OPUS 2

Scottish Covid-19 Inquiry

Day 18

December 5, 2023

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1 Tuesday, 5 December 2023
2 (10.00 am)
3 THE CHAIR: Good morning, everybody. Good morning,
4 Ms Bahrami.
5 MS BAHRAMI: Good morning, my Lord. We have three witnesses
6 today. The first witness is Carolyn Murdoch.
7 MS CAROLYN MURDOCH (called)
8 THE CHAIR: Good morning, Ms Murdoch. Please take a seat.
9 Make yourself as comfortable as you can and Ms Bahrami
10 will ask you some questions.
11 Questions by MS BAHRAMI
12 MS BAHRAMI: Good morning, Mrs Murdoch.
13 A. Good morning.
14 Q. Could you please confirm your full name?
15 A. Yes, it's Carolyn Murdoch.
16 Q. Thank you, and the Inquiry has your details?
17 A. Yes.
18 Q. You've provided a statement to us about your father,
19 John Connelly; is that correct?
20 A. Yes.
21 Q. For the record, the statement reference is
22 SCI-WT0163-000002. There is a restriction order in
23 place, I must remind you. You are able to mention your
24 father's name, but if you could refrain from mentioning
25 other individuals' names and the names of people

1 involved in the care of your father --
2 A. Yes.
3 Q. Thank you. The care home is able to be mentioned too.
4 So your father had been living at Ashton Grange Care
5 Home in Glasgow; is that correct?
6 A. Yes, it is.
7 Q. He died aged 104 --
8 A. Yes, he was.
9 Q. -- on 23 April 2020 at the Glasgow Royal Infirmary?
10 A. Yes.
11 Q. Would you like to tell us a bit about your father?
12 A. Yes, there's quite a bit to tell, obviously, at that
13 stage. Well, he was in the RAF and then he was -- he
14 worked as a delivery driver with Fyffes bananas after
15 the war and he was married to my mum for 36 years. She
16 died at 66 and he used to say he thought about her every
17 day. He was a character. He was involved with
18 different charities. My dad was one of these men that
19 they couldn't just join a club, they had to be
20 a treasurer or a secretary or an organiser of some sort.
21 He was involved in the Glasgow Old People's Welfare, as
22 it was known when he was in it, and he won the Glasgow
23 Community Champions senior award in 2013 at the age of
24 97. That was for his volunteering work in the
25 community.

1 He was also involved with the Masons and the
2 Provincial Grand Lodge, which is another charity. He
3 loved sports, football, ran pensioners' clubs, took them
4 away for a few days, organised day trips. He was a busy
5 wee man.
6 Q. Thank you. Now, prior to going into the care home, your
7 father lived with you at home?
8 A. Yes, he did.
9 Q. And you had help from paid carers multiple times a day?
10 A. No, it was like your carers that come in from the
11 community because with his age, he was entitled to that
12 for his personal care, et cetera, because obviously he
13 didn't want me doing that for him.
14 Q. No, sorry. The reason I said "paid carers" is to
15 differentiate from you as an unpaid carer --
16 A. Oh, yes. Sorry, yes.
17 Q. -- for that distinction because I appreciate that you
18 would have been an unpaid carer for him --
19 A. Yeah.
20 Q. -- at that point, as he was diagnosed with dementia.
21 A. Yes.
22 Q. So he did have --
23 A. He did. Three times a day.
24 Q. But there came a point where his doctor told you that he
25 would require 24-hour care?

1 A. Yes.
2 Q. And the doctor was concerned that, although he lived
3 with you, that wouldn't be sufficient; is that right?
4 A. Yes, he was becoming a falls risk. As the dementia
5 progressed, he was having more falls and then infections
6 and delirium. It was hard to keep him safe. We did
7 have an extension on -- we put an extension downstairs
8 earlier on, so that he didn't have to come downstairs,
9 it was easier for him coming in and out, but then the
10 problem that presented was, as his dementia got worse,
11 as his falls risk was worse, his mobility, we were all
12 upstairs at night and he was downstairs. So we then had
13 cameras installed in the house, but outside his bedroom
14 door, right next to the toilet. In case he fell during
15 the night, at least we would get notified or if I had to
16 go out and leave him, I'd get notifications of that,
17 anything happening with him.
18 Q. Thank you. At that point, you and your brother
19 reluctantly agreed to that and after much consideration
20 you chose a care home that was just a few minutes from
21 your house?
22 A. Yes, we did. We looked at several care homes, yes,
23 and -- yes, and when we went to the care home, we were
24 able to speak to residents' family members, who assured
25 us that their loved ones were well looked after and they

1 certainly did -- the residents certainly did look well
2 and the home was nice. It was being renovated at that
3 point, but there was -- upstairs had been completed and
4 downstairs was still being done, the workmen were in.
5 Q. Thank you. And your father moved into the home on
6 27 February 2020 --
7 A. Yes, he did.
8 Q. -- just weeks before --
9 A. Lockdown.
10 Q. -- lockdown. At that point, when he moved in, were you
11 all happy with the home and how he was settling in?
12 A. Yes, he had been in hospital and he had gone into one of
13 the -- there were local hospitals for rehabilitation,
14 and his mood was quite low in there because he was in
15 a room on his own and, when he came out of that
16 hospital, in there, he just sat up -- he was hanging in
17 a wheelchair. The next thing, he was sitting there, he
18 was getting all the attention. They were just -- then
19 he's eating, he started to eat again. He was doing
20 really well, really settled.
21 Q. As we mentioned, two weeks later, the care home locked
22 down.
23 A. Yes, it did.
24 Q. What happened at that point? Were you allowed to visit
25 at all?

1 A. No, I had been in to see my dad on the Thursday morning
2 and I said we'd be back down to see him at night because
3 I went twice a day to see him, and I got a phone call
4 from the home to tell me that that was it, we couldn't
5 come back in, it was locking down to try to keep the
6 residents safe.
7 Q. Were you allowed garden visits?
8 A. No.
9 Q. Were you allowed window visits?
10 A. No. On one occasion I went down to hand in sweeties
11 and -- he had a very sweet tooth -- and hand in his
12 sweeties and maybe a wee letter. I would write to him.
13 And I thought, "I wonder if he's sitting in that room,
14 the communal room". I thought, "No, don't look. If you
15 see him, it will upset you", and I did look and he was
16 just hanging in a chair, and that did upset me, that he
17 was so close.
18 Q. Just take a moment.
19 Were you given a reason why you couldn't have closed
20 window visits?
21 A. They just said they didn't want to do anything to upset
22 the residents, like if they saw -- if my dad saw me on
23 the outside and he was on the inside and yet I couldn't
24 touch him, I couldn't be with him, they said it would be
25 upsetting for the residents.

1 Q. What did you think of that reason?
2 A. It didn't make any sense to me. We were fortunate --
3 for the short time that my dad survived, the start of
4 COVID, the weather was really nice and I couldn't see
5 the harm in even bringing him to -- there's double
6 doors -- bring him to the front door. Even if someone
7 is with him, I could stand back, I could speak to him,
8 I could explain to him why I couldn't see him. I'm sure
9 he would have understood that because he recognised all
10 his family and friends. Although he had dementia, he
11 still recognised everyone and he could -- he may have
12 only remembered it for a short time, but I think it
13 would have been enough that he wouldn't have been upset.
14 He'd have been pleased to see us.
15 Q. But the care home just didn't facilitate any of that?
16 A. No.
17 Q. Were you able to use video calls with your dad?
18 A. We tried to Skype and my dad just didn't understand. He
19 was also hard of hearing and he just didn't understand.
20 When we did Skype, he would see me, and although I would
21 be waving to him, he would say, "Oh, there's a picture
22 of my daughter. Where did you get that?". He just had
23 no understanding of it.
24 Q. Were you able to use telephone calls?
25 A. Yes, that was difficult for him as well because of his

1 hearing, but we did. I phoned every day. Other family
2 members phoned as well.
3 Q. And were you able to speak to him directly that way?
4 A. Yes.
5 Q. Did the home ever call to provide you with updates?
6 A. Yes, they called me the first week -- around about
7 7/8 April, I think it was, to tell -- they did phone me,
8 but they phoned me this particular day to tell me that
9 several residents were displaying a range of symptoms
10 that wasn't particularly COVID. It could have been
11 stomach upsets, gastric or chest infections, but my
12 father wasn't one of them.
13 Q. But they told you that, at that time, even if residents
14 were symptomatic, they wouldn't be tested unless they
15 went to hospital?
16 A. There was no testing. I was told there was no testing
17 for residents and the only time staff would be tested
18 would be if they had any symptoms.
19 Q. Thank you. Now, at that point, during that phone call
20 or a subsequent phone call, did they want to take -- did
21 the care home tell you they want to take any
22 precautionary measures in respect of your dad since he
23 wasn't displaying any symptoms of anything?
24 A. Well, they had asked about keeping him in his room to
25 try and keep them isolated from -- and I thought, "Well,

1 okay". I obviously didn't know what kind of length of
2 time they were referring to, but I did say "Yes", and
3 that was fine. Then they called me a week later to say,
4 "Oh, your dad's mood has gone down. Would you mind if
5 we brought him out his room?". They had two big -- two
6 large communal areas and I said, "Yeah, if it's not in
7 amongst a lot of people". I would say that because, if
8 his mood is low, that's not going to help with his
9 dementia either. So they said they could do that, and
10 at least they would then be able to pop in and out and
11 see him more than -- because his room is upstairs and
12 maybe with them in a -- as I have found out, there was
13 quite a bit of COVID in the home, probably they were
14 under a bit of strain to keep an eye on him.
15 Q. Then, on 16 April, after your dad had been in the
16 communal area, they contacted you again --
17 A. Yes.
18 Q. -- and they told you that he had developed a slight
19 wheeze --
20 A. Yes.
21 Q. -- and that they'd requested antibiotics?
22 A. That's correct, yes. The doctor didn't come in but --
23 Q. His own GP wasn't visiting the care home at that point?
24 A. Yes.
25 Q. Then you say on Sunday, the 19th, when you spoke with

1 your dad, you detected a difference in him.
2 A. Yes, he really wasn't good at all and he didn't really
3 want to speak. He ended up just saying, "Och", and
4 handed the phone away, and I thought, "Oh no, that's not
5 him", because I would just talk -- he would talk away
6 quite the thing and -- no, I just knew there was a big
7 change in him and I said, "No, I can't have this. I'm
8 coming down. I'll be down tomorrow morning to see him.
9 There's something badly wrong with him".
10 Q. How did they respond to that?
11 A. The girl said, "That's fine. You can come down", yes.
12 Q. Did that seem strange to you, that they hadn't allowed
13 even window visits, but then, when you pressed --
14 A. This particular member of staff said to me, "He's your
15 dad. You come down and see him", really.
16 Q. So did it then seem to you that the policy depended on
17 who you were asking?
18 A. Well, it must have been because -- probably because they
19 saw the way my dad was as well, they probably thought,
20 "Well, yeah, she has got a right to see him". Obviously
21 I wasn't getting in the care home, you know, but they
22 were going to let me see him somehow, but I don't know
23 how.
24 Q. Now, the next morning -- sorry, so at that point it
25 wasn't clear that they would let you into the care home

1 but just that they would facilitate some kind of visit?
2 A. I could go down. I could go down.
3 Q. Okay. Now, the next morning, as you were getting ready
4 to go to see your father, you received a call -- another
5 call from the care home.
6 A. Yes.
7 Q. Can you tell us about that call?
8 A. Yes, the girl called and said that my dad had
9 deteriorated overnight and they were really concerned
10 about him and they said that they felt that he really
11 could benefit from possibly going into hospital, but at
12 that point they couldn't get an ambulance to come to the
13 care home with suspected COVID, so, "Could I call the
14 family doctor and ask them if they could arrange an
15 ambulance to come to the care home?".
16 Q. Okay. Was that -- did they explain to you why they
17 couldn't get an ambulance? Was this a decision the
18 Ambulance Service had informed them of or
19 Public Health --
20 A. They just said they couldn't get ambulances to come to
21 the care home.
22 Q. Okay, they didn't go beyond that with you?
23 A. No.
24 THE CHAIR: Did they ask you to contact the GP?
25 A. My GP.

1 THE CHAIR: Did they contact the GP and ask the GP?
2 A. No, the call was to me to say, "Could you phone your
3 dad's GP?", because I kept -- instead of the care home's
4 GP, I kept the family GP, and they just said, "Could you
5 ask because they won't send an ambulance here if we
6 request it, so if your GP does it, they'll do it".
7 THE CHAIR: Okay.
8 MS BAHRAMI: You then called the GP reception --
9 A. I did.
10 Q. -- and the receptionist told you a doctor would call you
11 back?
12 A. Yes, that's right.
13 Q. And you had to wait hours for that call?
14 A. I had to wait for a few hours. Well, 11 o'clock --
15 sorry, 11 o'clock in the morning I get a call from the
16 home and the ambulance I think arrived about 5/6 o'clock
17 at night.
18 Q. Did you tell the receptionist why you were calling?
19 A. Yes.
20 Q. She knew that your father needed an ambulance?
21 A. Yes.
22 Q. But either she wasn't able to or didn't ensure a quicker
23 call-back?
24 A. Well, it took a couple of hours, I would say, for the
25 doctor to get back in touch with me, but then obviously

1 it took those hours for the ambulance to come, yeah.
2 Q. What was going through your mind at that point when, you
3 know, you were being told that your father's unwell, he
4 needs an ambulance --
5 A. I would have thought time would have been of the
6 essence. He was already being treated with antibiotics.
7 He had deteriorated so -- he was an old man, he was
8 obviously frail obviously at this point, although we
9 hadn't seen him for weeks, and I just felt time was
10 going on and we were sitting there very anxious and
11 worried about him.
12 Q. When the ambulance did eventually attend, were you
13 allowed to see your dad?
14 A. We received a phone call from the home to say there was
15 a Red Cross ambulance there and that they had said we
16 could go down and see my dad, which was unbelievable
17 because, you know, I knew that that was not happening.
18 So we went down and -- my son and I went down and they
19 let me contact my brothers, and they waited and let us
20 see my dad in the ambulance.
21 Q. How was your dad at that point?
22 A. When they brought him out in the chair, as soon as he
23 saw us, his face just lit up, but once they got him
24 settled in the ambulance, he was quite agitated and
25 shouting for his mum, trying to get off the bed, but

1 they calmed him down. I just spoke to him and calmed
2 him, you know. But we got about half an hour I think
3 with him actually. But then they weren't sure -- the
4 way my dad was presenting, he didn't have a temperature.
5 His oxygen levels were still 90-odd, which was for him
6 -- you know, they sat at 93 and upwards -- so they were
7 very unsure if it was COVID that he had and they weren't
8 sure whether -- what to do with him.
9 So we had quite a discussion about it with the
10 paramedic, and he said, "Well, looking at what's
11 happened in the past with your dad, maybe we will get
12 him in". Obviously they were taking somebody to
13 hospital as well if they don't have COVID. But they
14 weren't sure. So they said, "We'll take him and we'll
15 see what happens". So they did, they took him in.
16 Q. Now, once your father arrived at the hospital, you
17 received a telephone call from the attending doctor --
18 A. Yeah.
19 Q. -- in the acute assessment unit. Please would you tell
20 us about that conversation.
21 A. Yeah. The doctor called and she said that she had had
22 my father there and that -- she asked me what it was
23 that I expected to happen to him, given his age and his
24 frailty, which took me back and upset me. I thought,
25 "Why would you ask me that?". I said, "I would think

1 you would just treat him the way he needs to be treated,
2 the way you have and the way he's been treated in the
3 past". When he went into hospital before, they would
4 tell me how they were going to treat him. They never
5 ever asked me what I expected to happen to him, so I was
6 really taken aback by that question.
7 Q. Were those the words that she used?
8 A. Yes.
9 Q. "What are you expecting to happen?"
10 A. "What would you expect to happen to your father,
11 Mrs Murdoch, given his age and frailty?", and I said,
12 "Well, I think you would treat him the way you would
13 normally treat him. Give him fluids, IV fluids, because
14 he could be dehydrated. He's had a chest infection".
15 Q. Just about a year before that --
16 A. In the January 2019 he had a fall and a slight fracture.
17 He'd been taken into hospital. When he was in the
18 hospital, given his -- now, he's 103 at that point, so
19 they were just giving him kind of bed rest and keeping
20 an eye on him, and then they proceeded to tell me that
21 they wanted to catheterise him to check his input, his
22 output. I asked, "Why? What difference is it going to
23 make to him?"; "Oh, we just would really like to do
24 this". I said, "Well, okay, two days and then that's
25 it", but my dad pulled the catheter out so that didn't

1 work. Then they informed me they thought he had cancer
2 and they wanted to scan him and I thought, "But what --
3 if he has got cancer, what are you going to do? You're
4 not going to be invasive to him". So, anyway, I agreed
5 and they gave him a scan and then they told me, "No, he
6 doesn't have cancer". I said, "Okay, that's fine".
7 So in January 2019, they were prepared to do all
8 this for him. He was back in again in the August, when
9 my doctor thought my dad wasn't going to pull through --
10 he'd been on several antibiotics, really quite ill.
11 They sat in the house and told me that my dad could pass
12 within days, and I said, "Please get him into hospital",
13 and once again they did everything. They treated him,
14 nebuliser, everything. But in April, what did I want to
15 happen to him? What did I expect to happen?
16 THE CHAIR: Did it occur to you, using probably an
17 old-fashioned term, that the doctor's bedside manner was
18 somewhat lacking?
19 A. Oh, very much so.
20 THE CHAIR: If the doctor had, for example, said to you,
21 "You appreciate your father is 104 years old. There's
22 actually very little we can do for him in his
23 condition", might that have been a bit more acceptable,
24 palatable message to convey to you?
25 A. Most definitely. I could have questioned. My brother

1 and I agreed for a DNR to be put on my dad the year
2 before, in the August when he was quite ill and they
3 didn't think he was going to pull through, because we're
4 realistic and his age, you know.
5 THE CHAIR: Quite.
6 A. He didn't want -- he had a good life. We wouldn't do
7 these things to him unnecessarily. So yes.
8 MS BAHRAMI: Thank you, my Lord.
9 In fact, after saying that to you, you had mentioned
10 to the doctor that you would like him to -- you would
11 hope that he would be put on a drip --
12 A. Yes.
13 Q. -- and, if he happened to pull the cannula out, well,
14 you would hope for the cannula to be bandaged up --
15 A. I asked for it to be back in.
16 Q. -- and, if he pulled that out, for it to go back in, but
17 this particular doctor told you that they wouldn't be
18 doing that?
19 A. What she said was -- I said, "Could you bandage the
20 cannula", because it does pull it. He pulled the
21 catheter out, he pulled the drips out. And she said,
22 "If your father's drip comes out, it's not going back in
23 again".
24 Q. So it wasn't just that she might even have thought that
25 there's not much they can do and phrased it poorly. It

1 was that, even when there is something they could do,
2 they didn't want to have to repeat it, it was one chance
3 and that was it?
4 A. It made me feel that -- she was, "There's no treatment
5 here for your father. There's no way back. I'm not
6 going to give him -- not going to do him". They were
7 just going to let him die is how it made me feel. That
8 was very upsetting. Because I got so upset, my son took
9 the phone from me and spoke to her, and her words to him
10 there, "This is end of life for your grandfather. He'll
11 die in the next two or three days".
12 Q. So they said they wouldn't be testing for COVID?
13 A. No, no.
14 Q. No chest x-rays?
15 A. No, she said she had done bloods and, looking at the
16 bloods, they thought it was COVID at that point. At
17 that point they hadn't done a test or they hadn't done
18 a chest x-ray. They did intend to. But the COVID test
19 at that point was the nasal as well as the throat so ...
20 which I understand could have been difficult, but they
21 did do that eventually, yeah.
22 Q. Now, later on that evening you called the hospital
23 again?
24 A. Obviously it wasn't sitting well with me, what I'd been
25 told.

1 Q. I understand you would have been in shock --
2 A. Yes.
3 Q. -- and you would have been quite upset at what you'd
4 been told and what your son was told?
5 A. Yes.
6 Q. So presumably you took some time, but then you called
7 them again?
8 A. I did. I called them later on that evening and I -- by
9 this point my father had been transferred to a ward.
10 Q. Okay, so no longer in the acute assessment unit?
11 A. No, he'd been moved. The nurse -- I said, "Look, I just
12 want to reiterate what I told the doctor, that if my
13 father's drip -- because he has a tendency to pull them
14 out, please make sure that he has that fluid going into
15 him". She told me that it had been agreed with the
16 doctor in the care home, as far as she was aware, that
17 this would not happen and I said, "Absolutely not",
18 I was power of attorney, "and I'm telling you that there
19 has never been an agreement". The care home -- I know
20 that the care home -- and I have spoken to the care home
21 about it, but at that point I thought, "There's no way
22 the care home has agreed to that. They don't have the
23 wherewithal to do that. They shouldn't have". And she
24 said, "Oh, well, leave it with me and I'll put a note on
25 for the doctor in the ward". And the ward doctor the

1 next day phoned me and told me if my father's drip went
2 out, it would go straight back in. He was on
3 antibiotics for pneumonia.
4 Q. When you say in your statement that you knew the care
5 home hadn't agreed to that, on what basis do you know or
6 do you mean that they shouldn't have agreed to that?
7 A. They shouldn't have and I have found out -- but not --
8 I just could not think for one minute -- the care home
9 knew we were power of attorney and I didn't know where
10 they would get that -- they would be allowed to make
11 that decision, and since then I've spoken to them and
12 they said, "Absolutely not. We don't have that -- we
13 can't took that decision for anyone".
14 Q. As you and your brother had power of attorney, is that
15 a conversation that you expect to be involved in as
16 a power-of-attorney-holder?
17 A. Oh, yes, I'd been involved in them -- I'd been
18 threatened before, if I didn't take my dad out of
19 hospital, they were going to put him in a care home.
20 And I said, "No, you will not. We have power of
21 attorney. You will not". I questioned a lot of things
22 for my dad. I was my dad's voice for years. He
23 couldn't -- he didn't know. He would just say, "Ask my
24 daughter, speak to my daughter", but yeah.
25 Q. How beneficial do you think it was having a power of

1 attorney during the pandemic?
2 A. Well, it didn't do much -- I don't know because my
3 father only lasted from -- you know, a few weeks
4 into April, so that was only a number of -- matter of
5 weeks so it didn't come into play really for me, not for
6 me.
7 Q. So in your experience they weren't respected at all?
8 A. No. No.
9 Q. Now, the next day, on Tuesday, 21 April, you spoke to
10 the ward doctor. Can you tell us about that
11 conversation?
12 A. Yeah, she was very nice and she had said that my dad was
13 very settled, they had him on the antibiotics for the
14 pneumonia, some kind of heat blanket or something to get
15 his body temperature regulated, and he was doing okay,
16 and then later on we got the call to say that he did
17 have COVID.
18 Q. During the first call with the ward doctor, did you
19 bring up the issue of the drip?
20 A. Oh, I did.
21 Q. What was her response?
22 A. And she said to me, "I can assure you, if your father's
23 drip comes out, it will be going straight back in
24 again".
25 Q. So there was a completely different attitude?

1 A. Totally different.
2 Q. Then you found out later that day your father tested
3 positive for COVID?
4 A. Yeah.
5 Q. The following day, April, 22nd, you received another
6 telephone call --
7 A. Yeah.
8 Q. -- informing you that unfortunately your father had
9 deteriorated?
10 A. Deteriorated, and he would -- they would move him to
11 a side room to allow me to go in and see him.
12 Q. Was he in a shared bay prior to that?
13 A. It was a ward, but there was just a private room.
14 Q. Sorry, before going into the private room, was he in
15 a shared bay?
16 A. Yes, he was, and they were moving -- because it was end
17 of life, he was getting moved into a side room, yeah,
18 sorry. And they said I could have half an hour with
19 him, and I said, "Can I not stay with him until he
20 passes?", and they said, "No, no, too much risk".
21 I then said that one of my brothers would like to see
22 him as well, and they said, "The only way is if you
23 share your half-hour, your brother stays in for
24 15 minutes and then he leaves and you're not in at the
25 same time", so ...

1 Q. Did you question that?
2 A. That was -- I asked them why and they said, "That's just
3 the way -- that's just the rules. We're letting you see
4 your dad for half an hour, but if you want to see him,
5 you have to split it, if you both want to see him", end
6 of, that was it.
7 Q. So your dad was at end of life at that point?
8 A. Yeah.
9 Q. And you say in your statement that you're aware that in
10 the same hospital, in other wards, people were able to
11 spend the whole of the end of life with their loved one?
12 A. Yes, yes.
13 Q. But in this ward you were given 15 minutes --
14 A. Yes.
15 Q. -- and that was it?
16 A. Yes, that was it.
17 THE CHAIR: Which suggests that there was no overall
18 policy --
19 A. No.
20 THE CHAIR: -- and it was left to the discretion, if that's
21 the correct ward --
22 A. Yes.
23 THE CHAIR: -- to -- I don't know. Who is in charge of
24 a ward? Is it the consultant or the nurse?
25 A. The staff nurse -- I don't really know.

1 MS BAHRAMI: Senior charge nurse?
2 A. Possibly. It was totally different. I know that.
3 THE CHAIR: I take it you don't actually know who took the
4 decision?
5 A. I don't know who took the decision in that ward, no, or
6 the person that I know in the other ward, I don't know
7 who took that decision.
8 THE CHAIR: I see that.
9 MS BAHRAMI: Can you tell us how that visit went?
10 A. It was very upsetting because my brother had gone in
11 first and he -- obviously I was waiting for him to come
12 out before I could go in, and when I saw my brother
13 walking out and he had to walk away -- he couldn't come
14 near me, he had to walk out a different direction.
15 I was standing here and he had to go that way. I could
16 see his face and it was, "Oh, God. What's my dad
17 like?". I didn't know what I was walking into. But, as
18 it was, my dad had obviously been given medication and
19 he was very calm.
20 He was aware I was there because I touched his feet
21 and they moved and I stroked his hair and all that,
22 spoke to him, but there was no flicker or anything, so
23 he was very calm, very peaceful. I don't understand why
24 my brother and I couldn't have been in there together
25 because it was a big room, we could have

1 social−distanced, we could have been there for each
2 other, but we weren't allowed.
3 Q. Did they give you any reason why you weren't allowed?
4 A. No.
5 Q. Just that −−
6 A. That was it. Blanket, that was it. That's what they
7 were doing.
8 Q. Would you have benefitted from having your brother there
9 with you?
10 A. Och, yeah.
11 Q. Would you have benefitted from other family members
12 being allowed to join?
13 A. Yes, yes.
14 Q. Do you think that could have made any difference for
15 your dad or do you think being able to get in a bit
16 earlier could have?
17 A. Well, I think, if I'd seen my dad before it came to that
18 point, it might have made a difference to him, but just
19 the way he was now, it was end of life. For us, it
20 would have made a difference to be with him, to know
21 that we'd seen him and been there with him until the
22 end. He was 104. You know, he'd lived a great life.
23 Why couldn't −− he was used to having his family and his
24 friends round about him. All of a sudden he had no one.
25 Q. Yes.

1 A. And I don't know if anyone was with him when he died.
2 Q. Yes, and that was just a few hours later, just into the
3 next day at 1.30?
4 A. Yes.
5 Q. How do you feel about that now? You know, a few years
6 have passed, how does it feel now?
7 A. Oh, it's still sore, still hurts −− guilt, yeah. We
8 should have been with him.
9 Q. You say in paragraph 52 of your statement about the
10 hospital arrangements after his death. You say that it
11 felt like he was toxic waste.
12 A. Yeah. He was put −− I know he was put −− my brother
13 works with a funeral undertaker and there was people we
14 had arranging it, arranging the service for my dad. And
15 we know, obviously, he was put into a body bag and
16 straight into the morgue. We were told obviously he
17 couldn't be dressed, and my dad was very much a collar
18 and tie man −− he couldn't be dressed and we couldn't
19 see him. It was going to be a closed coffin.
20 We were told to choose a coffin as quickly as we
21 could. It had to be done online obviously. We couldn't
22 go anywhere to look at them. So I was told I had to −−
23 my brother phoned in and said, "You really need to pick
24 a coffin, Carolyn, because they need to get dad out the
25 morgue to make room for the bodies". So we were trying

1 to organise −− it was just a horrible, horrible time.
2 And I just thought, at the funeral, two weeks later, my
3 brother and I were just out of −− we had to isolate
4 because we'd seen my dad, so we had to do that for
5 14 days and we'd just made it the day of his funeral.
6 No one could carry his coffin. It was wheeled in in
7 a trolley. It was just −− it was absolutely surreal.
8 Q. Were you given any explanations for why this had to be
9 the case?
10 A. Because he died of COVID.
11 Q. So nobody could −−
12 A. People dying of COVID now and the family can lift the
13 coffin, well, I think −− I'm not going to say that,
14 again because of my brother. Sometimes it happens,
15 sometimes it's a trolley, but they can still −− it's
16 totally different now. I don't understand why it was so
17 severe for us. It was 14 days since he had died. You
18 couldn't touch a coffin. It's just a traditional thing
19 for families, you know. Anyway, we were not allowed.
20 We were told no flowers, no order of service, you
21 couldn't sing a song. We had the music playing, so we
22 had a piper. We did order flowers because the funeral
23 undertakers did say to us, "We'll lift the flowers.
24 We'll lift the flowers if you really want flowers". So
25 we said, "Right, okay". You felt you were −− you just

1 kept doing something to try and honour him in some way
2 because you couldn't −− there would have been hundreds
3 at my dad's funeral. He was so well known.
4 Q. So even to have flowers there, you felt like you were
5 doing something wrong and having to be sneaky about it?
6 A. Yeah, but they did it and −− yeah, because they said we
7 could.
8 Q. You mentioned that you wanted to later have
9 a celebration of your dad's life.
10 A. Yeah.
11 Q. Were you able to do that?
12 A. We did eventually, but every time we arranged something
13 and we booked somewhere, we had to cancel because
14 Glasgow kept going back into lockdown and we couldn't
15 travel anywhere. We couldn't −− you know, we just
16 couldn't get together as a family to have something to
17 celebrate my dad's life.
18 Q. And the various lockdowns and restrictions meant that it
19 was a while before you could scatter his ashes; is that
20 correct?
21 A. We still have a lot of his ashes, but we have scattered
22 them, yes, in some places, yes.
23 Q. But you wanted to do that as a family?
24 A. As a family −− as a family we wanted to do it. And we
25 thought we would have like his grandchildren there −−

1 they're older -- but the grandchildren and there's quite
2 a number of family members that would have liked to have
3 been there. But we were told that we could only have
4 six people outside, wearing masks, to scatter ashes in
5 the garden of remembrance. So once again we were
6 restricted. We didn't do it.
7 Q. You couldn't decide who those six should be?
8 A. No, who to choose, the six, of the family we've got.
9 Q. Is it quite a big family you have?
10 A. Yes, well, between the grandchildren and the
11 great-grandchildren -- I mean, my dad's age, they're all
12 older, they're 18 and 20, and the grandchildren --
13 great-grandchildren -- sorry -- so, yeah, they would
14 have been able to be there if we had been allowed to do
15 it.
16 Q. Could you tell us about the impact of losing your dad
17 and having to go through all the relevant restrictions
18 that had been placed on you and on his care?
19 A. Well, obviously, as I say, my father had lived with us
20 for over 27 years, 26/27 years, so he was a big integral
21 part of our family, and all of a sudden -- I was his
22 voice and then I had nothing. It was just all taken
23 away. I had the guilt -- my brother and I both had the
24 guilt because we thought, "Okay, we'll put him in a care
25 home", and then we put him in a care home and then

1 COVID -- I know we weren't to know it, but COVID struck,
2 and we also believed what we heard, that the Government
3 was going to put this ring of steel round about the care
4 homes and everybody would be pretty safe in there.
5 I just live with the guilt and he has guilt as well,
6 that we think, "Did we do the wrong thing by putting him
7 in there?". Yeah, it's been pretty hard.
8 Q. You said there that you thought the Government would put
9 a ring of steel round care homes.
10 A. That's what we were told, yes.
11 Q. Given, you know, you would have been hearing and reading
12 headlines at that point about, you know, events going on
13 in care homes --
14 A. Yeah.
15 Q. -- when that information started coming to light, how
16 did you feel about what the Government had been saying
17 prior to that?
18 A. Well, it was obviously a piece of nonsense, wasn't it,
19 what they were telling us? There was no ring of steel
20 put round about. They were just left to flounder and
21 make these decisions or given decisions that seemed
22 nonsensical. I mean, I -- me, if someone had given
23 me -- like I know this happened in the Government.
24 That's why I'm saying it. If someone had given me
25 a piece of directive to say, "Yeah, you could send

1 people from hospital into care homes but you don't need
2 to give them tests", I would have thought, "You cannot
3 be serious". And for anyone in Government to look at
4 that and think that was a good idea is a piece of
5 nonsense. There was no ring of steel there, was there?
6 Q. So you think that not only in retrospect was that a bad
7 idea, but actually, with foresight, you could have
8 deduced that that would have been a problem, that that's
9 not something that should have happened?
10 A. Absolutely not. Absolutely -- I just don't know how
11 anyone could think that was a good thing to do -- could
12 look at that and say, "Yeah, let's agree with that".
13 Now, my dad went in on 20 April and on 21 April it
14 changed, the directive changed, that people should be
15 tested before they were moved. I mean, that doctor that
16 saw my dad and told me that if my dad did pick up and
17 could be discharged, even if he still had COVID, he
18 would go back to that care home with COVID, which
19 I questioned, and she told me, "Yes, he'll go back with
20 COVID. He'll be isolated obviously".
21 Q. Did she tell you that that was her view or did she tell
22 you that that was --
23 A. She told me (inaudible - overspeaking).
24 Q. -- that was a policy that had been -- had anyone told
25 her that this is what should happen or was that her

1 view, do you know?
2 A. No, no, she -- her words to me were, "If your dad ..."
3 -- because I said, "Well, he's rallied in the past and
4 this is why the doctor suggested that he comes in". She
5 said, "Oh, if he does rally -- if it's COVID and he does
6 rally, he will go back to the care home". I said, "If
7 he's still got COVID?"; "Yes, that's his home now and
8 that's where he'll go back to", which I thought was odd
9 as well.
10 Q. Now, you mention in your statement that one of the more
11 profound impacts, as well as not being able to see your
12 dad all the time, was not being with him when he was
13 unwell and when he passed --
14 A. Yeah.
15 Q. -- and you've told us how much that affected you.
16 A. Oh, it's ...
17 Q. Is that ongoing?
18 A. Yes, very much so. Very much so. It's hard to -- how
19 can I say? Normally you would start to have good
20 memories and think about the things he did, but it
21 always creeps back in.
22 Q. That you weren't able to be there?
23 A. Yeah. It's really terrible guilt.
24 Q. Would you like a glass of water?
25 Moving on from there to your business, prior to the

1 pandemic you had a small jewellery shop; is that
2 correct?
3 A. Yeah.
4 Q. Could you tell us about the impact of the pandemic on
5 your business?
6 A. Yeah, well, we had to lock down -- we were non-essential
7 so we had to lock down straightaway. Then my husband's
8 age and his health as well was quite a thing. We were
9 trying to make sure we kept him safe as well. So we
10 were locked down from the March until the end of July
11 and at that point we were trying to -- it was a small
12 shop so obviously we were trying to -- we could only let
13 -- we were then one of those shops that one customer
14 could come, but we were still trying to put everything
15 in place, like partitions between us and customers. So
16 this was difficult to get someone -- people are busy and
17 it was quite expensive as well for these partitions,
18 et cetera. Anyway, my husband is quite good with his
19 hands. He made something up and we were able to protect
20 ourselves and the customers, and we opened the shop up
21 with everything in place, sanitisers, masks, et cetera.
22 But people's attitudes kind of changed and
23 obviously, after losing my dad to COVID and the impact
24 that it had had on us, it was quite -- people were
25 saying things -- you know, they would have

1 a conversation. They would say, "COVID's not real.
2 It's not real anyway. This is just nonsense", and
3 a customer -- you need to be nice to your customer.
4 I would ask customers to wear masks. They would tell me
5 they didn't have to wear a mask. One girl started to
6 swear at me, and that wasn't very pleasant, and
7 I thought, "I really don't need this".
8 Then also -- then we locked back down again heading
9 towards Christmas. We had obviously restocked, you
10 know, to a degree and then -- first of all -- sorry --
11 there was a shop next to us that had had a fire and we
12 were smoke-damaged, so we closed for a few days, we had
13 to clean the shop and paint, et cetera. We opened back
14 up. Then we were locked down again in November. Then
15 we were locked down in December.
16 So it had quite an impact because like
17 November, December and January were our busiest times
18 and that was us locked down again. So, yeah, it did --
19 eventually that year, 2021, the following year, we just
20 gave up because you were having to try and build up your
21 clientele, people had changed their way of shopping, you
22 know, they were doing more online and, as I say,
23 attitudes -- I felt people were quite intolerant.
24 I don't know if it was just everything that people had
25 gone through. That's what we experienced.

1 Q. Yes. So alongside grieving and not being able to really
2 I suppose get closure in a way because the restrictions
3 prevented you from having a celebration or scattering
4 ashes, you were then also having to deal with the impact
5 of losing your business?
6 A. Yeah, we did.
7 Q. You then go on to say that another impact on you was
8 losing time with your grandchildren.
9 A. Yeah.
10 Q. Would you like to tell us a bit about that.
11 A. We used to have -- the two younger ones used to come
12 over and stay and then all of a sudden that was gone.
13 You couldn't see them. They stay in a different part --
14 where they live as well, we really couldn't travel. We
15 weren't supposed to travel as well. So what we did do,
16 when we could, we would just go out and stand in the
17 back garden -- they would stay in the house and we would
18 be in the back garden and we would see them that way and
19 we would -- you know, because it's okay talking to them
20 on the phone or whatever or a wee FaceTime, but to see
21 them and actually see what they're up to, it's -- and we
22 lost out on that.
23 Unfortunately my grandson, he was really quite
24 weepy. He had lost obviously his great-grandpa and then
25 his own grandmother had died. She'd been ill -- on his

1 mum's side -- and she had died as well. And then he had
2 gone from not being at school and not being -- he's
3 a very outgoing boy, and not seeing his friends, he was
4 quite -- it impacted him -- he was quite weepy as well.
5 It took him a wee while to come back. Once he got back
6 out there again, it did have an impact on him. He's the
7 older of the two.
8 Q. Okay, thank you. Now, following all of this, you made
9 a number of complaints about the treatment your father
10 received --
11 A. Oh, yes.
12 Q. -- and your experiences. You contacted your MSP?
13 A. Hmm-hmm.
14 Q. What did you say and what was the response?
15 A. Well, I just said about how my father was in a care
16 home, what had happened to him, how he had passed, and
17 I felt that if we had lockdown sooner, if people -- if
18 there was more testing, masks, people were wearing, if
19 they'd been testing, most -- you know, especially from
20 hospitals to care homes -- that lives could have been
21 saved because, I mean, people in care homes are some of
22 the most vulnerable in our society and they were just --
23 this was happening to them. It just shouldn't have
24 happened.
25 Q. Hmm-hmm.

1 A. To which he wrote back and told me that my experience
2 seemed better than some people had had. Anyway,
3 I suppose it was when you hear some of the horrific
4 stories that are out there, but it was still a huge
5 impact on me and my family. He also told me that there
6 was an argument both ways about lockdowns being sooner.
7 Some people may have just decided, "I'm not going to
8 stay in lockdown sooner than what they did". That did
9 happen, he told me. I said, "Okay, right". Then it was
10 the money that would have been spent on testing kits --
11 stockpiling test kits and PPE could have had an adverse
12 effect on the NHS for the nursing part of it and could
13 have increased waiting times in A&E. That's worked out
14 well, hasn't it?
15 Q. Yeah. Do you think that was designed to stop you
16 questioning further why this hadn't been done, so to
17 suggest that if you were questioning why money hadn't
18 been spent on testing that could have been
19 a preventative measure on PPE --
20 A. That was it.
21 Q. -- that could have been a preventative measure, then you
22 were suggesting that nursing care didn't matter and
23 hospital care didn't matter?
24 A. That was more important.
25 Q. So do you feel that that's --

1 A. Yeah.
2 Q. -- an alternative put there so you didn't push any
3 further?
4 A. Yeah, that's right, so that's "Well, the money would
5 have had to go somewhere, so better going to the nurses
6 than precaution here".
7 Q. Yeah. You then complained to the hospital about the
8 acute assessment doctor.
9 A. I did, yes.
10 Q. What was the response there?
11 A. That they spoke to other members of staff and they
12 were -- said she was lovely and compassionate and she
13 was a very good doctor. Fair enough. But they couldn't
14 find her. They couldn't contact her. They couldn't
15 trace her. They reckon she had moved to another health
16 board.
17 Q. Within Scotland?
18 A. Presumably, yeah, and they just couldn't trace her
19 anywhere to speak to her about what had happened with my
20 dad.
21 Q. What did you think about that?
22 A. I thought it was nonsense. I thought it was absolute
23 nonsense. I thought that they were -- doctors are
24 registered and they should know where they are and
25 should be able to contact them. But apparently not,

1 according to the letter I received. They couldn't do
2 that.
3 Q. Did you ever complain to Health Improvement Scotland,
4 the regulator for hospitals?
5 A. I didn't, no. Sometimes, when you get these negative
6 things back, you just go, "Oh". You know, you've got to
7 be in the frame of mind. You can be in a frame of mind
8 to deal with it at that point, and then you think, "Och,
9 no, here we go again", and there's another block for
10 you.
11 Q. Thank you. You also contacted the care home?
12 A. I did, yeah.
13 Q. What did you say to them and what was their response to
14 that?
15 A. Well, when I wrote to them, I just asked them about
16 the -- what policies, et cetera, and how did COVID get
17 into the care home. They did -- they wrote back to me
18 and -- a nice letter -- and they also included the
19 guidance that was there at the time. I asked about
20 the -- you know, about how things were conducted in the
21 home and they told me a bit. I mean, I did have
22 conversations with the home before I wrote to them as
23 well and the staff did say to me that they -- they did
24 follow the guidance but they also said to me that they
25 didn't bring in agency nurses at that point -- now,

1 I don't know -- that was early on -- because they had
2 members of staff who were nurses and they kind of
3 stepped into that role if need be.
4 Q. Members of staff who were nurses but in other roles
5 prior to this?
6 A. Yes, they worked in the office, but they had been nurses
7 previously and they were prepared to step in, so -- they
8 also said to me that after my dad -- I know my dad and
9 another resident died that week in hospital that had
10 been sent -- they'd managed to get into hospital. Then
11 they felt had they done the right thing because they
12 felt they couldn't maybe treat the person properly --
13 the resident properly in the home so they thought the
14 best place would be hospital. Then they heard how the
15 residents were being treated in hospital and they
16 thought, "Oh, we've done the wrong thing again", and
17 they felt guilty about that as well, so ...
18 Q. Thank you. Now, is there anything else that we haven't
19 covered which you would like to add or comment on?
20 A. Well, the thing -- another thing that annoyed me with
21 this AAU doctor is that it's written in my notes that
22 I was unrealistic about my father and his IV drip.
23 I mean, I've got my dad's medical records obviously
24 recently and I thought, "Why would you even put that in
25 about me? How is that unrealistic?". He was my father.

1 He was a human being. He had rights. I had rights.
2 Q. And all you wanted was for an IV to be put back in?
3 A. For my father to be cared for the way he should have
4 been cared for, given the treatment that he should have
5 had. It was basic treatment, but I was unrealistic
6 about it. As I say, no one had ever asked me those
7 questions any other time my father was in hospital.
8 Q. Hmm-hmm. And we didn't touch on it, but when your
9 father had previously been in hospital, a DNACPR notice
10 had been placed on file, but that should only relate to
11 CPR.
12 A. Yeah.
13 Q. It shouldn't relate to other treatment. Do you --
14 A. That happened -- sorry.
15 Q. Sorry.
16 A. That happened in the August the previous year, when my
17 dad hadn't been well and he'd been on numerous
18 antibiotics, which I've said before, and the doctor had
19 come in -- the doctor had been in on a couple of
20 occasions and she spoke to my brother and I about my dad
21 getting -- putting a DNR on him and explained the DNR,
22 about how he would still be given any other treatment he
23 required but not resuscitated, and we agreed that we
24 wouldn't want my father to go through that. It wouldn't
25 be beneficial for him.

1 Q. It was clinically appropriate to have that --
2 A. Yes, but anything else, he would be treated
3 appropriately.
4 Q. Do you think, though, that that being on the file could
5 potentially have affected the acute assessment unit
6 doctor's thinking --
7 A. It possibly could, that we'd agreed --
8 Q. -- and approach?
9 A. Yes, we only agreed to give him that.
10 Q. For CPR?
11 A. Yeah. That was not -- he was still entitled to basic
12 care that anyone should be entitled to.
13 The doctors -- when my dad used to go into hospital,
14 the doctors would say, "You don't even have high blood
15 pressure. Your blood pressure is normal, your oxygen
16 levels are normal. Everything is great". Everything
17 was great about him. You know, he was a man of that
18 age, "How did you get to 104?", and we would say, "Don't
19 eat vegetables and eat pieces and jam and you'll be
20 fine". That's what we did. No veggies. That was it --
21 because they couldn't believe that -- he didn't have any
22 medication -- he was on no medication, so there we go.
23 But he was entitled to get the treatment he should have
24 had and sooner, I think, than what he had it, but
25 anyway.

1 Q. Thank you. Is there anything else that you would like
2 to --
3 A. No. I just hope it never happens to anyone else, I can
4 assure you of that, because it's horrible.
5 MS BAHRAMI: Thank you very much for attending today.
6 A. Thank you.
7 THE CHAIR: Thank you, Mrs Murdoch. Very good. Now, we're
8 ahead of schedule again, ladies and gentlemen,
9 Ms Bahrami. If it's possible to have the next witness
10 in at 11.15, we could have them. I don't know if that's
11 possible, but we'll try, as we usually do. As you know,
12 it's not entirely straightforward, but if it's possible,
13 we'll start 15 minutes earlier.
14 (10.53 am)
15 (A short break)
16 (11.15 am)
17 THE CHAIR: Good morning, Mr Caskie.
18 MR CASKIE: Good morning, sir. We have a witness for you.
19 THE CHAIR: Very good.
20 MR CASKIE: The witness is Sharon McBride. We can name her.
21 We can also, as of a variation in the restriction order
22 yesterday, I think --
23 THE CHAIR: I think that's right.
24 MR CASKIE: -- name her mother.
25 THE CHAIR: Very good. Thank you. If we could have the

1 witness.
2 MR CASKIE: Is someone going to get her?
3 Here we go.
4 MS SHARON MCBRIDE (called)
5 THE CHAIR: Ms McBride, please have a seat. Make yourself
6 comfortable.
7 Questions by MR CASKIE
8 MR CASKIE: Good morning, again.
9 Would you tell the Inquiry your full name, please?
10 A. Sharon Ann McBride.
11 Q. And you're here today to talk about your mother?
12 A. Yes.
13 Q. And there was a variation in the restriction order which
14 prevents people being named which allows you to name
15 your mother.
16 A. Yes. She's Janet McBride.
17 Q. Janet McBride. As I understand it, your mother was born
18 on 14 October 1940 --
19 A. Yes.
20 Q. -- and regrettably died on 20 January 2021?
21 A. Yes.
22 Q. She had five children, including yourself?
23 A. Hmm-hmm.
24 Q. And we're not going to be naming any of the other
25 children.

1 Now, you have helpfully provided the Inquiry with
2 a very detailed witness statement, and I don't want to
3 go through everything within that, but if I can
4 summarise parts of it with you and ask you to expand on
5 parts of it. I understand that your father, your mum's
6 husband, died in 2000 --
7 A. Yes.
8 Q. -- and he had been a golf club steward. After his death
9 or before his death, your mum and dad had been living in
10 accommodation provided by the golf club; is that
11 correct?
12 A. We had a house near the golf club and we had -- there
13 was accommodation in the golf club as well.
14 Q. After your father's death, they'd moved to a new home?
15 A. Yeah.
16 Q. And that was provided by a housing association?
17 A. Initially, no, it was a private rented property.
18 Q. Then did they move into a housing --
19 A. Then we had a council house and then we had a housing
20 association.
21 Q. You provide a very brief description of your mum before
22 these events happened at paragraph 17. Can I ask you to
23 look at paragraph 17 and you can read what's there?
24 A. Yeah.
25 "Before mum [sic] died, mum was very sociable.

1 After he passed, she became more isolated. She did
2 spend lots of time with her family and [she] always
3 enjoyed seeing me and my brothers and sisters and all
4 her grandchildren."
5 Q. Right. Can you tell us a bit more about your mum just
6 in that time?
7 A. Yeah, so my mum was born in Blantyre in 1940. She was
8 the second-oldest of seven children. She was born
9 during the Second World War so things were quite tough.
10 She was clever, she passed her eleven-plus to go to
11 grammar school, but, because the family was poor, they
12 couldn't afford to send her to the school. So she --
13 when she left school, she worked in a factory, she
14 worked as a clippie on the buses, she worked as a cook
15 in the golf club. She was a very good cook. She was
16 a character, to put it mildly. You didn't mess with
17 her. She was very feisty, very outspoken. She had
18 a very sarcastic sense of humour, but she made us laugh,
19 but she also -- because she was so outspoken, she was --
20 your heart was in your mouth every time. Yes, she was
21 definitely what you would call a character.
22 Q. She did crosswords?
23 A. She did crosswords. She was very good on the cryptic
24 crosswords. She did The Wee Stinker in The Herald.
25 Very good on the English language, much better than us.

1 She always corrected us. Her kind of word knowledge was
2 amazing. She enjoyed the sunshine especially. She
3 hated the Scottish weather. She was always looking to
4 go abroad and get some heat and some warmth.
5 Q. I think we all know how that feels.
6 A. Yeah. Before, as I said, they had a very wide social
7 circle when she was -- my dad was there, so they were
8 always at events and they went on holidays together, big
9 groups of them. Then, when my dad died, she kind of
10 became more isolated from them. I think she --
11 Q. I'll come on to that.
12 I understand -- and we've already said -- that your
13 father died in 2000 --
14 A. Yes.
15 Q. -- and three months later she suffered a stroke; is that
16 correct?
17 A. A heart attack.
18 Q. A heart attack, sorry. And then her health to an extent
19 deteriorated over time?
20 A. Yeah.
21 Q. And you've provided details in the witness statement of
22 the health problems that she developed. Rather than
23 have you provide those details, if you could just
24 correct me if I get any of these wrong. She had angina,
25 chronic obstructive pulmonary disease. Although she had

1 mobility problems, she was able to get around the house;
2 is that correct?
3 A. Yeah, I mean, it was only in the latter years that she
4 really stopped going out, but, even after the heart
5 attack, she was going on holidays and things, so ... but
6 in the house, in the latter years, she was very mobile.
7 She was never off her feet. She wasn't one for sitting
8 down.
9 Q. Okay. I understand she also developed osteoporosis,
10 which affected her back.
11 A. Yeah.
12 Q. Towards the end of the time she was in the house, she
13 had particular sleep arrangements. Can you tell us
14 about those?
15 A. Yeah. Initially because of the pain in her back, she
16 had a -- we got her a chair, a reclining chair, and she
17 preferred to sleep on that with a -- not a mattress,
18 a kind of -- I'm not sure what you would call it, but it
19 gave her support on the chair. She preferred -- instead
20 of trying to go up the stairs, she preferred to lie
21 there until we got her a bed-raiser from the kind of
22 occupational therapist team.
23 Q. Right. At paragraph 23 you say there wasn't a care
24 package in place and that you very much organised her
25 care. Can you tell me about your involvement with your

1 mum while she was still at home?
2 A. Well, I probably dealt with all her kind of medical
3 issues, her kind of financial details, you know, like if
4 she had bank things to set up or she had to -- hospital
5 appointments or that. I kind of organised all that.
6 I mean, she was more than capable of doing it herself
7 but she was getting a bit frustrated towards the end
8 with the surgery.
9 Q. With the surgery?
10 A. The GP surgery.
11 Q. Right, right. I'll come back to that. At
12 paragraph 23/24 you also talk about her having contact
13 with a dietician.
14 A. Yes.
15 Q. Some of us need contact with a dietician because we're
16 too heavy. Tell me about your mum.
17 A. My mum had started saying she was feeling sick all the
18 time and she didn't feel like eating. She wasn't -- she
19 would have porridge in the morning and maybe a sandwich
20 in the afternoon, but it wasn't obviously enough and she
21 was losing weight. And we got the dietician in, who
22 suggested that she start taking kind of high-calorie
23 drinks to supplement what she was eating, but she used
24 that as her main meals and she dropped the food
25 altogether. She was just drinking the energy drinks,

1 they were called.
2 Q. Just the supplements?
3 A. Supplements, yes.
4 Q. What impact did that have on her weight?
5 A. She just was getting thinner and the physiotherapist
6 came out and said, "Your muscles are gone. They're in
7 danger of re-feeding or feeding themselves. You have to
8 start eating more", but that just went in one ear and in
9 the other.
10 Q. Were the family able, when she was at home, to encourage
11 her to eat?
12 A. Yeah, we did try and encourage her, "Mum, what -- we'll
13 bring something in for you". She liked a particular
14 little cake. We'd bring that in because the dietician
15 said the higher calorie, the better. She would like
16 custard. She liked her custard so we would bring that
17 in, try and get her to eat that, anything high calorie.
18 Anything that she had a fancy for, we would bring it.
19 Q. You said there was a problem with the surgery --
20 A. Yeah.
21 Q. -- by which you mean the GP's practice. I don't want to
22 ask you what the difficulty was at this stage, but can
23 you just tell us, what was her medical need to be in
24 touch with the surgery?
25 A. She was feeling sick all the time and she said that she

1 was having UTIs, urinary infections. When we were
2 handing -- initially they would just give her the
3 antibiotics and then they said, "No, we need samples".
4 Nothing was showing up on the samples and she was taking
5 like kind of sachet things from the -- because she got
6 nothing from the GP, she wanted these little sachets for
7 cystitis from the supermarket because she was in pain
8 and she was running to the toilet all the time, but ...
9 Q. Can we go back and just tell us a little bit about the
10 house that she was in. Where was the toilet located
11 within the house?
12 A. It was upstairs.
13 Q. Upstairs?
14 A. Yeah.
15 Q. So if she had cystitis or something --
16 A. Yeah, she had to go upstairs.
17 Q. -- she had to go upstairs to use the toilet. I think
18 something happened in October/November 2020.
19 A. Yeah, she -- we didn't realise that -- we'd tried to
20 phone her that morning and there was no response, so we
21 started to get a bit anxious about her and when we got
22 over there, we found that she had lain on the top step
23 of the stairs all night. She'd fallen up the stairs for
24 some reason and she was very confused and cold and she
25 was complaining her shoulder was sore, so we ended up

1 calling out the NHS 24.
2 Q. What happened in terms of at that point when she was
3 found?
4 A. She said she had managed to -- she lay there -- she
5 didn't know how long she lay there but she managed to
6 crawl into the room, I think she said, and then she just
7 had lain there. So we tried to get her kind of -- tried
8 to get the story from her because she was a bit confused
9 about what had happened and we weren't entirely sure.
10 We finally got the story.
11 Q. And what was the story?
12 A. That she had just tripped going up the stairs and she
13 couldn't get herself back up again.
14 Q. Right. Now, I understand that within the family you
15 took steps to provide protection for your mum in the
16 future. Now, without naming any member of your family,
17 can you tell us what happened?
18 A. So after that fall and her discharge from hospital, we
19 asked if my brother -- he was in the shielding category.
20 He was living in Eyemouth. He was on his own. We asked
21 him if we could come and get him, one person in a car,
22 because there was still restrictions, and bring him up
23 to stay with my mum because we were a bit concerned
24 about her mental health and the fall.
25 Q. And did he agree to do that?

1 A. Yeah.
2 Q. So until then, until he moved in -- and that would be
3 in December 2020 --
4 A. Yeah.
5 Q. -- or thereabouts?
6 A. Yeah.
7 Q. How did she deal with the lockdown up to that point? We
8 know it started in March, so March until December she
9 would be living on her own presumably?
10 A. Yeah, so she got a letter saying she was in the
11 shielding category and basically she should avoid
12 contact with anyone, so we -- like we visited frequently
13 during the week.
14 Q. Well, tell me about that. How often was someone going
15 in?
16 A. So I'm --
17 Q. I mean, there were five children. You were five
18 children.
19 A. Yeah, I was over three times a week myself. My brother
20 in Eyemouth, he obviously wasn't in, but the rest would
21 drop in during the week between them so most days
22 someone was in, and she really enjoyed that because she
23 liked to talk. She liked to chat and she liked to tell
24 you what was on the news and she liked to tell you what
25 Boris Johnson was saying today. So she liked politics

1 and she liked to talk about that.
2 Q. Now, during this period, the period of lockdown, you had
3 spoken about samples having to be taken to the GP
4 practice and about her contact with the dietician. Did
5 any of that continue during lockdown?
6 A. No. Before lockdown the GP would do the home visit.
7 That was an argument every time with them because she
8 wasn't fit to go in the car because she had vertigo and
9 she got really sick travelling any short distance. So
10 it was an argument every time to get them to come out on
11 a home visit, but they did come out on a home visit and
12 the dietician did come out. So all that stopped with
13 COVID.
14 Q. And you had said that she had a UTI and she had provided
15 samples and you indicated there were problems with the
16 GP's practice. Can you tell us about those problems
17 now?
18 A. The GP surgery was only open certain times and they had
19 a window -- not the main door -- so it was a window that
20 was opened and they would raise the shutter at a certain
21 time and you would have to wait in the cold for them to
22 come to the window and for you to hand in what you
23 needed to hand in. And with restrictions on travel
24 around that time, trying to organise people to get the
25 sample and take it up there, yeah, it was difficult ,

1 especially the amount of times she was complaining about
2 it .
3 Q. Okay. At paragraphs 36 and 37 you provide more
4 information about her not eating and tie that in,
5 I think, with isolation . Can you tell us about that?
6 I'm not going to ask you to read it, but ...?
7 A. So, as I said, before lockdown she was mentally very
8 sharp. With lockdown and no one was visiting her and
9 she was on her own, her memory started to decline
10 particularly --
11 Q. I'll come back to that. You had said there were lots of
12 visits from the family, almost every day. How did that
13 come to an end?
14 A. When we got the shielding letter, we made a decision
15 amongst us that we had to stop -- we had not to go into
16 the house. It was too risky.
17 Q. And did that have an impact on how she was eating?
18 A. Yes. We would ask her on the phone, "Have you eaten
19 today?"; "No". We'd say, "Mum, you have to eat";
20 "Yeah". And that was the way she went. If she didn't
21 like what you were telling her, she just hung up on you.
22 That was a --
23 Q. She was quite bolshy.
24 A. Yeah, very bolshy.
25 Q. You talk about her mental decline at paragraph 37. I'd

1 like to read -- I'll read to you paragraph 37 and the
2 beginning of 38:
3 "She began to decline mentally. I personally think
4 she had undiagnosed dementia. She would accuse us of
5 stealing from her, despite the fact we had not been in
6 her house. Then she stopped answering the phone when we
7 were calling ... We used to have to turn up at her door
8 to ensure she was ok. This was difficult as there were
9 restrictions on travel, and I stayed in a different area
10 from her.
11 "Lockdown definitely contributed to her mental
12 decline."
13 Tell me about that, the contribution in your view.
14 A. So we made up almost like a timetable where we would go
15 down to maybe the garden and talk to her in the garden,
16 maybe bring in food, but the food didn't get used, but
17 we would bring it in anyway, and we would stand at the
18 door and talk to her. So we had a kind of timetable
19 with that, and she would say, "Come in, come in", and
20 we'd say, "No, we're not coming in". As time went on,
21 she'd get more frustrated with that, "I've not got
22 anything". I said, "I know you haven't got anything but
23 we might have".
24 So she then -- she would make accusations that
25 things were getting taken from the house. She accused

1 my sister of taking something, then she accused me of
2 taking something, and apparently my partner was the
3 distraction while I took the items, so Bonnie and Clyde
4 here. So we couldn't reason with her that it wasn't
5 possible that we took anything, but because she maybe
6 forgot where that item was, she thought someone had
7 taken it. So she was accusing -- everybody was
8 horrified, "Mum thinks I took that", and it's like she
9 just doesn't remember where it is. But I can't say
10 I was patient with it. I was too frustrated with her
11 because I knew her before, and now that she wasn't, to
12 me, being reasonable because she wouldn't accept that
13 nobody took anything from her and then --
14 Q. Was it difficult for you, who was in touch with her
15 frequently at that time, to measure the decline?
16 A. You couldn't measure the decline because just -- she
17 started repeating the same things as well. I said,
18 "Yeah, you just told me that one, Mum", or on the phone,
19 "Oh, right" -- then it escalated from that to, "You're
20 taking things. You're all taking things from me", and
21 then she would take the huff with you and she wouldn't
22 answer the phone because, in her mind, you had done
23 something to upset her, but you didn't know what you had
24 done, but she wouldn't answer the phone to tell you. So
25 because she was on her own, we needed to know she was

1 okay and she just stopped answering the phone. So you'd
2 turn up at the door, she wouldn't answer the door.
3 "Are you okay, Mum", you'd shout. You'd get a face from
4 her, but you'd know then she was okay. I found that
5 really difficult, especially when she stopped answering
6 the phone to us, because it was difficult enough to try
7 and keep an eye on her without her cutting off the
8 communication as well.
9 Q. And that was, as far as you're concerned, a function of
10 the deterioration in her brain?
11 A. Aye, yes, I believe so.
12 Q. But you weren't able to get a work-around for that,
13 apart from turning up at her door?
14 A. No.
15 Q. I understand that she went into hospital fairly briefly.
16 She went into Hairmyres?
17 A. Yeah.
18 Q. Why do you think she went to Hairmyres?
19 A. She went to Hairmyres because Monklands was busy.
20 Q. Sorry?
21 A. She went to Hairmyres because Monklands was busy,
22 I believe -- busy in terms of didn't have any room for
23 her.
24 Q. I understand she was in an elderly care unit.
25 A. Yeah, they'd put her in there, which was a different

1 building from the main building.
2 Q. How did she physically transfer from home to Hairmyres?
3 A. It was an ambulance.
4 Q. And was there anyone in the ambulance --
5 A. Just her.
6 Q. -- apart from the paramedics?
7 A. No, just her. I don't think anyone was allowed in the
8 ambulance at that point unless they were ...
9 Q. So she was in Hairmyres for a wee while and then back
10 home?
11 A. Yeah.
12 Q. And how did she get back home?
13 A. I picked her up.
14 Q. And was it at that point that your brother moved in?
15 A. Yeah, we'd asked him to come and stay with her.
16 Q. So he's now living with your mum. Was there
17 communication on in particular 19 December from him and
18 what was he saying to you?
19 A. He said that -- he phoned to say Mum was complaining
20 about pains in her back and her stomach, so I told him
21 just to phone NHS 24 because I think it was -- I might
22 be wrong -- I think it was a weekend, a Sunday maybe.
23 Q. Then, at paragraph 48, you talk about going to the
24 Monklands this time.
25 A. Hmm.

1 Q. Sorry, I'm from that part of the world. Everybody
2 refers to it as "the Monklands" rather than "Monklands".
3 At paragraph 49, you talk about her being tested for
4 COVID.
5 A. Yeah. So they -- when I reviewed the notes, on the 20th
6 they tested her, it's true, and she was negative, so
7 they put her on what's called an "amber pathway".
8 Q. Aha, can you explain the pathway system, as far as
9 you're aware?
10 A. So the hospital explained to me that the only people who
11 were given a green status were those who had been
12 isolating in hospital before an operation. Anyone else
13 who was not positive was put on an amber pathway and red
14 was for the positive COVID.
15 Q. And which pathway was she put on?
16 A. Amber.
17 Q. You talk about getting a phone call from a doctor in
18 admissions at Monklands.
19 A. Yeah.
20 Q. What was that about?
21 A. So I think they called me to get some background on why
22 she was in, a little bit of her history. I have put in
23 my notes that I think the DNR was mentioned there. I'm
24 not sure it was on that first phone call, but it was
25 fairly soon after that it was mentioned.

1 Q. You and your family had a particular attitude to do not
2 resuscitate notices?
3 A. Yeah.
4 Q. Can you tell us about that?
5 A. So they mentioned to us on 29 December -- she was having
6 an endoscope on the 30th -- that they wanted to put
7 a DNR in place. I said, "I'm not in favour but I'll
8 speak to my brothers and sisters", and they were not
9 happy with that at all. And I said to them, "We're not
10 happy with that going on". They explained in great
11 detail about what exactly happens during the CPR, and
12 I said, "I understand that, but we want her to have
13 every chance". So on 29 December they said, "We'll talk
14 about this again", and it was left at that.
15 Q. So at that stage it was left at that?
16 A. Yeah.
17 Q. But they do return to that actually later?
18 A. Yeah.
19 Q. Tell me about Christmas 2020.
20 A. So initially when she went in there, the initial
21 indications were that she would be out fairly soon,
22 so -- Christmas was my mum's favourite time of the year
23 so we obviously wanted her home for Christmas, but she
24 didn't obviously get home. So we took turns going to
25 the ward door. They would let us stand at the ward door

1 and she was at the top of the ward and we could kind of
2 shout up to her. We handed in presents for her, but
3 later we found they all came back unopened. She didn't
4 want to be in hospital for Christmas so she didn't open
5 any presents.
6 Q. There is talk in your statement about her moving between
7 wards. Can you just summarise that for us?
8 A. Yes, she got moved to another ward when she tested --
9 Q. You can give the ward numbers, I think.
10 A. Yeah, so she was in ward 17 from her admission up until
11 2 January and, 2 January, when she tested positive, they
12 moved her to ward 2.
13 Q. So at that point she tested positive for COVID?
14 A. On 2 January, yes.
15 Q. When she had gone into hospital, she had been tested and
16 at that stage had been negative?
17 A. Yeah.
18 Q. So when she gets moved -- which ward did she get moved
19 to, do you recall?
20 A. Ward 2.
21 Q. So she goes from ward 17 to ward 2. How long does she
22 stay in ward 2?
23 A. So she stays -- she gets returned back to ward 17 again
24 on 13 January.
25 Q. Right. So that would be what?

1 A. Around ten days after.
2 Q. Around ten days. Do you know why she was moved back?
3 A. They said that it was capacity reasons. At a meeting
4 with the hospital, they clarified that there was people
5 who needed the treatment in that ward that Mum --
6 Q. This is ward 2?
7 A. Ward 2 -- that my mum didn't need.
8 Q. Aha.
9 A. So they basically needed the bed in ward 2.
10 Q. Right, and was ward 2 a red --
11 A. It was a high dependency.
12 Q. An HDU?
13 A. Hmm-hmm.
14 Q. So she's initially in ward 17, she then gets moved to
15 ward 2 and then, ten days later, she gets moved back to
16 ward 17. Did they say anything now at the point at
17 which she gets moved from ward 2 to ward 17, before she
18 was moved -- did they do a COVID test before she was
19 moved?
20 A. Yeah. So they said on 1 January that her inflammation
21 markers were a little high and she was feeling cold. On
22 2 January they said, "We're running blood cultures", and
23 they couldn't determine the cause of the infection, so
24 they were going to do a BioFire swab for COVID, and they
25 phoned me and told me they were going to do that, and

1 they moved her into a side room within ward 17.
2 Q. Did she get the results from any of those tests?
3 A. Yes, so they called me and told me it was positive.
4 Q. So this was roughly 2 January --
5 A. It was the 2nd, yes.
6 Q. -- that you're told she's now positive for COVID, having
7 been negative?
8 A. Yeah. They have said in their letters to me that it was
9 hospital-acquired.
10 Q. You refer in your witness statement to you being told
11 that your mum was the index patient.
12 A. Yeah.
13 Q. Tell me a bit about that.
14 A. So, of course I have questions about, "How did she catch
15 COVID? She's supposed to be in an infection-controlled
16 environment. What are you doing for testing?". They
17 said they were only testing people who were symptomatic,
18 so they said she was the first case in that ward, but
19 they couldn't and they still can't, to this day, tell me
20 where she got it.
21 Q. You had -- give me just a second. Yeah, I'm now looking
22 at paragraph 74. Now, you had said in your evidence to
23 Lord Brailsford this morning that the numbers were
24 raised in relation to her inflammation --
25 A. Hmm.

1 Q. -- and you understood that to be a bad thing, but you
2 were also being told, until 2 January, that she was
3 COVID negative.
4 A. Yeah.
5 Q. Did you think you were receiving consistent information
6 from the hospital?
7 A. Well, up until she got COVID, we were more concerned
8 about getting the endoscope done and getting the results
9 of that and getting her fed because she wasn't eating,
10 so at that point it wasn't really about getting stats as
11 such. She was okay at that point. There was no --
12 after 2 January, I was the main point of contact, I'd
13 phone three times a day, so I was then relaying that
14 information back to the family.
15 So every day they might have said, "Her oxygen level
16 is this", or the next day it might be lower, so the
17 family were getting mixed messages. So the doctor was
18 basically telling me, "She won't survive this", but the
19 stats were saying they were reducing oxygen -- they
20 would reduce it and then put it back up, then they would
21 reduce it again, and people -- we were thinking, "That's
22 a good thing. You know, she's fighting it". We just
23 felt a bit -- I had several conversations with the
24 doctors in there to clarify because, obviously, the
25 family had questions, and they just kept reiterating to

1 me -- "It's just -- we don't think it's a survivable
2 event", they said.
3 Q. At paragraph 76 you talk about an event that took place
4 on 18 January. Can you tell us about that and then --
5 yeah, just tell us about that first.
6 A. So 18 January they said that her inflammation markers
7 had gone a bit high again. They started her on
8 antibiotics again. They said she now had
9 hospital-acquired pneumonia and that it was just
10 a matter of time now.
11 Q. Then on the 19th, the next paragraph, you were given
12 more information?
13 A. Yes, I got a phone call about 1.00 in the morning from
14 the nurse to say, "You have to come in now".
15 Q. Was the whole family allowed to go in at that stage?
16 A. No, just one person.
17 Q. And who was that person?
18 A. So I had to make a video call to my brothers and sisters
19 at 1 o'clock in the morning, which they're obviously
20 distressed about, and I said, "One person", so they said
21 that I should go.
22 Q. That it should be you?
23 A. Yeah.
24 Q. You talk about going in and you went into a side room in
25 ward 17; is that correct?

1 A. So the doctor took me into his room first of all. He
2 showed me basically the lung pictures and how bad they
3 were basically. He said he was the doctor who had first
4 met my mum when she come into hospital and he thought
5 she had beaten COVID, but she wasn't -- basically he
6 said -- he was basically saying, "You can continue
7 treatment, but in the end it's not really going to -- to
8 prolong this basically. There's no recovery from this".
9 So I said -- "We either make her comfortable or we
10 continue the medication", that was my choice, so, again,
11 I made the call to my brothers and sisters and they
12 said, "Make her comfortable", so we agreed just to make
13 her comfortable.
14 Q. And that was the provision of drugs to do that?
15 A. That was the provision just -- so they withdrew
16 basically all other medication apart from, I think,
17 a sedative and morphine and her oxygen.
18 Q. At that point were you being told how long they thought
19 she had to go?
20 A. Yes, so a consultant came in at some point in the
21 morning and I asked her, "How long?", and she said,
22 "About 12 hours", and she was almost exactly right.
23 Q. And how long at that point had you been there?
24 A. I'd maybe been about five hours at that point, I think
25 the consultant came in at 5.00 or 6.00 in the morning,

1 and she passed away the following morning, around
2 4 o'clock.
3 Q. I understand that an arrangement was made within the
4 family for someone else to attend. Can you tell us
5 about that?
6 A. Yes, so this is a big regret for me. I was having
7 a breakdown, I couldn't kind of watch her die. I wish
8 I had stayed now -- on hindsight, I wish I'd stayed with
9 her, but I just couldn't. I couldn't. I don't know --
10 I couldn't watch it, but I should have. But, anyway,
11 I asked them if there was someone else -- could there be
12 other arrangements. I didn't want to leave her on her
13 own. So if they'd said no one else, I would have
14 stayed. They spoke with infection control and they said
15 one -- "If you go out, you don't get back in, and if one
16 person comes in, that's them, that's it".
17 So I made a call to my brothers and sisters and
18 said -- and my older brother wanted to come, but he'd
19 been waiting ten days for a COVID result and hadn't got
20 it and struggled to get that result, so he was angry
21 that he couldn't get in because he didn't have his COVID
22 result and didn't want to take the risk. So in the end
23 my younger sister decided to do it.
24 Q. And did she effectively swap places with you?
25 A. Yeah.

1 Q. And was she there at the end?
2 A. Yeah.
3 Q. So your mum had someone with her?
4 A. Yeah.
5 Q. In the witness statement at paragraph 91, you talk about
6 the difficulties with electronic communications and so
7 on before your mum finally deteriorated. Do you have
8 anything to say about the availability of that?
9 A. I thought it was terrible for an elderly person. We had
10 gotten her a mobile before which she couldn't really
11 work, but we handed it in at one point. We thought we
12 could maybe phone her. She could pick up. She never
13 really picked up. So sometimes when we phoned, the
14 nurse, if they had time, would take the phone round.
15 I asked if we could have an iPad, but they said, "No,
16 the iPad was only for admin use", so we couldn't do
17 that. And then, when they were trying to get her to do
18 the endoscope, the mum -- the doctor phoned me from her
19 phone and got me to speak to my mum. But we'd never
20 seen how bad she was --
21 Q. When you say "they were trying to get [my mum] to do the
22 endoscope", she wasn't keen to do the endoscope?
23 A. No.
24 Q. When you say that they were trying to get her to do it,
25 were they trying to convince her to do it or were they

1 physically trying to do it?
2 A. No, they weren't physically -- they were trying to
3 convince her that she needed to get it done.
4 Q. And you were contacted to speak to your mum?
5 A. Yeah.
6 Q. Was that an effective way -- did she change her mind
7 when she heard from you?
8 A. She did, but she was not happy with me at all. It was
9 none of my business. But in the end I persuaded her
10 because I said, "This is for your own good, Mum. You've
11 got a blockage, they think, and they need to find out
12 why", so she had it done.
13 Q. Right. You talk about -- you will know that you're one
14 of a series of witnesses who are providing evidence on
15 a variety of events. At paragraph 92 you have
16 a heading -- or just before paragraph 92 there's
17 a heading, "Infection control". Is there anything in
18 particular in that section which goes down to 98 that
19 you want to raise?
20 A. So, like I said, when we visited ward 17, we could go to
21 the door. Sometimes it was only the nurse would only
22 answer and take in whatever we were handing in. I don't
23 remember the -- I don't think it was a COVID ward as
24 such at that point so I don't remember the PPE being
25 extensive. We had masks on because that was hospital

1 policy. When she went to ward 2, when the consultant
2 called, the consultant basically said, "You'd better
3 arrange visits now".
4 Q. And did you understand that to be because it was end of
5 life?
6 A. Yeah, because -- I don't know if you're coming back to
7 this, but during that conversation, previous to that
8 a DNR had been put in place on 1 January, which I wasn't
9 aware of, because I thought we hadn't finished the
10 conversation on it. Also an escalation plan was put in
11 place, I think it's called a "TEP", and that was almost
12 like a score chart for ventilation.
13 Q. Hmm-hmm.
14 A. And if you didn't get the right score based on your
15 health conditions or based on frailty, then you didn't
16 get ventilation. On 1 January, though, along with the
17 DNR, that was completed, and it said that she should get
18 CPAP and that's why she was moved to ward 2. When the
19 consultant -- there is a point to this. So when the
20 consultant phoned, she said she was now downgrading that
21 from the previous doctor's opinion, and another one of
22 these forms was filled out again and it was -- in this
23 case it was decided that she wasn't getting ventilation.
24 Q. Okay. Now, you said that a doctor said she should get
25 CPAP and then subsequently another doctor decided that

1 she couldn't get ventilation of that sort.
2 A. Yeah.
3 Q. Were you given any explanation as to why there was the
4 change? Had her condition deteriorated? Was that
5 explained to you?
6 A. No, the consultant said that it was because she was
7 frail and the mask wouldn't fit on her face. She was
8 too thin and too frail and she didn't think the
9 treatment would be successful. But what I didn't
10 realise was behind that was this TEP form.
11 Q. At paragraphs 105 to 107, you're talking about earlier
12 in the process, so can I just have you read 105 to 107?
13 A. "In retrospect ... we should have made a bubble sooner
14 for her.
15 "I don't know if it was right for her mentally, but
16 we could not have lived with ourselves had we gone into
17 [the] house and passed anything on to her.
18 "We protected mum only for her to get Covid in
19 a so-called infection-controlled environment."
20 Q. You talk at paragraphs 108 through to 114 about the DNR
21 order and you've said quite a lot about the DNR order
22 orally this morning. Is there anything you want to add
23 in relation to the DNR?
24 A. When I had the last conversation with them on
25 29 December, I thought we had left it at, "We're coming

1 back to this", then I found it on her file dated
2 1 January along with her escalation plan. And on
3 2 January, when I spoke to another doctor, we were still
4 talking about the DNR. They hadn't said it had been
5 placed on her. They said that, "Oh, we can make the DNR
6 mandatory for medical conditions", and they didn't tell
7 me that they'd already put it on her file.
8 THE CHAIR: Have you seen the DNR form?
9 A. Yeah, I've got it.
10 MR CASKIE: And we can maybe take a copy of that.
11 THE CHAIR: Well, I think that would be helpful if you're
12 happy to do that.
13 A. Yeah.
14 MR CASKIE: Had your mother signed it?
15 A. No, they said that she didn't have the capacity to
16 understand. It was ticked as, "Does the patient
17 understand?", and it said "No".
18 Q. So were you given any explanation as to why they were
19 relying on a form that she couldn't understand?
20 A. So we'd said to them when she went in that we were
21 worried about her capacity. They tested her on the
22 20th and she passed, no impairment. Before they did the
23 endoscope, they did another one, which was a low score,
24 so the endoscope was actually put through on medical --
25 they decided on the endoscope, not my mum, and they end

1 up -- because of capacity -- on the 29th and the 30th
2 they did more of the capacity assessments and on
3 the 30th it showed capacity and impairment unlikely, but
4 yet the DNR and the treatment escalation plan were
5 filled out as if she was incapac- -- she didn't have the
6 mental capacity to understand.
7 THE CHAIR: Was that for the endoscope?
8 A. The endoscope?
9 THE CHAIR: Yes.
10 A. What was it for?
11 THE CHAIR: The consent form in relation to the endoscope,
12 did it say that she had capacity or lacked capacity?
13 A. Lacked capacity.
14 THE CHAIR: Lacked capacity?
15 A. Yeah.
16 THE CHAIR: And therefore it was done on medical grounds
17 only?
18 A. Yeah.
19 THE CHAIR: And the doctor certified that?
20 A. Hmm.
21 THE CHAIR: I think we should see these medical records in
22 this case.
23 MR CASKIE: Sorry, sir?
24 THE CHAIR: I think, if it's possible, we should see the
25 medical records in this case.

1 MR CASKIE: Okay.
2 Now, we know that sadly your mum died on --
3 THE CHAIR: Sorry, before you go there, can I be absolutely
4 clear? You had a conversation with a doctor -- I don't
5 want you to name the doctor -- but I think you said it
6 was on 29 December 2020 --
7 A. Hmm.
8 THE CHAIR: -- and there was a discussion about DNR. You
9 indicated that you weren't enthusiastic but you wanted
10 to consult with your siblings. You did so and they
11 shared your concerns. You went back to the doctor?
12 A. I believe I went back and said, "I'm not convinced about
13 this", and he said -- because I wrote everything down
14 with conversations after I spoke to them, and they said,
15 "Okay, we'll leave this discussion for another time".
16 THE CHAIR: Right. That's what I thought. Therefore, so
17 far as both you and the relevant doctor were concerned,
18 the matter had not been concluded and was to be
19 discussed further?
20 A. Yeah.
21 THE CHAIR: And yet there was a DNR in place on --
22 A. The 1st.
23 THE CHAIR: -- 1 January 2021?
24 A. Hmm.
25 MR CASKIE: And we know that your mum died on 20 January.

1 I'm going to paragraphs 115 through to 117. What
2 you say there is this:
3 "The impact on the family of mum passing, as I said
4 previously, is that we were surprised, due to the
5 conflicting information we were given from the medical
6 staff. Some would advise her blood markers were good
7 but then we were told to prepare ourselves for the
8 worst.
9 "We were all isolated in different houses when we
10 found out that mum had actually died. This was
11 extremely difficult for us all. Even though we all had
12 our own families, as a group, we could not get together
13 to mourn. Everything was done over the phone.
14 "My sister had to tell us via an app that mum had
15 passed away. That is how we found out. At 3.00 [am]
16 ... I think we all took it in different ways."
17 Then you say something about how your brother took
18 it, and we are talking about the brother who had moved
19 into your mum's house. Again, without naming him, can
20 you provide us a description of his reaction?
21 A. So my brother had been -- when we did the swap-over, he
22 had wanted to go. He was the oldest. He was angry and
23 he's still angry that he never got in to see her that
24 day. So when she passed away -- he's now on his own in
25 my mum's house. The rest of us have got someone with

1 us. He doesn't have anyone. So we all communicated via
2 an app, and he was really frustrated and angry, and he
3 started to feel not well and -- he just seemed not to
4 take it well, and I think that was all related to the
5 fact that he couldn't get in to see her, he never saw
6 her.
7 Q. And within your family and your wider community,
8 would it have been normal for the body to be viewed
9 after a death?
10 A. Yeah.
11 Q. So there would be a general expectation that he would be
12 able to see the body?
13 A. Hmm.
14 Q. But that didn't happen at any stage?
15 A. No, because it was COVID, it was a closed coffin.
16 Q. You said that you had swapped places with your sister
17 and that she was there when your mother passed away.
18 Can you tell us about the impact on her?
19 A. The impact is really harsh on her. She's the youngest
20 so she took it the hardest. And then I don't -- I think
21 that's related to the fact that she was there and
22 I should not have put that on her. I should have stayed
23 as the older sister. I shouldn't have put that on her
24 because now I can see that she's really struggling with
25 the fact that she was the last person to see her.

1 Q. At paragraph 121 -- you say that you got the death
2 certificate fairly quickly, at 122 -- and it provides
3 a series of reasons at 121, causes of death. How
4 did you get the death certificate or the information
5 from the hospital?
6 A. By email.
7 Q. They just emailed you?
8 A. Yeah.
9 Q. And you spoke a moment ago about how difficult your
10 sister was finding it. Let me just explore that
11 a little more. Do you think it would have made
12 a difference to you if she hadn't been there?
13 A. It would have made a difference to me because I think it
14 was too much responsibility for her. It might have been
15 different if all five of us could have went in and we
16 had support for each other, but she was just left on her
17 own, just our mum.
18 Q. Have you discussed that with her?
19 A. Yeah, I mean, I have advised her -- I think she should
20 speak to someone about it, you know, a counsellor maybe,
21 but she won't.
22 Q. She won't or she hasn't?
23 A. She won't.
24 Q. Do you think that will change?
25 A. No.

1 Q. At paragraph 125 you talk about the funeral process
2 beginning effectively the night before the funeral and
3 you said I think that it was a closed coffin. Was there
4 a priest present?
5 A. The coffin -- we are Roman Catholic so normally the body
6 would be taken to the chapel the night before. In this
7 case, it had to be kept in the funeral home. So they
8 allowed us to do -- it's called a "rosary service" --
9 the night before. They allowed 20 people, I think, in
10 the hall and it's just a kind of prayer.
11 Q. Did you and your family take comfort from that?
12 A. Yeah.
13 Q. You say that the funeral was available online.
14 A. Yeah.
15 Q. And then you talk about complaints towards the end of
16 your statement, and I just want to ask you a bit about
17 that and try to sort out -- make clear what the timeline
18 was.
19 A. Yeah.
20 Q. Your mother died in January 2020 and you put a complaint
21 in in June?
22 A. No, so --
23 Q. Sorry.
24 A. -- the dates on that are actually -- so it should
25 be June 2021 that the complaint went in --

1 Q. Right.
2 A. -- and they didn't respond till January 2022.
3 Q. So it took them 18 months --
4 A. No, from June --
5 THE CHAIR: Seven months.
6 MR CASKIE: Seven months, it took them seven months to
7 reply?
8 A. Yeah.
9 Q. And you were then offered a meeting?
10 A. So they replied and I didn't agree with the response,
11 and I wrote them another letter in the April 2022 and
12 they said, "Well, we'll have a meeting then". They did
13 arrange a meeting for the August and then they called it
14 off an hour before the meeting was due to start.
15 Q. Can I ask, where was the meeting in August due to take
16 place?
17 A. Monklands Hospital.
18 Q. So less than an hour's notice the meeting was called
19 off?
20 A. Yeah.
21 Q. Did they rearrange it?
22 A. Yeah, so it wasn't rearranged until I think it was -- it
23 was another couple of months, end of October --
24 31 October, I think it was.
25 Q. From your side, who attended?

1 A. Just me and my aunt.
2 Q. You and your aunt?
3 A. Who was my dad's sister.
4 Q. Again, that was in Monklands?
5 A. Yeah.
6 Q. How many people from Monklands attended?
7 A. So I just re-read the notes again. So there was I think
8 six of them.
9 Q. Right. We don't want you to name any of those.
10 A. No.
11 Q. So there was you and your aunt. Are either of you
12 medically qualified?
13 A. No.
14 Q. The people who attended from the hospital, were they all
15 doctors? Were any of them doctors?
16 A. Apart from one notetaker, they were all -- the notetaker
17 and the director of hospital services, there was
18 a consultant, a doctor and two senior nurses.
19 Q. And there was a notetaker present?
20 A. Yeah.
21 Q. Have you been provided with a copy of the notes?
22 A. Yeah.
23 Q. And was that sent to you shortly after the meeting?
24 A. No, again that took -- there was a delay getting that.
25 So the meeting was in October and I didn't get the

1 response until January 2023.
2 Q. Now, you say "the response" --
3 A. The response with the meeting notes.
4 Q. With the meeting notes?
5 A. Yeah.
6 Q. Tell me what the response was.
7 A. So the response was -- do you want me to read it out?
8 I have it with me or ...
9 Q. No, if you could just summarise what it is.
10 A. So there was different issues that I had, including
11 interactions with her medication, the testing, the
12 eating, the incapacity. So they were responding to
13 that. On the front of the letter they said straightaway
14 we should have tested her on day five, after admission.
15 So she'd come in on the 19th. They should have tested
16 her, according to Scottish Government guidelines, on day
17 five, and they didn't, so they obviously didn't test
18 anyone in that ward on day five. They said they
19 don't -- they can't find the documentation around that,
20 as to why it wasn't done, but they can only apologise.
21 Q. Was there anything else that they apologised for?
22 A. They apologised for some lack of notes in terms of her
23 mobility and in terms of -- really all they were
24 apologising for was forms, admin, and that they hadn't
25 taken maybe proper notes or ...

1 On the first letter to me, they apologised for her
2 getting COVID in hospital. In this letter, they
3 apologised for not testing her on day five, and the rest
4 of the points were more or less dismissed to be honest,
5 apart from "We'll change admin on that" or "We'll change
6 this".
7 Q. Were you given any opportunity to follow up on the
8 response that you received from the hospital?
9 A. No, so that was the end of the complaints process with
10 the hospital. So I've now raised it with the ombudsman,
11 the Scottish --
12 Q. Scottish Parliamentary Ombudsman?
13 A. Yeah.
14 Q. Is that still ongoing or has it concluded?
15 A. Yeah, so that was raised in October and I haven't had
16 a response yet.
17 Q. Towards the end of your witness statement,
18 paragraph 138, you talk about lessons learned.
19 Paragraph 138 talks about GPs and presumably also
20 dieticians. Can you tell us what you mean by that,
21 what's in 138?
22 A. So it seemed to be -- I don't know if it was
23 a Lanarkshire Health Board directive or not, but
24 certainly I didn't hear of any GP visiting patients
25 during COVID. I did hear -- because I mentioned this to

1 someone who had a relative who was a doctor, a GP, and
2 they said -- she said, "No, he's been visiting
3 patients". So it seemed that -- whether it was a health
4 board decision or a GP decision, but it didn't seem
5 across the board. Some GPs were visiting patients at
6 home, some were not, and my mum's were not visiting at
7 home. No medical staff came in, and that's why we had
8 to rely so heavily on NHS 24.
9 Q. At paragraph 139 you talk about the failure to vaccinate
10 your mum once the vaccine became available because the
11 vaccine became available roughly at the point at which
12 she went into hospital. Tell me your ...
13 A. Yeah. So the family had asked this and they said it
14 wasn't appropriate in this case, I think.
15 Q. Well, if I was to give an answer like that to
16 Lord Brailsford, he would say, "That's a conclusion.
17 That's a conclusion and not a reason". Were you given
18 any reason that it was not appropriate?
19 A. No, I believe that it wasn't widely available at that
20 point and it wasn't being done in hospitals, is what
21 I was led to believe.
22 Q. At paragraph -- you then talk about your hopes for the
23 Inquiry at paragraph 141. What you say is, at 141:
24 "I will be honest, having seen other Inquiries,
25 I hope it does not become political and the truth does

1 not get swept under the carpet."
2 You continue:
3 "I also struggle with the fact that nobody is held
4 accountable. Although the findings may issue
5 recommendations to health boards [and governments], they
6 are not enforceable.
7 "I want the truth to come out and people held
8 accountable for the mistakes they made as well as
9 lessons to be learned. There should have been a degree
10 of planning before this happened. It seemed like it was
11 all reactive and haphazard. Guidance was changing by
12 the minute, and nobody seemed to know what they were
13 doing. The result was people ended up dying due to [a]
14 lack of proper planning.
15 Those final words, "due to [a] lack of proper
16 planning", is that your opinion?
17 A. That's my opinion, and in my last letter from the
18 hospital, when they apologised for not testing her, they
19 more or less said it was because Scottish Government
20 guidance was changing all the time. So they were kind
21 of saying it was hard to keep on top of it, I think is
22 what their message was on that. So because in my mum's
23 case they didn't test her -- had they tested her at that
24 point, had they tested anyone else in that ward, could
25 she have been saved?

1 Q. You don't know the answer to that?
2 A. I don't, no.
3 Q. Those are all the questions I have for you. Is there
4 anything that's important that we've not addressed?
5 A. I've read over my mum's notes again and I've mentioned
6 them several times here, the treatment escalation plans.
7 I find that a very -- I didn't even realise those forms
8 existed and apparently they only came into place during
9 COVID. They were adapted from another form. And it's
10 basically a life or death form. If you have that score,
11 well, CPAP or ventilation is not appropriate in this
12 case, and that was down to medical opinion and that
13 could be subjective. As in the case of my mum, one
14 doctor said she should get CPAP, the next one said she
15 shouldn't. So I would like to know more about these
16 forms and what they were used for.
17 Q. And a recurrent theme in your evidence seems to be an
18 absence of explanation?
19 A. Yeah, because I didn't pick up on them until recently
20 but they seem to have been a form used to make decisions
21 on the ventilation requirements.
22 Q. And that's because you only got the medical records and
23 the other materials and records --
24 A. No, no, no, I had been through it all before, but I must
25 have looked at it in more detail this time and saw it

1 was related to the DNR and then looked in more detail
2 and found she had three on her records.
3 Q. Anything else?
4 A. No.
5 THE CHAIR: Can I ask a question? The treatment escalation
6 plans you drew attention to at the very end, when you
7 were asked if there was anything you would like to
8 emphasise or say more about, I'll be candid. I've
9 looked at an awful lot of people's medical records over
10 the years and I've never heard of a treatment escalation
11 form. Can you tell me from your memory -- and don't
12 worry if you can't -- was it a form which was unique to
13 Monklands Hospital or --
14 A. No.
15 THE CHAIR: -- unique to a part -- this was a wider form?
16 A. Hmm.
17 THE CHAIR: Who was the author of the form?
18 A. Well, I understand it came from another kind of
19 treatment form that was introduced in 2016 and they
20 adapted it for COVID, for non-COVID patients. I think
21 it was to make sure the patient was not given treatment
22 they didn't need.
23 THE CHAIR: So it seems to have been a form that was in
24 existence prior to COVID but was adapted specifically
25 for it, and from the way -- no criticism of you -- the

1 way you've described it for me, it didn't emanate from
2 a single hospital, so it sounds as if it came from
3 a health board --
4 A. Yes.
5 THE CHAIR: -- something like NICE or something of that
6 order?
7 A. Yes.
8 THE CHAIR: Good. That's about as much as you can tell me
9 about it. No criticism intended. I think I've already
10 said I'd like to see the medical records in this case,
11 the medical records of your mother. I think we should
12 look into the issue of treatment escalation forms, if
13 you would put that --
14 MR CASKIE: Yes, it's quite unusual for us to ask for
15 medical records, but in this case I think there's
16 specific reason for doing so, so we'll issue an order in
17 respect of that.
18 THE CHAIR: Yes, thank you.
19 A. Okay.
20 MR CASKIE: I don't have anything else. Is there anything
21 else that you want to say?
22 A. No.
23 MR CASKIE: Thank you very much indeed for your evidence
24 today.
25 A. Thank you, thank you.

1 THE CHAIR: Yes, thank you.
2 Very good. Right. We've finished early again.
3 I've already asked if arrangements can be made, if it's
4 possible, with the next witness coming earlier, that
5 we'll start at 1.30. I don't know if that's possible or
6 not, but we'll hope to start at 1.30. If not, it will
7 be 1.45.
8 MR CASKIE: Yes, it's Ms Bahrami this afternoon.
9 THE CHAIR: I knew that. I would like a word with you
10 actually, please. Right, thank you.
11 MR CASKIE: Thank you, sir.
12 (12.25 pm)
13 (The short adjournment)
14 (1.30 pm)
15 THE CHAIR: Good afternoon.
16 MS BAHRAMI: Good afternoon, my Lord. The next witness is
17 William Scott.
18 MR WILLIAM SCOTT (called)
19 THE CHAIR: Mr Scott, in you come. Make yourself
20 comfortable, please, and you will be asked some
21 questions by Ms Bahrami.
22 MS BAHRAMI: Thank you, my Lord.
23 Questions by MS BAHRAMI
24 MS BAHRAMI: Good afternoon, Mr Scott.
25 A. Hi.

1 Q. Please could you confirm your full name?
2 A. It would be Billy Scott or William Scott, to give my
3 Sunday name.
4 Q. Thank you. And the Inquiry has your details?
5 A. Yes.
6 Q. You're aware that a restriction order is in place --
7 A. Yes.
8 Q. -- so please don't mention any names. You are able to
9 mention the name of the hospital but please don't
10 mention any individuals' names. Thank you.
11 Now, you've provided a statement to the Inquiry
12 about your mother; is that right?
13 A. That's correct, yes.
14 Q. And for the record, the reference for that statement is
15 SCI-WT0029-000001. Now, your mother sadly died aged 87
16 at the University Hospital Ayr; is that correct?
17 A. That's correct, yes.
18 Q. Prior to going into hospital, she'd been housebound but
19 she'd been happy and --
20 A. Yeah, she was housebound. She was -- she wasn't mobile
21 at all. Her movement was only to kind of transfer to a
22 commode, you know, for her toilet, but, yeah, she was
23 happy enough watching the telly, her friends came round
24 at times. She was kind of -- she was focused on getting
25 to her 90th but it was a few years away.

1 Q. Could you tell us a bit more about your mum?
2 A. I could tell you lots. Well, basically, my mum,
3 I suppose she was quite unfortunate in life. In 1971
4 her husband died, as did her mum and dad the same year,
5 and from them she brought up the three of us herself.
6 Once we kind of left the nest, if you like, she then
7 maybe -- she got into her bowling, so her bowling was
8 a large part of her life. A lot of her friends and that
9 were from her bowling so her life was her family and her
10 friends really. That's -- there's loads to tell, but
11 I could be here all day. I assume we've got other
12 things to get on with.
13 Q. Thank you. Now, you mention in your statement that on
14 27 April 2020, after the pandemic had started, your mum
15 developed a blood clot in her leg and was persuaded to
16 go to hospital; is that right?
17 A. (Nods).
18 Q. But she'd initially been reluctant as she was concerned
19 about catching COVID?
20 A. Yeah, she was reluctant to go and then, I think the day
21 before she went, her legs -- I think because she was
22 immobile, her legs got kind of bandaged a lot, so that
23 was obviously one of the issues -- probably the fact she
24 wasn't moving, she developed issues with her legs. She
25 had -- I think it was cellulitis in her leg and they

1 thought she'd developed a clot and they wanted her to go
2 to hospital just to check. Eventually the kind of nurse
3 phoned my sister, who persuaded her that she had to go
4 in, you know, just to kind of make sure -- to get the
5 clot treated or the suspected clot treated, and it
6 turned out that it was a clot, so if she hadn't gone in,
7 it would have been fatal anyway probably.
8 Q. Then your mother at that point was taken to hospital by
9 ambulance. Were you allowed to join her in the
10 ambulance?
11 A. No, my sister went to my mum's house about 1 o'clock and
12 the ambulance turned up at -- it was about 25 past 6
13 that the ambulance turned up. Once the ambulance turned
14 up, my mum was taken to the hospital and my sister
15 couldn't go with her, no. So that would be the last
16 anybody had seen her family-wise.
17 Q. So you weren't allowed to visit her in hospital at all?
18 A. No, not at all.
19 Q. Were you able to get updates from the hospital at all
20 about your mum's condition?
21 A. We did. The kind of rule of thumb was one person would
22 phone kind of every day because initially she was in
23 accident and emergency, then there was a kind of two-day
24 stay in a kind of reception ward, if you like, before
25 she went to a medical ward. Unfortunately, the first

1 phone call to the medical ward was not very good. It
2 was just to -- I don't know if it was the sister in
3 charge, what it was, but -- whether she was under
4 pressure or not, but it was a kind of -- she just --
5 I was like a burden the first day I phoned, which was
6 unfortunate because, when I phoned the second day,
7 I spoke to the same person. The only reason I knew it
8 was the same person, because of the huge difference in
9 attitude, was because she mentioned that I'd spoken to
10 her the day before, so it was a kind of bad first call.
11 But, you know, after that, I phoned every day. I've got
12 two sisters, but it was kind of -- looking at the
13 website, that was the kind of protocol. It was one
14 person phoning kind of once, which I did. So we phoned
15 every day, usually just me, but sometimes my sister
16 would have phoned as well, and we'd get medical
17 updates -- not the best medical updates, when I look
18 back at her medical notes. There really wasn't a great
19 update at all.
20 Q. So really what was going on wasn't being conveyed to
21 you?
22 A. No, it was, "She'd had a good night, she was on maybe
23 a litre of oxygen". It was basic information. My wife
24 was a nurse, so some of the basic information, you know,
25 my wife was kind of translating it for me, for want of

1 a better word. I don't have an understanding, but
2 I have a kind of idea, you know, what it was. I was
3 getting her oxygen stats, which is just a number to me,
4 but my wife was kind of, "That's not a bad number", and
5 then later on it did kind of drop below a kind of
6 acceptable level, if you like.
7 Q. After that first phone call -- you mentioned during that
8 first phone call you were made to feel like a nuisance.
9 A. Yeah.
10 Q. In subsequent phone calls, did that -- was that present
11 or --
12 A. No, no, it was only that one phone call. But the only
13 thing, I never really knew who I was speaking to a lot
14 of the time. You know, it was maybe a ward clerk or
15 a nurse that wasn't looking after my mum so it was
16 secondary information. So, in that respect, you know,
17 looking at WhatsApp messages between the family, you
18 know, it was a discussion -- we're kind of talking
19 between ourselves what might be going on, but it was
20 just -- basic updates was all we really got until --
21 I believe the first phone call from a doctor was on
22 12 May, which was quite a period into her stay.
23 Q. Okay, thank you.
24 Before that point, before the doctor had called you,
25 on 4 May you spoke to a nurse and you found out that the

1 clot had cleared and your mum was medically fit to go
2 home; is that correct?
3 A. Yes, she was on whatever they put her on for the clot,
4 it was either cleared or -- she was certainly medically
5 fit to go back home, yeah.
6 Q. But her discharge was delayed because the hospital
7 thought she needed more care at home and they were
8 arranging that?
9 A. Yeah, my mum certainly was a bit confused. Prior to
10 going into hospital, she had care twice a day. There
11 was carers in the morning and at night. That was
12 supplemented by a friend, who used to kind of cook her
13 meals for her. My sister used to go in at the weekend
14 and make the meals, and -- I was just going to say her
15 name there, sorry -- my mum's friend would cook the
16 meals, and much as she did very well, it probably hid
17 the fact that she needed more care. So in the hospital,
18 with their reservations -- and I spoke with the nurse
19 and it was agreed that, yeah, she probably needed kind
20 of care four times a day.
21 Q. Do you know why the arrangement of that care was taking
22 a while?
23 A. No idea. It was just, I suppose, there's a lot of
24 people needing care now and to increase it and --
25 possibly people off sick with COVID and stuff like that

1 as well, so it's not ... but, no, there was never
2 a reason given to say exactly why it was taking that bit
3 longer. And my mum was a nightmare at that time. She
4 just -- she literally phoned about a dozen times a day
5 between me and my sisters. She was dreadful.
6 Q. So you were still able to communicate with your mum by
7 phone?
8 A. Oh, yeah, aye.
9 Q. Were you able to have video calls with her?
10 A. No.
11 Q. No, just phone calls --
12 A. My mum didn't have that type of phone. I did mention it
13 to the hospital, but it was never an option because
14 later on, when I was going to visit, my idea was to
15 maybe take my iPad in so I could speak to my sisters as
16 well, but that never happened.
17 Q. While those arrangements were being made for the care at
18 home and your mum remained in hospital, what happened
19 during that time?
20 A. I know she was in station 6 in Ayr Hospital. I know she
21 got moved while she was in that ward and also the ward
22 was very quiet, but I never really thought anything of
23 it. I just assumed, you know, with people getting moved
24 to care homes, which was obviously a whole separate
25 issue -- but, no, we just contacted her every day.

1 Bizarrely, we could -- worked out really good, we could
2 take her washing home, which I found quite strange.
3 I remember asking the question, and the hospital saying,
4 "Yeah, you can come up and get it". There was like
5 I think two time slots. You could go up and you could
6 take the dirty washing and leave fresh nighties for her,
7 which I say was great for my mum. But it didn't come
8 with any washing instructions, which seemed -- again, my
9 wife, working there, usually when you take or get soiled
10 washing, some of it had been soiled, you would get what
11 you call "Athena instructions", but there was nothing.
12 Q. Okay, and that would presumably tell you the temperature
13 at which to wash or the cycle or setting?
14 A. Yeah. Again, my wife -- it was handy having her there,
15 but I did, in a later phone call, ask about washing and
16 I was told just kind of 60 degrees, but, no, I was
17 really -- aye, and then it was the same in the COVID
18 ward as well. You know, you could still get her washing
19 home, which ...
20 Q. During that time as well, your mum then caught COVID
21 while she remained in hospital; is that right?
22 A. Yes. I would say that's quite a debate between me and
23 the hospital about whether she actually caught it in the
24 hospital or not. I'm certainly convinced she did, but
25 the hospital kind of clung to the fact that she could

1 have brought it in with her because they kind of --
2 I think she tested positive on her seventh or eighth day
3 in hospital and it had to be the tenth day for it to be
4 hospital-acquired definitely.
5 Q. That would be the technical definition or the regulatory
6 definition as opposed to a scientific definition or --
7 A. I think at the time it was kind of -- whatever, it was
8 the definition that the hospital used for it definitely
9 to be hospital-acquired. It had to be the tenth day,
10 that was the tenth day for a positive test and albeit --
11 my mum tested positive on, as I say, the seventh or
12 eighth day, albeit she'd had two previous negative COVID
13 tests. She'd had a scan which showed nothing as well.
14 Q. Part of the reason -- you say in your statement I think
15 that part of the reason you believe she acquired it in
16 hospital is because there had been an outbreak in the
17 ward; is that correct?
18 A. Yes, aye. Station 6, I found out just after my mum died
19 that there had been an outbreak. I think 36 people had
20 been affected, which broke down as 26 staff members and
21 ten patients. So, yeah, the fact that there was an
22 outbreak in that ward. Nobody who my mum had contact
23 with developed COVID at home and she was immobile, so
24 Mum certainly couldn't have --
25 Q. So you think, "Where else could she have got it from?"?

1 A. Yeah, so ...
2 Q. You mention that you found that out later, that there
3 had been 36 people affected?
4 A. Yeah.
5 Q. So presumably you weren't told at the time or ahead of
6 your mother contracting COVID that there was this
7 outbreak. How did you feel about the hospital not
8 keeping you informed of outbreaks?
9 A. Well, there had been a few issues, you know, prior to me
10 eventually kind of complaining to the hospital, and that
11 was the straw that broke the camel's back because
12 I'd got my mum's kind of obituary in that paper, so I
13 turned up to get the paper -- excuse me -- and the
14 headline was "Outbreak in the COVID ward", so that was
15 the first I'd known about it. So, yeah, it was pretty
16 devastating, to be honest.
17 Q. Yes, finding out about it in the paper that your
18 mother's obituary appeared in?
19 A. Yeah, and her obituary was in it as well, so ...
20 Initially I was actually angry with the reporter, I have
21 to admit, you know, just putting in a sensationalist
22 headline, but then, when I read through it, and you
23 think, "Oh really, he's reporting what's happened", and
24 it was factually correct, what he'd written. Initially
25 I thought maybe it wasn't factually correct, but it was.

1 Q. Hmm-hmm. You go on to say that on admission your
2 mother's oxygen saturation was at the acceptable
3 threshold of 94% --
4 A. Yeah.
5 Q. -- but once COVID developed, took hold, it dropped into
6 the 80s. At that point was your mother given
7 supplemental oxygen?
8 A. My mum, from her first admission, was on and off one or
9 two litres of oxygen.
10 Q. Right, okay.
11 A. She was always kind of on oxygen. They weren't really
12 sure why, whether there was a secondary pneumonia or
13 something like that, but they were certainly always
14 working to get her off it. Sometimes she was off it and
15 I think -- I quote these numbers because I was told in
16 one phone call with nursing staff, "No, your mum's
17 maybe -- her oxygen stats are 91, for example", and
18 they're going, "There's no need to worry unless they
19 drop below 90". Then in a phone call -- I think it was
20 14 May -- her stats were like 88, so that was kind of
21 the first indication that it was maybe, you know, going
22 to be a poor outcome, if you like.
23 Q. Did they ever consider non-invasive ventilation like
24 CPAP or BiPap? Was that ever discussed?
25 A. I'm not sure. I know there's different types. She did

1 have -- it was -- the oxygen was just up her nose, as
2 far as I know, but I think later on it was a kind of
3 mouth -- it was, when she was on a kind of -- she was up
4 to like 50 litres of oxygen at the end. So that would
5 have been --
6 Q. But still just pure oxygen rather than a machine that
7 would forcibly push oxygen in?
8 A. No. Not forcing, no.
9 Q. And that was never discussed with you, never presented
10 as an option?
11 A. No because, if you look at my mum's admission notes, it
12 was kind of -- I think ward level care was how it was
13 mentioned, and there was a DNACPR on as well on
14 admission.
15 Q. Yes, and I'm going to come on to the DNACPR.
16 A. Yeah, okay, sorry, jumping ahead.
17 Q. No, that's okay. It's absolutely fine to bring that up.
18 Once your mother's oxygen levels had dropped
19 significantly and the supplemental oxygen was being
20 decreased, were you at that point kept updated? Did you
21 have to keep calling? Did they ever call you?
22 A. Most of the calls were myself to the hospital. I think
23 before the 12th -- I think the only phone call I got
24 from staff was from the nurse who was trying to arrange
25 the care. The first phone call I got was on the 12th,

1 from a doctor, and then I think subsequently on the --
2 in fact I got a phone call from the doctor on
3 the 13th -- sorry, the 12th, a different doctor on
4 the 13th, then the same doctor again on the 15th.
5 I think that was really the only calls I got from the
6 hospital.
7 Q. And did you find that helpful, to be proactively
8 informed?
9 A. I mention in my statement that it was actually nice to
10 have that update, and that's -- I think I've put that
11 that was on the 15th phone call. That was probably more
12 in relation to the 12th and/or 14th phone calls because
13 the updates were quite promising, whereas the 15th was,
14 you know -- that was kind of the day where you thought
15 she's probably not going to make it.
16 Q. Okay. Thank you.
17 A. But certainly the first update from the doctor, yes, it
18 was -- it was nice to speak to somebody at a bit of
19 length, get questions answered and get a proper update.
20 Q. You were then told that your mother could be discharged
21 from hospital notwithstanding she had COVID.
22 A. Yeah.
23 Q. But the only issue was the delay in organising the care
24 she needed. What did you think of that?
25 A. Aye, yeah, the fact she said herself, it would have been

1 nice for Mum, but -- yeah, it seemed quite bizarre, the
2 fact she could come home with COVID once the isolation
3 period was over and the family could get back in and
4 visit but -- aye, it was -- and I checked that as well
5 and that was correct, it could have happened. I think
6 it was my sister who had mentioned it and I spoke with
7 the hospital and she'd gone, "Yeah, that could happen".
8 Q. So if the care at home could have been arranged, your
9 mother could have gone home and after a period you could
10 have visited --
11 A. Yeah.
12 Q. -- but given her health being in the same condition you
13 weren't allowed to visit in hospital at all?
14 A. No. There was -- no doubt you'll touch on it later
15 on -- the end of life -- potential end of life visit.
16 Q. Yeah, okay.
17 Then you go on to say that -- as your mother's
18 condition deteriorated and the saturation dropped
19 further, you've told us that your wife helped you
20 understand what was occurring and explained things to
21 you --
22 A. Yeah.
23 Q. -- but you were then contacted by a doctor to provide
24 you an update and to prepare you for what might come?
25 A. Yeah, that was on the 15th I got the phone -- that was

1 the second --
2 Q. That's paragraphs 20 and 21.
3 A. Yeah, because her oxygen stats -- if I remember rightly,
4 it was on the 14th, the conversation with the nursing
5 staff. They said her oxygen stats were -- I'm sure it
6 was 87, 88, and, as I say, it was just internally
7 I thought, "Oh, that's the number they mentioned it
8 might be an issue". And it was on the 15th I get
9 a phone call from the doctor, for which -- yeah, it
10 was -- they were obviously very concerned. They were
11 putting her on a kind of water tablet, I believe, to try
12 and reverse, but the kind of next 24 hours were going to
13 be critical.
14 Q. On the Sunday morning, they called you and you say that
15 they called you to say basically that she was going.
16 A. Yeah.
17 Q. Can you tell us about that conversation?
18 A. It was probably quite a brief conversation. It was a
19 bit -- just before 8.00 in the morning. They just
20 said -- I suppose basically getting my permission --
21 they were going to withdraw care, and I was in agreement
22 with that, I wouldn't want Mum to suffer, so that was
23 fine.
24 Q. Did they explain to you why it would be clinically
25 appropriate to do that?

1 A. I think I was of the opinion that, if this water tablet
2 didn't work, her heart would be struggling to get the
3 fluid out her lungs and so on and so forth, so it would
4 just be a losing battle and you would just be prolonging
5 the agony. So I was kind of aware of that from previous
6 phone calls, conversations with my wife.
7 Q. You were also told during that phone call that if you
8 visited your mum at the end of her life, that you would
9 have to isolate for two weeks and you wouldn't be able
10 to attend her funeral; is that right?
11 A. Yeah, that conversation was in a phone call on the 15th.
12 Because my mum had deteriorated, the doctor said it
13 would be appropriate for an end-of-life visit, you know,
14 assuming the ward sister agreed to that. But it was
15 kind of one person, possibly two, but you had to fit
16 a kind of health criteria as well, which precluded my
17 sister, my older sister, going because her son has got
18 cerebral palsy and in the shielding group, her
19 daughter's a key worker, and my younger sister's down
20 south, doesn't drive, and she was kind of concerned
21 about the drive up, you know, because kind of
22 inter-border travel was not allowed at the time. I'm
23 sure it would have been okay, but my sister was
24 concerned about it. She doesn't drive, as I say, so she
25 was concerned about coming up. So it was kind of myself

1 that would be -- I was going to say left with the visit,
2 but it was me that was intending to go.
3 Q. When you were told that, that, you know, essentially you
4 were told choose between seeing your mum at the end of
5 her life or going to the funeral, what impact did that
6 have on you? What went through your mind? Did you
7 challenge that?
8 A. No, I didn't at all because -- the doctor initially just
9 said it was an end-of-life visit, she didn't mention the
10 kind of two-week isolation. It was when I phoned back
11 and then the nurse had said, "If you visit, you'll have
12 to isolate for two weeks", and, I mean, I should have
13 went anyway, it was stupid not going, but, you know, the
14 history of my dad and stuff like that, I didn't. And
15 I thought I would have to do the arrangements for the
16 funeral. I didn't -- as it happened, most of that was
17 remote anyway and I could have went in that respect,
18 but -- and there wasn't isolation for funerals, which
19 I didn't find out until I put my first letter of
20 complaint in to the hospital and they replied to me.
21 And when they replied, they gave me a leaflet which
22 outlined there was actually an exemption for funerals.
23 Q. But you hadn't been told that at the time?
24 A. No, and the hospital did -- I'm sure they apologised and
25 admitted -- well, admitted -- they said it wasn't on

1 their website at the time. So that certainly wasn't
2 there.
3 Q. So you'd been given incorrect information --
4 A. Yeah.
5 Q. -- and that's what led to your decision. You mentioned
6 there your father. You say in your statement you'd been
7 unable to attend his funeral.
8 A. Well, as a kid. They didn't want me to go, so that's --
9 Q. And that influenced your decision to --
10 A. Yes. Oh, definitely.
11 Q. Had you been given the correct information, would you
12 have visited your mum?
13 A. Yes. I mean, I still don't see why you'd have to
14 isolate after it because, I think, as far as I remember,
15 it was a short visit. You had to wear PPE and the nurse
16 I was with would have had the same PPE on and it just
17 seemed bizarre that I had to isolate after it, and --
18 sorry.
19 Q. Sorry, please continue.
20 A. The day after my mum died there was an article --
21 sorry -- a news report I think from Paisley Hospital,
22 and there's a BBC news crew in the COVID ward and they
23 were back on the telly the next night, obviously not
24 isolating, so it just -- I don't know if that was a --
25 I'm sure the hospital said it was a Scottish Government

1 guideline. I don't know. But it certainly wasn't ...
2 Q. You mentioned that it was a short visit you were
3 offered; is that right?
4 A. Yeah, I'm sure it was maybe kind of a 30-minute --
5 I don't think --
6 Q. So you weren't given the option of being with her
7 until --
8 A. No, and I'm sure later on -- hearing some of the other
9 evidence, I think later on in the pandemic people could
10 sit with loved ones, you know, at the end for, maybe a
11 longer, a longer period.
12 Q. Does that still have an effect on you? Has that stayed
13 with you?
14 A. Yeah, definitely, yeah. I mean, because I should have
15 went so, you know, I've kind of let my mum down in that
16 respect.
17 Q. Now, you go on to say that the Saturday before your mum
18 died, she called the whole family.
19 A. Well, yeah, we all managed to speak to her individually
20 or as a group because, bizarrely, you know, the phone
21 call from the doctor detailing how bad she sounded, when
22 she phoned she sounded fine. It was quite -- it was
23 crazy. You know, she was talking away -- considering
24 she'd be dead within 12 hours, she's talking to you.
25 Yeah, crazy. But, yeah, she did. I think all the kind

1 of close family spoke to her on the Saturday, yeah.
2 Q. Then you just mentioned within 12 hours your mum sadly
3 died.
4 A. Yeah.
5 Q. How did you find out about that? Did the hospital
6 contact you?
7 A. Well, as I say, 8 o'clock in the morning I got the phone
8 call from the hospital to say she wasn't going to make
9 it, so obviously I let my family members know what was
10 happening. And at about 9 o'clock, I think -- because
11 my wife had said to us, "Look, it might take a while
12 before she passes". About 9 o'clock I get a phone call
13 from my younger sister, who is quite a volatile person
14 at times, and she's going, "Has hospital phoned you?",
15 and I'm going, "No, they haven't phoned me". She'd
16 phoned the hospital just to pass on a message to my mum.
17 And the hospital is going, "Has your brother not phoned
18 you?". So basically, when my sister phoned, she had
19 died -- well, she died at 8.00 in the morning. I think
20 she died probably when I was on the phone, hence the
21 confusion that I would presume without knowing.
22 Q. So the hospital hadn't called you, they hadn't called
23 anyone else in your family, and when your sister called
24 them, they seemed to have the impression that somebody
25 had called you?

1 A. Yeah. There'd obviously been a confusion, presumably
2 because my mum's died so soon after the initial phone
3 call, you know, and, looking at the medical notes, she
4 was probably already dead when they phoned, you know,
5 apart from doing the kind of formalities, you know,
6 because it says in her medical notes they go into the
7 room and she's unresponsive.
8 Q. You say in paragraph 26 of your statement:
9 "When the staff took Mum off her meds she passed
10 away quickly. It was a mix up. I was upset but it was
11 just a mistake."
12 What do you mean by that?
13 A. Yes, that's got to do with the meds. I'm just saying,
14 once they phoned to say they were withdrawing care,
15 she'd obviously died very quickly.
16 Q. Okay, so it wasn't a consequence of medication being --
17 right, okay.
18 A. No, no. It was just a mix-up, but it was the fact that
19 they forgot to tell me there's been something happened.
20 I can deal with that, it's a mistake. People make
21 mistakes. It was difficult at the time -- don't get me
22 wrong -- but people make mistakes. Some of my other
23 later complaints seemed a bit more maybe hiding things
24 to a degree or whatever, and if you don't get the truth,
25 you're going to make up your own mind. Maybe that's

1 very far from the truth, but if you don't get the truth,
2 you just make things up, I suppose, or get your own
3 theories.
4 Q. Fill the gap --
5 A. Yeah.
6 Q. -- with, you know ... Did you make complaints about the
7 hospital and the care that your mother received?
8 A. When the article came out in the paper, I put in
9 a complaint regarding not being -- basically not being
10 told of the outbreak, and on the basis of some of the
11 mis- -- sorry, lack of information we received, I was
12 wanting to make sure my mum's care was as it should have
13 been.
14 You know, I didn't have any concerns about her care
15 because my mum phoned us on a daily basis and she had
16 never slated or spoke badly of any nurses or her nursing
17 care -- not that she was a complainer person, but she
18 would have mentioned if there had been any issues. So
19 we had no issues with her care, but I just wanted to
20 reassure myself and the family that that was indeed the
21 case.
22 Q. You mention also in your statement that you wrote to
23 your MP about the care received. He responded, telling
24 you that he couldn't do anything because it was
25 a reserved matter, and at that point you wrote to

1 Jeane Freeman --
2 THE CHAIR: Devolved matter.
3 MS BAHRAMI: Sorry, yes, a devolved matter. Apologies, my
4 Lord.
5 A. Because like when I -- because my mum's -- the story in
6 the paper, the headlines about the outbreak in the COVID
7 ward, it was -- my local MPs had an advert below that,
8 which is why I phoned my Westminster MP. He was
9 actually very good. He phoned us back a couple of times
10 to see how I was, you know, fair play to him, but
11 because it was a devolved matter, no, he couldn't get
12 involved in any issues with the hospital and it was at
13 a later date that I wrote to the Health Secretary. I
14 take it I can't name her either.
15 Q. I think it's fine to name her.
16 A. I emailed Jeane Freeman. Jeane Freeman's constituency
17 covers Ayr Hospital, I had initially written to her
18 constituency email, but because I didn't stay within her
19 in her catchment area, she couldn't take my complaint in
20 that respect. So I then forwarded her email to our
21 Health Secretary address because I'd messaged her in
22 relation to one of the briefings. They had mentioned
23 they were wanting to get accurate figures in relation to
24 nosocomial infections in relation to hospitals and
25 I thought my mum's was kind of a figure -- I don't know

1 where that figure is, if it's anywhere, the fact that
2 she died from it, and I don't know if anybody else died
3 in that outbreak either. I know staff didn't because
4 that would have then been reported to probably the
5 Health and Safety Executive, if staff had died from it.
6 Q. What response did you receive from Jeane Freeman?
7 A. If I remember rightly, the kind of target response time
8 is seven days or eight days. After that period had
9 elapsed, I didn't have a reply so I kind of got in touch
10 again, but I believe that day I did get a reply, quite
11 a sympathetic one, "Sorry your mum has passed" type
12 thing, and they were kind of looking into it. After
13 that it was all generic replies.
14 Q. Okay. Was it passed back to the hospital to look into?
15 A. After five or six emails, a couple of conversations,
16 they must have phoned the hospital because at that time
17 I had a meeting set up with the hospital in the November
18 and the guy that phoned just said, "I spoke to the
19 hospital. You're meeting with them, so you can ask
20 them". So it was like a kind of -- I don't know --
21 the Lonnie Donegan song about a little bucket. It was
22 just round in a circle and back to nothing, so it was
23 disappointing certainly from the -- because I thought
24 they were looking for accurate figures. I wasn't sure
25 how Mum was recorded and -- yeah.

1 Q. You wanted it to be recorded as COVID acquired in
2 hospital but they were recording it as --
3 A. Yeah.
4 Q. -- just COVID in general?
5 A. Because when I first got my mum's death certificate, it
6 said "COVID-19" and I didn't think much of it. But, you
7 know, you get hospital-acquired pneumonia as a death
8 certificate cause, so I was kind of wondering why it
9 wasn't hospital-acquired. So, yeah, I became rather
10 focused on that. I remember speaking to the Registry of
11 Scotland and other various groups and trying to get the
12 report from our hospital, from the outbreak there as
13 well, but didn't really get anywhere.
14 Q. Yeah, because later on in your statement, at
15 paragraphs 38 to 40, you talk about that and it seems
16 you were given conflicting information about whether
17 that could be recorded on a death certificate.
18 A. From my complaint, one of my issues was, "Why isn't my
19 mum's death down as hospital-acquired?", and the answer
20 to that was, again, back to the fact, "Your mum tested
21 positive on the eighth day so she could have brought
22 that in from the community so we don't know if it was
23 hospital-acquired", but -- do you want me to go on with
24 the ...?
25 Q. Yes.

1 A. Because at the meeting with the hospital, I asked the
2 same question and the doctor -- his explanation was that
3 hospital-acquired COVID was not something that could be
4 put on a death certificate. It simply wasn't a kind of
5 COVID -- whatever you want to call -- that they used --
6 Q. At all?
7 A. At all. You know, so it was an easy answer, but the
8 hospital were so defensive in relation to this. You
9 know, "Your mum might have brought the COVID in with
10 her". In fact, at the meeting, the doctor said, he's
11 gone, "Look", I don't know if he said, "I would gladly
12 put 'hospital-acquired'". Maybe that's not the right
13 expression, you know, but he would have been happy to
14 have made it hospital-acquired if that had been
15 something he could have. It wasn't him that wrote the
16 death certificate, though, but, as I say, it wasn't an
17 option.
18 Q. But, to his knowledge, that was just not something they
19 were able to write?
20 A. No, and, as far as I know, there's certain codes and the
21 wording you can use in a death certificate. Whether
22 it's changed now, I don't know, but that was the
23 explanation rather than all the kind of waffling about,
24 "Your mum might have brought it in with her".
25 Q. Did you discuss anything else at that visit with the

1 doctor and the hospital administrator?
2 A. I had a whole list of things to discuss. I've got
3 a huge folder and I touched -- they were very -- they
4 seemed genuinely, you know, willing to help. I was
5 supposed to go to the meeting with my sister, but she
6 stayed in North Ayrshire and travel between North and
7 South Ayrshire at that time was forbidden, so I went
8 myself and it didn't work out from my point of view as
9 well as it could have. I got a few questions answered
10 but there was certainly bits and pieces.
11 You know, the whole bit about -- you know, I was
12 never advised of the COVID outbreak. The hospital were
13 sticking to their guns that they did tell me, albeit
14 that they told me late, so I didn't get that resolved,
15 but I don't think I even brought it up. I got a bit
16 upset at the meeting so I didn't get as much out of it
17 as I should have, but, to be fair to the people there,
18 they did seem genuinely looking to help me.
19 Q. Thank you. You go on at paragraph 37 of your statement
20 to talk about really what happened after your mother
21 passed away. You say -- and you've already told us
22 about this -- that you were allowed to freely collect
23 her washing, drop off fresh washing, but following her
24 death you weren't allowed to just pick up her belongings
25 in the same way. They were put in a bright biohazard

1 bag?
2 A. Yes, that was -- on the day of her funeral, I went into
3 the funeral parlour just to collect her belongings.
4 They'd obviously taken it. They handed me this bright
5 yellow bag with "Biohazard" on it, which ...
6 Q. What did you think of that?
7 A. Yeah, that was a shock. That was ten days after Mum
8 died and it was just -- because obviously I was quite
9 embarrassed walking out -- there was only 12 at the
10 funeral, but you're walking out with this yellow bag to
11 put it in the boot of the car. So that was -- yeah,
12 that kind of brought home the whole emotions thing, and
13 then that. I'm sure the funeral parlour said, when they
14 collected Mum's body, you know, it was full PPE and it
15 was a closed casket and it wasn't her own clothes and
16 that, so -- you know, it was just a white shroud.
17 Q. But what did you think of that? Was your mum
18 a religious person? Would she have wanted --
19 A. She went to church, she did. It was a minister who took
20 the ceremony, so it was -- yeah, she was not overtly --
21 overly religious or that, but, yeah, she certainly went
22 to -- she hadn't been to church for a while because she
23 was obviously immobile, but, yeah, she was brought up in
24 the church and continued to go.
25 Q. For her funeral, were you able to carry out the

1 practices that otherwise would have been carried out or
2 was that prevented? You know, was there anything that
3 you would have done as part of the faith that your
4 mother had that you weren't able to do?
5 A. No. No.
6 Q. Okay, thank you. You also mentioned that you tried to
7 collect your mum's watch but that it was lost.
8 A. Yeah, that was -- when I got my mum's belongings back
9 from the funeral parlour, went home and went through
10 them, and her watch wasn't there. It wasn't a big
11 issue. To be honest, it wasn't an expensive watch. The
12 hospital actually focused on it more than I did. They
13 seemed to keep phoning about the watch, and I'm going,
14 "I really couldn't care less about the watch", but,
15 yeah, her watch was certainly missing.
16 Q. But the hospital was trying to help you to -- well, they
17 were trying to find it?
18 A. Yeah, I think the safe in the ward wasn't working or
19 something, they said, but -- not great, but it wasn't,
20 as I say, an expensive watch or anything.
21 Q. Thank you. Now, moving on to the issue of DNACPR which
22 you touched on before, could you tell us about the
23 DNACPR that was placed on your mum's file?
24 A. Yeah, I had discussions with my mum previously in
25 relation to that. My wife worked in a ward where she

1 carried out CPR and it's obviously a -- the actual CPR,
2 it can be a brutal, you know, experience. So we were in
3 agreement with my mum. It was my mum's wishes that she
4 wouldn't want it.
5 Again, looking at my mum's medical notes, on the day
6 she was admitted, there was a DNACPR form filled out,
7 which we weren't aware of. Again, I think I -- in the
8 conversation -- I think the second conversation with the
9 doctor, I probably asked about DNACPR because I was
10 aware of my mum's wishes and I was told then there was
11 one in place. But reading in her medical notes,
12 certainly twice -- at least twice, maybe three
13 occasions -- there was kind of a query if she understood
14 what it was.
15 Q. Did you hold a power of attorney for your mum?
16 A. Not in that respect, no.
17 Q. Do you think that your mum had capacity to understand?
18 A. She had understanding but she wouldn't have remembered.
19 Q. Okay.
20 A. You know, you used to go to Mum's and you would have
21 a conversation, then you would have the same
22 conversation a little bit later, which was kind of --
23 could be quite funny, I suppose, but -- yeah, she had an
24 understanding, but there was certainly issues with
25 retention of information.

1 Q. The doctor who told you that this was on the file, did
2 that doctor explain to you why it was clinically
3 appropriate or was there an understanding between you
4 that it was?
5 A. I think probably I asked the question with a view to
6 hoping it was -- wishing it was there, so I didn't
7 really, you know, go into the kind of whys and
8 wherefores. I was happy enough that it was in place and
9 they wouldn't be breaking her ribs in a kind of a futile
10 attempt to keep her alive.
11 Q. Now, we've touched on the day of the funeral, but if we
12 go on to the funeral arrangements themselves -- the
13 funeral itself -- you say that 12 people were allowed
14 and that actually worked well for your family.
15 A. Yeah, it was -- one of my sister's sons didn't want to
16 go, but that just -- so 12 -- we could [sic] have fitted
17 him in anyway because my aunt and her son went, so that
18 was the 12. If it had been 40, it would have been
19 embarrassing because I would have had to have invited
20 people, which I don't think it's appropriate to invite
21 people to a funeral, you know.
22 So in that respect, yeah, it was poor because there
23 was 12 of us there, you know, there's the hymns she'd
24 have wanted but it's just plain that we're not going to
25 be singing with 12 of us in the crematorium. A lot of

1 her bowling friends and that I don't know, so it would
2 have been nice to have met them as well. So, yeah, it
3 wasn't —— it was poor, but it was unfortunately the way
4 things were at the time.
5 Q. Thank you. Moving on from there, you say in
6 paragraph 43 that you don't think hospital staff were
7 wearing proper PPE outside the COVID ward, and I'd like
8 to understand why you say this. So, firstly, what
9 do you class as appropriate PPE and, secondly, what were
10 the staff wearing?
11 A. Right. I mean, I know there are different types of PPE.
12 I can only go on what my mum said because she said, "No,
13 the staff weren't always wearing PPE". I believe at the
14 time, when I went to the meeting, the instruction was
15 staff, when they were within 2 metres of patients in
16 non—COVID wards had to wear masks, et cetera, so my mum
17 would have seen them properly, if you like, maybe not
18 having masks on. Obviously that was within station 6,
19 as opposed to the COVID ward. I would make an
20 assumption that they would all have been wearing proper
21 PPE then.
22 Q. Yeah. So outside the COVID ward, it wasn't even that
23 they weren't —— according to your mum, it wasn't that
24 they weren't wearing proper PPE, it's that they weren't
25 wearing PPE ——

1 A. Yeah.
2 Q. —— at points?
3 A. Mum wouldn't know the difference between a paper bag and
4 a proper face mask anyway, so ...
5 Q. Is that something that concerned your mum, that there
6 were people around the ward without masks?
7 A. No, she —— when my mum was first diagnosed with ——
8 a positive COVID test come back, prior to us being
9 advised that she had COVID, I think my sister and her
10 friend —— my mum had phoned them to say, "I've picked up
11 some infection". So Mum was aware, but she wasn't aware
12 she had COVID. We thought it was maybe, you know, a
13 urine infection or something because she had a catheter
14 or something in, but —— so before we knew she had COVID,
15 we knew she had an infection, and then later on we found
16 out from the hospital that she'd tested positive for
17 COVID, which is what my mum's been told but not fully
18 understanding of what's happened.
19 Q. And the next section of your statement, you go on to
20 talk about the impact that the experience had on you.
21 Could you tell us a bit about that, the impact that it
22 had on you at the time and the impact that's continuing
23 now?
24 A. It's the same with everybody else, you know.
25 Everybody's going to lose their parents and it's going

1 to be horrific. The fact we didn't see her for three
2 weeks, it's devastating for us, but I think from my
3 mum's point of view ...
4 Q. Would you like a glass of water?
5 A. As a family, we got over it, but the fact that ——
6 I suppose she brought us up for all those years and to
7 not have the dignity in death that merited, it's
8 devastating. It's going to continue to be so. In the
9 three years since —— almost since she died, you know,
10 it's not that you can flick up wee happy memories, which
11 does happen, but every day it's a memory of the three
12 weeks —— you know, COVID has been mentioned every day,
13 it still will be for a number of years yet, and that's
14 all you keep thinking, is the three weeks that she spent
15 in hospital by herself, and she died, as I say, you
16 know, in anguish. Normally the family would have been
17 there to hold her hand, put her oxygen mask back on,
18 whereas, best will in the world, nurses ain't going to
19 be there all the time. So yeah, it is ...
20 Q. And nobody was allowed in?
21 A. Yeah, it's devastating. But, as I say, I will —— we
22 will live on and go on, but we can't change what
23 happened in the last three weeks, you know, of her life.
24 Q. Thank you. And, finally, you then talk about the
25 lessons that you believe should be learned and your

1 hopes for the Inquiry. Can you tell us about those?
2 A. Again, just —— we need an honesty, you know. My
3 statement, some of it may well, later on in the
4 pandemic, be better. It might —— hopefully it was
5 better for some people. But unless people are,
6 I suppose, honest, you know, and move on and learn
7 lessons, the same things could potentially happen again.
8 You know, nobody should die like that, you know. There
9 has to be proper stuff put in place. We have to be more
10 prepared.
11 Certainly without honesty —— and hopefully —— in
12 this Inquiry and the UK Inquiry, hopefully people will
13 admit their mistakes and we can learn from them because,
14 if people dig their heels in and say they've done well,
15 you know, they haven't. And that's fine. You know,
16 politicians have difficult decisions. People were going
17 to die anyway. But if they were made in the best of
18 intentions —— I can forgive bad decisions that were
19 made, but ...
20 Q. Do you think later —— well, at some point, there were
21 exceptions for end—of—life visits? Would that ——
22 A. I think that's ——
23 Q. The last period of life, do you think that's ——
24 A. Yeah, I think that's —— it's a must. You know, if I'd
25 been given —— it seemed to me that staff had a lot of

1 information changing all the time. Surely if the
2 Government are giving information to senior management
3 at that hospital, they can get that out in a kind of
4 proper format so that staff are aware of it, rather than
5 giving poor information, you know, to families.
6 Q. So you think part of the issue is that the information
7 hadn't been filtered down properly or uniformly?
8 A. Oh, I think so, yeah, because my kind of last letter
9 from the hospital after the meeting -- you know, I never
10 had any issues with staff, but the apology from the kind
11 of medical director was something like, "Sorry the staff
12 didn't keep you informed". I'm going, "That's not my
13 issue. The issue is the staff didn't have the tools to
14 keep us properly informed".
15 My daughter's friend just qualified as a doctor and,
16 if I remember rightly, she worked up in the north of
17 Scotland, I think she'd come back from her uni early so
18 that she could be in a liaison post, just for
19 communication. Whether that was different in different
20 boards, I don't know, but certainly Ayrshire and Arran,
21 everyone I spoke to will have Clerkesses. I spoke to --
22 in fact there was one phone call -- I phoned to get
23 results on Mum's scan and the nurse said, "I can't give
24 you information on the phone", and I'm thinking, "How
25 the hell am I going to get it?". That was -- I think

1 there was staff outwith their normal roles in wards that
2 they weren't sure of or didn't know, so it was more
3 difficult. So you have to be clearer in relation to the
4 information there, the information given out, to make
5 sure there's an understanding.
6 Q. And perhaps a point of contact for clarity to be sought?
7 A. Yeah. As I said, my mum's ward was relatively quiet.
8 I don't know if that was just because of the COVID
9 outbreak or if hospitals are generally quiet. I don't
10 know. But, yeah, I would think a kind of liaison
11 officer/nurse to kind of get the information -- have the
12 knowledge, maybe have time to phone or they phone the
13 relatives at a certain time to keep you updated,
14 because, looking at my mum's -- my mum's medical notes
15 probably answered more questions than anything because
16 I could go through them and you could see her care was
17 good, but there was certainly a couple of times it said,
18 you know, that my mum's temperature has spiked through
19 the night or COVID seems to have taken hold, and that
20 was like on 7 or 8 May. I had no knowledge until
21 the 14th -- 14 May -- that COVID was going to be
22 potentially fatal.
23 Q. Do you think that would have helped you to manage your
24 expectations better and to prepare yourself better, had
25 you been informed?

1 A. Well, yeah, if I'd been informed earlier -- maybe I was
2 in ignorant bliss, you know, until the kind of 14 May.
3 Up until then I just assumed -- again, my first
4 conversation with the doctor, she'd mentioned there was
5 a nodule -- the first kind of x-ray she got, it was
6 clear for COVID but there was a nodule that was possibly
7 cancerous. She was talking about that might be an issue
8 in a couple of years. So there was no indication that
9 this was a kind of life-ending thing my mum was going
10 through, until -- as I say, that conversation on
11 the 14th about her stats being under 90 just kind of
12 rang alarm bells for me and then the phone call from the
13 doctor on I think it was the 15th, where it wasn't
14 looking good at all.
15 Q. Thank you. Is there anything else that you'd like to
16 add that we've not covered?
17 A. Yeah, there was ... my big issue with the hospital was,
18 you know, they're not acknowledging the fact that they
19 didn't tell me I had COVID -- my mum had COVID --
20 sorry -- there was an outbreak in the ward. And the
21 first phone call from the doctor, the medical notes does
22 say -- let me just wait till I see it -- I've written
23 them down somewhere which is easy to find.
24 Q. Just take a moment.
25 A. Yeah, on the 12th I got a phone call -- it starts off

1 saying it was a general update, but further down the
2 page it says, you know, my mum's COVID is the result of
3 an outbreak in station 6 unfortunately. So that's what
4 they're basically -- you know, the doctor did say in her
5 notes that we discussed the outbreak. We didn't.
6 I can actually kind of still remember the
7 conversation because the fact that Mum had COVID and my
8 sister was with her for five/six hours till the
9 ambulance came -- I know her daughter contacted the kind
10 of COVID helpline to get advice on whether she should be
11 going to work, with whether she would be positive at
12 all, and their advice was, you know, there was two
13 negative tests, "Unless you're showing symptoms, you
14 should be okay".
15 The fact that they continued to say or apologise for
16 telling me late as opposed to never telling me at all,
17 I really -- I ... It's pretty distressing, the fact --
18 if we can call a liar. I'm not saying the doctor was
19 lying, but I'm sure she was aware of the fact there was
20 an outbreak on station 6 and maybe assumed I knew, and
21 the conversation was round that, you know. And the
22 outbreak was over on 9 May, that conversation was on
23 12 May and a doctor from a different ward. So it
24 doesn't make any sense, the fact that that was me told.
25 Q. Okay, thank you.

1 A. And the politicians as well, just to mention briefly the
2 UK politicians.
3 THE CHAIR: I don't have any jurisdiction in relation to
4 them.
5 A. No, it was just an issue. First impressions, as
6 I mentioned earlier, is quite important. The first
7 impressions from the UK Government was quite a kind of
8 flippant, "I'll shake hands with everybody and wash your
9 hands to Rule Britannia". Then my second kind of
10 indication that they maybe weren't taking it that
11 seriously was the Barnard Castle kind of thing, which
12 was the day after my mum died, and you've got
13 politicians defending a kind of schoolboy attitude to
14 breaking guidelines and then obviously latterly
15 Partygate and stuff like that.
16 So I certainly wasn't impressed with the
17 UK Government. The Scottish Government came over better
18 in briefings, but I obviously wasn't that impressed when
19 I actually reached out for help from them. That was ...
20 I don't think -- would you mind if I flick through my
21 notes just in case there's anything?
22 Q. Sure.
23 A. I don't think ... I think I've covered everything.
24 (Pause)
25 I'd also -- sorry, there's another thing. Yeah,

1 after my mum passed, I kind of made different enquiries
2 to different bits and pieces, and the COVID outbreak on
3 my mum's ward, I was told it was referred to
4 Health Protection Scotland. Then I contacted them to
5 try to get the report, but I didn't get anywhere. But
6 there was also a subsequent article in the
7 Ayrshire Post, a local paper, maybe two weeks after my
8 mum died, saying that the person who wrote it, some
9 health tsar, whatever, he reckoned it should have been
10 reported to the Health and Safety Executive. I don't
11 know. It wasn't reported to the Health and Safety
12 Executive. But when I asked the question, "Was my mum's
13 death recorded as part of the outbreak?", the answer
14 was, "All deaths were reported to Health Protection
15 Scotland". They didn't categorically say, "Your Mum's
16 death is part of that outbreak", because that outbreak
17 was over the 9th, Mum didn't die till the 17th, so in
18 theory -- it would just be nice if -- as I say, she died
19 a kind of poor death -- if it was certainly recorded
20 somewhere that she acquired it in hospital because,
21 again, if we don't have accurate figures, how can we
22 move on and learn properly?
23 MS BAHRAMI: Thank you. I don't have any other questions
24 for you. Thank you very much for attending today.
25 A. No problem at all.

1 THE CHAIR: Thank you, Mr Scott.
2 A. Thanks for the time.
3 THE CHAIR: Very good. 10 o'clock tomorrow morning.
4 MS BAHRAMI: Thank you, my Lord.
5 (2.31 pm)
6 (The hearing adjourned until
7 Wednesday, 6 December 2023 at 10.00 am)
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