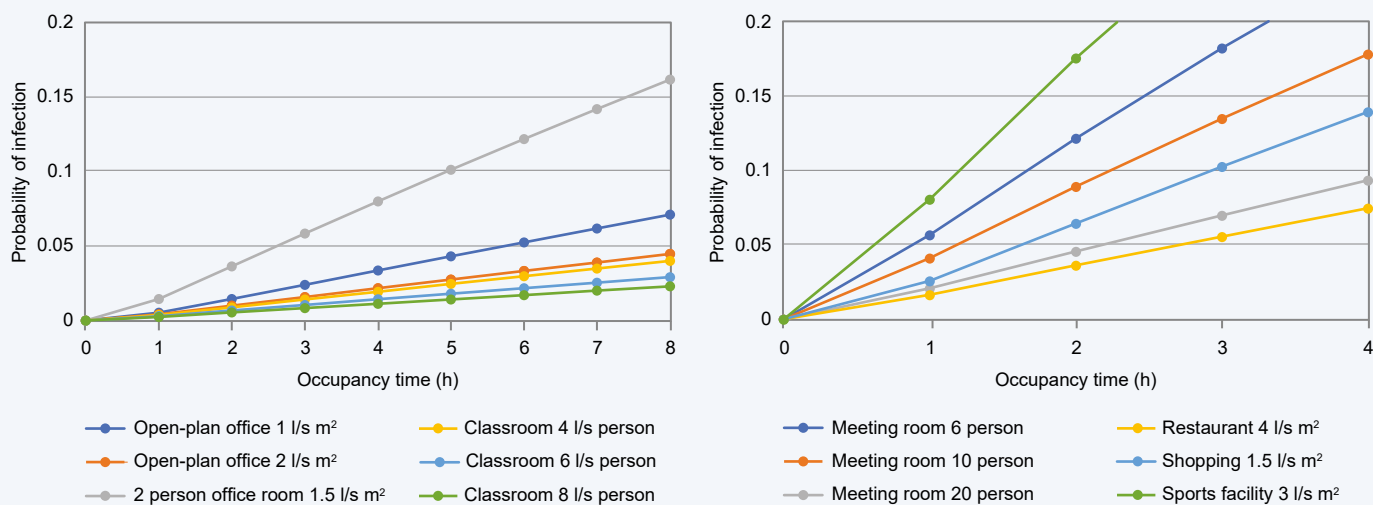


Figure S1
Infection risk assessment for some common non-residential rooms and ventilation rates, calculated using the REHVA COVID-19 ventilation calculator. Ventilation rates used in the calculations: 1.5 l/s per m² for two-person 16 m² office; 4 l/s per m² for a meeting room
Source: REHVA³

The Wells–Riley model can be used to calculate infection risk estimates and to compare the effects of ventilation and room parameters. On this basis, REHVA has developed a COVID-19 calculator for designers. Example calculation results for commonly used ventilation rates and rooms are shown in Figure S1. It is assumed that in all the rooms there is one infected person.

The overall dose when exposed to a virus (e.g. when sharing a room with an infected person) is equal to the product of concentration and time. To reduce the dose, and thus the risk of infection, ventilation must be increased and the occupancy time reduced. However, the limitations and uncertainties in the calculations due to variations in aerosol emission rates from infected persons, differences in individual risk across the population and the ventilation effectiveness in a given space, make it impossible to predict the absolute infection risk. That said, the model does allow comparison of the effectiveness of different solutions and ventilation strategies in limiting infection risk, enabling informed choices to be made. An example of calculated results of the relative risk of infection in an open-plan office is shown in Figure S2.

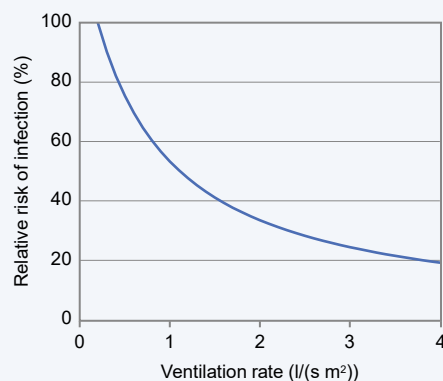


Figure S2
Relative risk of infection in a 50 m² open-plan office (reference ventilation rate 2 l/s per person (0.2 l/s per m²) and a superspreading event with 100% relative risk)
Source: REHVA³

Air-cleaning technologies

Air filtration

HEPA (high-efficiency particulate arresting) filters can be used to remove virus particles from air streams.

Air filtration is typically used in the supply air plant of HVAC systems to improve indoor air quality by removing particulate matter such as dust and pollen from the intake air. Air being drawn into the plant from outside should not be contaminated with virus particles, and therefore there is usually no need to install HEPA filters, because normal grade filters would be suitable where the supply plant utilises 100% outdoor air.

It may be beneficial to use HEPA filters in central air handling systems where air is recirculated, but their application needs to be assessed on a case-by-case basis. However, the higher the efficiency of an air-filtration system the higher the pressure drop and space requirements. In addition, they are not easy to retrofit into existing systems, and would normally result in a reduced airflow, which would have a disproportionately negative impact for any perceived benefit.

Portable and fixed room-air cleaners using HEPA filters and recirculating fans can be deployed within an occupied space to remove and inactivate virus particles and other pollutants in the air. However, at this time there is little evidence to demonstrate how effective they would be in mitigating aerosol transmission.

Anti-microbial and anti-viral technology

Manufacturers have responded quickly to the challenge of COVID-19, integrating anti-microbial and anti-viral technology into their products. Some technologies that until now have only been used in the healthcare, food production and pharmaceutical sectors are starting to be considered for use in commercial buildings.

Ultraviolet germicidal irradiation (UVGI) is a disinfection method that employs short-wavelength ultraviolet light (ultraviolet C (UV-C)) to kill or inactivate microorganisms.⁴

Recent research⁵ has suggested that a small band of far-UV light (wavelengths of roughly 220 nm) can damage viruses but is still safe for humans. The deployment of UV devices utilising these wavelengths needs to be comprehensively proven before they can be considered for use.

UV lights can be installed within air-handling units and fan coil units to disinfect the airstream and prevent the build-up of biofilms on wet surfaces such as cooling coils. An alternative approach for cooling coils would be to use all-copper coils, which naturally prevent the build-up of biofilms.



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However, UV light needs to be used with caution. Prolonged exposure to germicidal wavelengths of UV light can produce rapid sunburn and skin cancer, and exposure of the eyes can produce extremely painful inflammation of the cornea and temporary or permanent vision impairment, including blindness. Another potential danger is the production of ozone, which can be harmful to health. The maximum recommended daily exposure to ozone is 0.1 ppm, as exposure to levels higher than this can directly damage the lungs and olfactory bulb cells.

Several manufacturers offer various types of *ionisation technologies* to distribute high volumes of ions into a space to potentially remove viruses and other pathogens from the breathing zone. These systems can be added to ventilation plant and terminal devices such as fan coil units. They need to be deployed close to the point of use, as the ions lose their charge as they travel through ductwork systems. However, great caution should be exercised in their use, as there is no clear evidence demonstrating the effectiveness of these devices against the SARS-CoV-2 coronavirus.

The potential health benefits of ionisation have been claimed for some time, but these claims have not been proven by research. However, a recent test on a coronavirus surrogate⁶ showed a reduction of 99% in airborne virus and 80% in virus on surfaces in 10 minutes, and this has led to growing interest in the use of ionisation technologies.

Even the best ionisers produce a small amount of ozone. There is no scientific consensus on what a ‘safe level’ of ozone is. In California, for example, all portable indoor-air cleaners must meet an ozone emission concentration limit of 0.050 ppm. Therefore, care needs to be exercised in their use, particularly in unventilated spaces.

Some of the science and understanding of the application of these technologies in this context is still at an early stage, and there is limited research to verify their efficacy against COVID-19. It is therefore important to take a precautionary approach and use only equipment that is suitable for the intended application and that will not result in unintended exposure and alternative health risks in the future.

Useful guidance is given in a publication by SAGE-EMG.⁷

Existing system operation

REHVA provides comprehensive practical guidance for the operation of building services systems during a period of pandemic infection. The advice covers 15 main items, most of which relate directly or indirectly to the part played by ventilation in minimising the risk of airborne transmission of disease (Figure S3).

1. Ventilation rates – increase supply and exhaust ventilation.
2. Ventilation operation times – start ventilation plant 2 hours before occupancy and switch it off or change to a lower setting 2 hours after occupancy.
3. Disable ventilation demand control settings – change CO₂ set points to 400 ppm.
4. Window opening – use windows more, even when this causes thermal discomfort.
5. Toilet ventilation – extend operation times similarly to the recommendations for general ventilation systems.
6. Windows in toilets – avoid the use of windows where mechanical extraction is employed.
7. Flushing toilets – flush with lids closed to minimise air contamination.
8. Recirculation – avoid central air recirculation if possible. Where it cannot be avoided, use HEPA filters in the return air or install disinfection devices such as UVGI.
9. Heat recovery equipment – where rotary equipment is used, ensure that air leakage rates from the exhaust air stream into the supply do not exceed 5%.
10. Fan coils and split units – adjust systems to avoid high air velocities, and maintain units regularly.
11. Heating, cooling, and possible humidification set points – maintain normal settings.
12. Duct cleaning – maintain normal cleaning procedures.
13. Outdoor air filters – there is no need to upgrade or change normal maintenance and replacement procedures.
14. Maintenance works – adopt safe working practices using appropriate PPE when inspecting or replacing filters (especially extract air filters) or working on extraction systems and heat recovery equipment.
15. Indoor air quality monitoring – install CO₂ sensors to warn against underventilation, especially in spaces that are often used for one hour or more by groups of people. ■

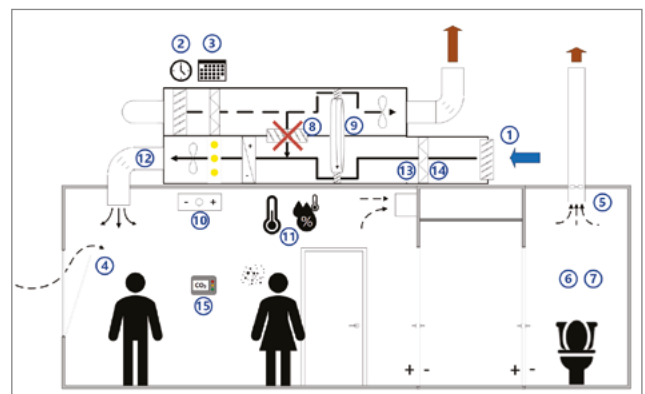
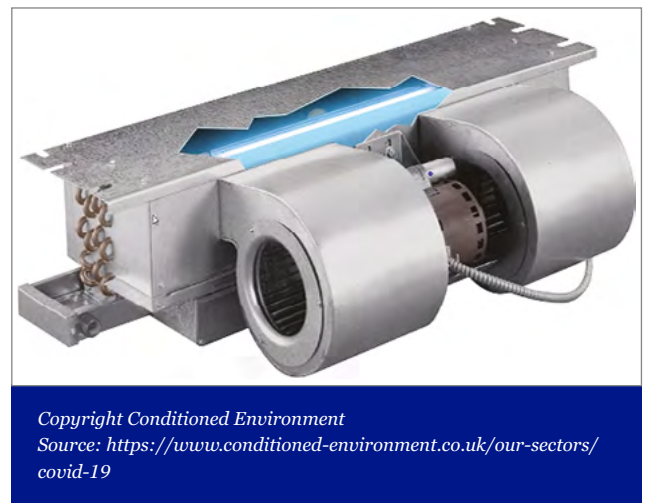


Figure S3
Main items of REHVA guidance for building services operation
Source: REHVA³

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ABOUT THE BCO

The BCO is the UK's leading forum for the discussion and debate of issues affecting the office sector. Established in 1990, its membership base comprises organisations involved in creating, acquiring or occupying office space, including architects, lawyers, surveyors, financial institutions and public agencies.

The BCO recognises that offices don't just house companies, they hold people and so what goes on inside them is paramount to workplace wellbeing.

ABOUT THE AUTHORS

The Technical Affairs Committee (TAC) is the voice for the BCO on technical aspects of the built environment. It is responsible for the organisation's globally recognised best practice guides on office specification and fit-out, and acts as a forum for new ideas and discussion to address the technical challenges facing the workplace sector. This briefing note has been based on a technical paper prepared for the BCO TAC by Derek Clements-Croome, Professor Emeritus at University of Reading and Visiting Professor at Queen Mary University London. Derek is a member of the TAC and a key contributor to the 2019 BCO *Guide to Specification*. Derek was also one of the 239 signatories to the letter to WHO, and a contributor to the WHO report *Natural Ventilation for Infection Control in Health-care Settings* (2009).

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