

## Scottish Covid-19 Inquiry

### Witness Statement

Statement taken at 1100 hours on Thursday 5 October 2023 on videoconference. Witness Number is HSC0078.

Witness interviewed by Witness Statement Taker [NR] Statement noted by Paralegal [NR]. Consent Form signed.

### Witness Statement of Amanda BURNETT

#### Background

1. My name is **Amanda Jane BURNETT**. I am 55 years of age, and my date of birth is [PD] I live at [Personal Data] I work at the British Broadcasting Corporation (BBC) as a Producer.
1. I am willing to provide a statement and have my information contained within reports. I am aware that my statement will be published, and that I can withdraw my consent at any time.
2. I have previously provided notes to Aamer Anwar & Co Solicitors and Notaries. I am happy for you to use these notes in my statement.
3. My father is [NR] He was known as [NR]. His date of birth is [NR] He passed away on 17 January 2021. He was 82 years old when he died. He lived [Personal Data] in East Dunbartonshire with my mum. Dad worked at Scottish Power (then SSEB) and was in charge of the west coast region until he took a redundancy in his mid-fifties.
4. My dad was admitted to Gartnavel Mental Health Unit at Gartnavel Royal Hospital located at 1055 Great Western Road, Glasgow G12 0XH. He was transferred to Queen Elizabeth University Hospital at 1345 Govan Road, Glasgow, G51 4TF, where he passed away. The local authority was East Dunbartonshire (area of residence, not hospital). The Health Board was Greater Glasgow and Clyde.

#### Before the Covid-19 pandemic

5. Dad lived independently with my mum. He had barely seen a hospital in his life. He was very fit, healthy and mobile.
6. In 2019, my dad started to wander and his speech became a bit tricky. It was manageable during the day and he would still drive, do the weekly shop and went on a cruise with mum that year. It was just little things in terms of behaviours and mood that the family noticed a change in.
7. In 2019, we raised our concerns with [NR] and [NR] at [NR] [NR] I called [NR] and [NR] on various occasions and

spoke to them about dad's symptoms. I thought dad had depression, but [NR] [NR] said it could be dementia. [NR] saw dad but no referral was made. Dad passed the memory tests but that's not unusual. After some more conversations over 2019, [NR] eventually instigated a memory clinic referral.

8. On 29 January 2020, staff from East Dunbartonshire Older People's Community Mental Health Team, Glenkirk Centre, G15 6BN visited dad at home and did some basic testing. The staff member spoke with dad and decided to do a bit more digging around dad's speech and language and the way we felt his behaviour was changing.
9. In March 2020, dad was referred to Glenkirk Centre, which is a memory clinic in Kirkintilloch. I believe it is the memory clinic where most East Dunbartonshire residents go for specialist referrals.
10. On 11 March 2020, my dad had an appointment at Glenkirk Centre with [NR] [NR]. At this point lockdown was coming. They planned on getting an MRI scan, but dad didn't get the MRI before we went into lockdown. I wasn't there for the appointment because I was at work. Mum told me she received a call from the consultant to cancel the MRI because all non-urgent scans were being cancelled.

### ***Lockdown in March 2020***

#### **Lack of diagnosis and support**

11. In March 2020, we started talking to different agencies about help and support during lockdown. As dad was undiagnosed and not already in the system there was no support available.
12. At this time, I was still working as I was classed as critical for broadcasting. I was having minimal contact at work, we were wearing masks and social distancing. I only went into a studio in the evening once or twice a week with 1 other person to broadcast and worked remotely and at home on preparation. I was effectively bubbled with mum and dad.
13. I took on a lot of the support for mum and dad. I set up an online food shop. I was calling a lot of different organisations to try to get support for dad. It was like playing phone tag. As dad was undiagnosed before the lockdown there was no support offered at all. The journey of diagnosis was paused. There was nothing, no appointments, no assessments and no home supports. We had to manage ourselves as a family unit.
14. Doctors were not offering any social support. I quickly discovered health professionals work in very different units with very little communication or sharing of information or support plans. The GP did not want to see mum or dad in person. Glenkirk was not conducting assessments or scans.
15. Whenever I spoke with the doctor they were unable to practically assist and would suggest different prescriptions to 'try' to manage Dad's agitation. On one occasion a Dr who had never met Dad prescribed haloperidol over the telephone with no discussion about side effects and risks.

16. I reached out to a local charity – Carers Link - that offered to call mum on a regular basis to check in. They could not come to the house, but they offered some advice and support over the phone.
17. A Memory Clinic Dr eventually agreed to a home visit requested by us in summer. She confirmed she thought Dad had dementia but not exactly which type. She gave him her diagnosis and left with no additional advice or support. No leaflets or signposting.

### **Impact of the lockdown**

18. Dad struggled through the first lockdown. It was difficult for him to comprehend that all of a sudden everyone had to wear facemasks, he couldn't go to his favourite cafe and he wasn't allowed to hug a friend he had known for years. The world was topsy turvy enough for everyone at that time, never mind someone like dad whose perception was shifting because of a disease.
19. I was concerned with Dad wandering every night. It was really dangerous. I think his night wandering escalated during lockdown because he had no social interactions during the day and was not able to go out.
20. Mum was finding it increasingly hard. Mum was a woman in her late 70's (she is now 81). She was up all night because dad was not sleeping, other than 1-2 hours of sleep at dawn. He would get out of the house and walk the streets. When this happened, either Mum or I would go out, find him and take him back home. All of this would happen around 2am in the morning then I would have to get up in a couple of hours for work.
21. The impact on mum and I was really tough. We felt like we were on our own. I had the underlying anxiety of the pandemic, including being very conscious of symptoms and death numbers, along with the practicalities of living every day. I had to manage supporting my daughter with remote learning, going into work to deliver live programmes while also making sure mum was supported and dad was ok.

### ***Easing of restrictions in August 2020***

22. On Saturday 1 August 2020, we went to Crieff Hydro for some family time with mum, dad, my sisters family and my family. We weighed up the risk and thought it would be beneficial for mum and dad to see the grandchildren. That's what dad and mum live for. That trip was the last time our family were all together in person.
23. A family trip would normally be a lovely time for dad, however we realised very quickly that he found it overwhelming. It was quite challenging being there. During the family trip dad found it really difficult for mum to be out of sight and did not relax and enjoy time with his grandchildren, which was so out of character. We had to ensure he was not left alone at any point in case he disappeared.
24. On Sunday 2 August 2020, I drove mum and dad home. When I left mum and dad were unpacking and putting food in the fridge.

25. Later on Sunday evening, I got a flurry of phone calls from mum. Mum told me she had locked herself in the bathroom. It was shocking to me that she would be scared of dad. It still doesn't feel real.
26. Mum told me dad tried to get out of the house which was all locked up. Mum had previously been advised by the local charity workers to lock every door and window. I had been a bit alarmed at doing this in case there was a fire.
27. Dad had been trying to get the keys out of mum's hand and it had escalated. Mum said that dad had tried to climb out of the first-floor window. Mum had been calling the whole family trying to get someone to pick up.
28. After I spoke to mum, I got in my car to drive there and rang the Crisis Number run by the Memory Clinic. They told me they could not help. I called the police. The police arrived quickly and mum and dad were both safe. The police were very supportive. They told me that they spend a lot of nights picking up vulnerable people. The police said this incident needed to be flagged so that we could receive urgent and essential social care support. They wrote a report that helped kickstart things into action.
29. On Monday 3 August 2020, the following morning, the police let me know the report had been sent off. Soon after the memory clinic were in touch and agreed to come out and see dad.
30. The woman from the memory clinic was named [NR] and I am not sure of her title. [NR] asked me what I wanted to happen. I told her I wanted dad to be assessed, for a care plan to be put in place and to have a safety plan so that mum and I can manage it. I told her that if dad needed more care, I wanted to know what options were open to us.
31. [NR] thought dad might be agitated because of a urinary tract infection (UTI) and told us this can affect peoples behaviour quite badly. She told us that there was a unit in Gartnavel Royal Hospital (**Gartnavel**) where dad could go in for a day or two to be assessed. She asked if Mum could pack an overnight case for Dad in case it was needed and did I think that Dad would go with her and colleague to Gartnavel willingly. I said that I thought he would with Mum reassuring.
32. [NR] visited mum and dad's house with her colleague that day. I was working so I was not able to be there. [NR] spoke to mum and dad and decided not to refer dad to be admitted. I rang Mum to find out how the meeting had gone. My mum was tearful and incredibly upset that there were no options for support. I phoned [NR] urgently to find out more. She said dad was calm and there was no need for him to be admitted. I was incredibly angry and told [NR] I was concerned about mum's welfare and dad's safety. I told [NR] that I wanted to hear from the consultant [NR] within an hour. I explained that mum and dad could not be left in an unsafe situation.
33. [NR] of East Dunbartonshire's Older Peoples' Mental Health Service called me. [NR] was not based at Gartnavel and dropped in to assess and treat clients at Gartnavel Royal Hospital Cuthbertson Ward (the elderly care unit). After I explained what happened the night before [NR] agreed dad should



be admitted for assessment. [NR] asked if we could pack an overnight bag for dad and drive him to Gartnavel Royal for admittance that night.

34. We were not given any indication of how long dad was being admitted for. The plan was for dad to be assessed face to face by a specialist doctor. We assumed he would only be in there for a couple of days.
35. Gartnavel had secure wards with locked units. The Cuthbertson ward that dad was placed in had elderly patients with severe challenges. I was not sure that dad needed to be in a ward like that, but it was the only option at that point given the danger he and Mum had been in the previous night. Gartnavel also had a general hospital on the campus in a different building.
36. At that time the Glasgow's tier was lower, so I thought the hospital would be safe. Given that he was not getting any support at home I thought this was the best option. I felt like there was a window of opportunity and I did not want to miss it. I wasn't aware there was another wave of covid coming.

### ***Gartnavel Royal Hospital***

#### **Admission**

37. I drove mum and dad in to Gartnavel. I was allowed to walk into the building with them but I wasn't allowed past the door of the unit. Mum was allowed to enter to help dad be admitted. That was the last time I saw dad. I did not even get a hug goodbye.
38. When dad was admitted mum had to fill in a very brief getting to know me form. I didn't know it at time because I was not involved in the admission. When I saw the form later I couldn't believe how brief it was. It was a really minimal A4 sheet. There was no attempt by staff to expand on it as dad's weeks in hospital went on. There was nothing about his interests. I got another one and filled it in in more detail.
39. After dad was admitted, it was explained to us that he would be tested for Covid 19 and then isolate until a negative test came back. He isolated in a room to himself with a bathroom and shower. I felt like that would be challenging for dad because he was used to always being with mum and rarely away from home without her company. I assumed that because they are specialists, the nursing staff would know how to welcome and reassure him.
40. I do not know how many people were in the ward. I believe dad had his own room when he got out of isolation.

#### **Treatment and care**

41. I was not allowed to visit dad and mum did not speak to me about his treatment and care in specifics. She was just happy to see him. Mum and dad would have a chat and have tea and biscuits. No body spoke to us about treatments initially.
42. [NR] colleague, [NR] phoned during lockdown to say they thought dad had dementia and Alzheimer's. [NR] said they could not tell us what type or be more specific because there were no scans at the time.

43. The doctors stripped away all dad's medication and started him on new ones. It was clear that [NR] wanted to get dad's medication right before discharging him. I was not aware of any care plan.
44. During this period, East Dunbartonshire Social Care got in touch to assign a Social Worker and deliver a door sensor/alarm. Neither were of any use at this point.
45. I would get a weekly call from the [NR] after their meeting. All meetings and assessments etc were being done behind closed doors. It was particularly difficult as there was no advocacy for dad. Sometimes the call would be conducted by a Nurse. They were not scheduled so it was hard to know when to be available and for how long.
46. I asked about a discharge date. I was told they were still trying to work out the right mix of medication and support at home. [NR] was always vague about discharge. Some weeks I got the sense we were in a spiral of trying treatment and trying something new and dad reacting. I felt this was a never-ending journey. And to whose benefit was all of this?
47. [NR] said it might be worth considering a care home. I did not really understand the care home options or finance implications. There were no support services to tell us about the different options. I read so many leaflets but they were no help. I felt like I was being sent down a path with minimal information.
48. We did look in to care home options and it gave us something to focus on. We were not allowed to see inside any care homes or meet managers face to face. Everything was conducted remotely. We were worried about him going into that environment. Ideally, we really wanted him home.
49. Towards the end of the year the doctor said dad could be out for Christmas. At that stage cases were rising and we felt strongly that he was more at risk of catching Covid staying at Gartnavel where there was more mixing.
50. Christmas came and dad was still in Gartnavel. My goal was to get him home. [NR] [NR] said it was unlikely dad would get home as he needed 24-hour care. I challenged this on the basis that dad could have come home with care. Mum and dad were in a position to facilitate this.
51. I was desperate to get dad out. I hadn't seen him in person for nearly 5 months. He was clearly upset and distressed. He was missing us like mad. I thought if we couldn't get him home immediately, we could move him into a care home for further assessment and put things in place at home. We would also be allowed visits.

### **Violence and assaults**

52. I was told by a nurse that dad had been assaulted while on the ward by a new patient.
53. He was assaulted several times. Sometimes we were told, sometimes not. I do not know if the incidents were reported to the police.

## Visitation and restrictions

54. For the first month mum was allowed to visit. I would drive her to the hospital every day and she would sit with him for the visiting session. That was helpful for both of them. She would take dad's clothes home to wash so she felt she was still doing something for him.
55. Mum didn't express any concerns. I think it was tough for dad when mum left the visit. I was told that every time she finished the visit he wanted to leave with her and it was distressing.
56. In September 2020, Glasgow went into a higher tier and visiting was stopped. No one told us. I had seen the news and phoned Gartnavel. Initially they did not seem to know what was happening. Later Gartnavel confirmed that mum could no longer visit. I could still drop gifts and comfort items off at the door as long as it was pre-planned.
57. I started thinking about how we could visit dad as family and routine was very important for him. I argued for mum and dad to be able to have garden visits because mum was at home not mixing with anyone. It would have been beneficial for both mum and dad's health. I suggested garden visits to staff on the phone and when I spoke to [NR] [NR] operated at a distance because he didn't always work in the Cuthburston ward.
58. It felt like there was no real line of command in that ward when dad was in there. I was not clear who the head of the ward was and who to direct questions to. It felt like a lot of people were not quite sure who could make decisions. Only this year I discovered the manager of the ward was signed off as shielding.
59. Ultimately, Gartnavel were not willing to have garden visits even though they had a closed garden. Gartnavel were inviting musicians and artists into the garden for entertainment. I am not sure if these people were tested. I thought it would be more beneficial for my dad's wife to be allowed in the garden, rather than strangers playing music. I was not told why it was not possible for mum to have garden visits. They didn't really seem to be thinking about the patients.
60. Not being able to visit dad had a devastating impact on mum. We were still trying to understand why he was in that unit a month after he was admitted. There was no information coming out. Mum had nothing else going on in her life. Her life absolutely stopped when dad went in and revolved around her visit, doing dad's washing and her next visit.
61. I felt there was a lack of flexibility in terms of active visiting procedures that would be beneficial to patients. There were exceptions laid out in their guidelines, and it included exceptions for dementia patients. 'Essential visits include, but are not limited to...supporting someone with a mental health issue such as dementia...where not being present would cause the patient to be distressed.'
62. I wrote a complaint to our MSP, Rona Mackay. I got a response via Ms Mackay from Greater Glasgow and Clyde National Health Service (GGC NHS) on 9/12/20 saying that visiting would only be allowed if they felt the patient was in distress.

They said dad wasn't distressed. (Jane Grant letter 9/12/20) ...the clinical view is that family members not visiting him is not causing him distress.' On one zoom call, Dad expressly said 'I wish I was dead', 'What's the point?' and 'Why can't I see you'. The nurse present said she would document this.

63. It was becoming harmful to dad's health not being able to see anyone. We noticed the changes in him as the weeks went on. Dad was struggling with dementia, dealing with it in a pandemic, shut off from everyone he recognised and knew and loved and living in an environment where he got assaulted by other patients.
64. We tried zoom calls. We thought these would be beneficial for dad, to let him know we had not forgotten about him, but dad regularly got up and walked away in distress.

### **Power of attorney**

65. Mum had power of attorney and I helped her support dad. Having power of attorney was pretty meaningless during lockdown because mum was not able to visit and was not aware of what was going on. It felt like dad's advocacy and rights to make healthcare decisions were meaningless. No one was in the room to support dad and we weren't invited to contribute to decision making.
66. Having a power of attorney is a safety net for your loved one, that was the intention. This was worthless in lockdown.

### **Infection control and testing**

67. The staff were wearing masks and I think maybe plastic aprons. I can only comment on what I saw during the zoom calls as we weren't allowed to visit. If we were dropping stuff off at the door for dad the staff would have masks on. I remember they were very careful with presents at Christmas. They said they would need to isolate them.
68. Although it was a secure unit, it was not a prison. I am aware the patients were moving freely and mixing within the unit. There must have been mixing because there were occasions where nurses told me dad had been assaulted.
69. I will never know exactly what went on because I was not allowed in. I don't know whether staff were adhering to protocols or how often they were testing. I had no idea about guidelines for testing of staff or residents. Dad just went into a black hole.
70. I don't know how strict they were about wearing masks. During a zoom call my partner noticed the nurse was not wearing a mask. On another occasion, mum went up to the door to visit and she was told she didn't need to wear a mask because she has asthma. Mum was taken aback by this because she had always worn masks and it did not affect her asthma. Mum used hand sanitizer and wore a mask whenever she visited.
71. I don't know if there were regular admissions and / or discharges. However, during a call about dad being hit by another patient I was told the incident involved a new patient.



## **Vaccinations**

72. The vaccinations started. I was overjoyed. I had not seen dad in nearly 5 months at this stage. I got a copy of the Scottish Government's Vaccination Programme Covid 19 Service Delivery Framework Wave One Document (9/12/20).
73. From 7 December 2020, the framework said priority groups including long term inpatients over 80 years old were to receive a vaccine. My dad fitted into this category.
74. From 14th December 2020, the vaccine was due to be rolled out to care home residents.
75. Dad should have been in the first lot to be vaccinated. If they were going to keep dad in Gartnavel I was desperate for him to get the vaccine as he was very vulnerable.
76. I could not understand why dad had not received a vaccine as the days ticked by. I was hearing about unit staff, doctors. Non-patient facing administrative staff working from home were receiving vaccines and being offered 'spare' doses. No one could tell me when my dad was going to be vaccinated.
77. I would ask questions about dad getting the vaccine to anyone who would listen. This included [REDACTED] NR and every nurse I spoke to. I did not know who else to speak to. I made lots of phone calls. I wrote letters to my MSP, Rona Mckay. I tried to find the name of the person who was in charge at Gartnavel. I sent him an email but never received a reply.
78. I am still waiting for an answer as to why dad was not vaccinated. I have been told by the police that they know whether others in the ward were vaccinated.

## **Outbreak of Covid-19 at Gartnavel Royal Hospital**

79. I was very upset as dad wasn't discharged for Christmas. I was very worried as people were starting to mix again. During this period people were being encouraged to relax and spend time with their family. I could see that after Christmas there would be a higher chance of an outbreak in the ward. Regular staff would be mixing, knowing they were vaccinated, and temporary staff would be coming in and out of various settings.
80. Dad was still wandering and I was told it would be challenging for a care home to look after him. I was considering one to one care at home. I found it really difficult to find out information. It felt like I was trying to ask the right question to elicit an answer and not getting anywhere. It was hard to make decisions without information and engagement.
81. On Saturday 9 January 2021, we had a zoom call booked with dad. We received a call from the ward to tell me dad had covid symptoms and they had tested him. I was told that dad had a temperature that was being well managed by paracetamol.

82. I was told there was an outbreak in the ward. They didn't say how the outbreak occurred or if anyone else tested positive. I was told dad was being isolated. He would have been terrified. We weren't offered any other communication with dad. I was very angry because this outcome was absolutely predictable. I knew dad would have been increasingly likely to catch COVID after Christmas and less able to fight infection as he was unvaccinated.
83. I felt like everything, all their processes, just seemed very haphazard or non-existent. Some days you would call Gartnavel and the phone would ring out. Other days a nurse would answer and be very curt. I felt like they would not tell you how dad actually was, for example whether he was eating and sleeping well. When I asked if I could speak to dad I was given a vague rebuttal. Occasionally someone would pass the phone to him if he was nearby. Dad was never really able to communicate the impact because there was always someone sitting right on his shoulder. There were people coming and going from his room all the time.

***Events leading to dad's death***

84. On Monday 11 January 2021, dad's test result came back positive.
85. On the morning of Tuesday 12 January 2021, I was told dad slept well into morning and his temperature was well managed with paracetamol.
86. On the evening of Tuesday 12 January 2021, I got a call from a doctor at Gartnavel to say that dad's oxygen levels were down to 84 and they thought it best to move him to Queen Elizabeth Hospital. It was a doctor I had never spoken to before. The doctor had called because he wanted to let the family know dad was being moved by an ambulance that night. I was told I could not accompany dad in the ambulance.
87. Later on the evening of Tuesday 12 January 2021, Dad was transferred to the Queen Elizabeth Hospital. I couldn't get in contact with anyone at the hospital that night. I think dad had been in various places within that hospital. It felt like no one knew where he was or what was happening. I was calling any number I could find on the internet. My sister and I were both trying desperately. I realise that the last thing staff want to do is pick up a phone when they are busy saving lives. I just wanted to know where dad was.
88. Some time within 24 hours of receiving the call from the first doctor at Gartnavel, I received a second call from [NR]. I told [NR] I was very angry because I had been trying to avoid this. [Name Redacted] started talking about putting a Do Not Resuscitate (DNR) in place for dad. I was furious talking about the potential that dad could lose his life. This could have been avoided if he had the vaccine. After the call with [NR] I thought I actually don't think [NR] [NR] should be phoning me, he should be speaking to mum. I phoned back and left a message with his personal assistant to call mum.
89. On Wednesday 13 January 2021, I eventually got to speak to a Dr at the Queen Elizabeth Hospital. The Dr said dad had been sent by Gartnavel and that DNR's were being discussed.

90. The consultant said dad was quite distressed. Dad wouldn't keep his mask or gown on. I could hear dad in the background in a very distressed state. The Dr asked what was wrong with him. It felt like the Dr was dealing with dad like he was a problem patient. I asked if they had read dad's notes and knew that dad had dementia. The consultant had not seemed to realise this.
91. The Dr told me that a chest x-ray showed that dad's lungs were severely affected, and he was not going to survive this. The consultant said all they could do was make dad comfortable. I offered to come in or speak to him to try and reassure him. I was told no, I wasn't allowed in. I asked about zoom calls but was told there wasn't an iPad available to facilitate that. I knew it was important that dad saw us. Dad had no problem with recollection, he knew who we were.
92. Dad was denied the comfort of his family. For him to get to the point that he was so distressed and alone is shocking to me. Dad's instinct was to get his mask off, put his clothes on and go home. I just wanted mum in the room. Mum did not care about catching covid, she just wanted to be with dad. I was told mum could not go in until the final hours of dad's life.
93. On Friday 15 January 2021, we got a call to say dad was unlikely to survive the night. I asked if mum could go in. They said it would be a risk to her but she wanted to go in so they said that it was ok. They made up a makeshift bed for mum and allowed her to stay with dad. She said the nurses were wonderful. Mum stayed with dad till he passed away on the evening of Sunday 17 January 2021. I feel like dad hung on because mum was allowed in.

#### ***Mum's isolation***

94. Mum was told she had to isolate when she came home from the hospital. She caught a taxi home from the hospital alone. I met her at the house with a care package of things but I could not give her a hug or go inside. She had to stay in the house herself. We couldn't even hug her. It was really hard. Mum was absolutely broken.
95. There was no signposting for support services and no help in the community for mum or the immediate family.
96. I booked her a covid test as soon as I could and by some miracle she was negative.

#### ***Funeral arrangements***

97. During this time, I was working every day and my daughter was home schooling. I took on the job of informing friends and relatives that dad had passed away.
98. I had to arrange dad's funeral. We couldn't have the funeral until over a month later. We couldn't get a window at the crematorium until Monday 15th February 2021.
99. There were still restrictions in place so we could only have 10-12 people at the funeral. There was a zoom link for the people that couldn't attend.

100. There had to be no singing and no hanging about. We weren't allowed to carry the coffin, it had to be wheeled in. It was really short, it felt like we were in and out really quickly.
101. Mum wasn't strong enough to have a wake. We haven't been able to scatter his ashes yet either.
102. I feel like there has been no real recognition of people's losses. It feels like it all happened in a vacuum. Everyone is just encouraged to move on like it has not happened.

### ***Complaints to Gartnavel Royal Hospital***

103. We received a condolence call from dad's consultant but nothing from the unit at Gartnavel. My husband collected Dad's clothing which was handed to him in several bin bags. Not all the clothing was Dad's. They sent mum more clothes and unopened letters through the mail. They did not think to call me to collect found items. These letters and cards had been written by his wife & family to reassure dad and no one thought to open and read them to him. They continued to mail out items to her home address with no covering note in the coming weeks after his death.
104. Dad's watch was missing. Gartnavel Cuthbertson Ward staff initially said he hadn't been wearing a watch. Then they said that he went to Queen Elizabeth Hospital wearing it. I retraced Dad's movement around QEH to try and locate it in vain. I finally called Lost Property at Gartnavel Royal and they confirmed it was there and they had had it for months.
105. I spent time dealing with these things whilst grieving for dad. I wrote to Gartnavel about the treatment and their unwillingness to engage with the family regarding the lack of visiting and vaccination. I had doubts about dad's treatment and how timely it was.
106. The response I got wasn't satisfactory. They said that as soon as the vaccine was available it was offered to the appropriate groups but unfortunately there was already an outbreak in the unit.
107. They said the route for transmission was from the hospital but they were unable to identify from exactly where. I assumed this was in connection with the main hospital.
108. I strongly believe dad would have been in better health and more resilient to fight Covid if he had been allowed visits from his wife and had received the vaccine when recommended.

### ***Complaints to Crown Office and Procurator Fiscal Service***

109. In November 2021, I referred dad's case to the Procurator Fiscal. I had read on the BBC news website that a Covid-19 unit had been set up to investigate cases where covid was on the death certificate. Dad's death had not been referred to them. They agreed they wanted to know about it.



110. The Covid-19 unit instructed Police Scotland to look into the case. I have prepared witness statements for the police. They are currently speaking to the key people dad was in the care of. The investigation is still ongoing.

***Impact of losing dad***

111. There was a lot of things that should have happened but didn't. The voices of dementia patient's families were shut down during the pandemic. For dementia patients to be denied family and familiar faces or surroundings would have been detrimental. We felt like the families were being forgotten about. It felt like there was no sense of direction in the unit and they were simply firefighting.

112. Mum and dad met when Mum was 17 years old and married when she was 21 years old. Mum was lost. She aged in front of me.

113. Dad enjoyed life to the full. He liked his days out and holidays etc. Only 6 months before he died dad was planning a holiday with mum.

114. Everyone was so shocked at what happened in the space of a few months. We are still going through the grieving process. We feel lessons need to be learned. That's why it is important that we share our experiences.

115. I have had bereavement counselling. We spent a lot of time with mum and dad so we really struggled when dad died. I have never had mental health issues or time off work before dad passed. I started having flashbacks, anxiety and extreme reactions when in pressured environments at work. I had fight or flight reactions when I was under pressure and recognised these as signs of PTSD. I have since read research papers about how pandemic grief is similar to violent death grief.

***Lessons learned***

116. There should have been a plan for what would happen in the event of a pandemic. Nobody had thought about the day-to-day management for patients like dad. No one thought about the impact of shutting down clinics, scans and GP's.

117. We need a plan for how to manage a pandemic situation and protect vulnerable patients but also balance human rights and welfare so they are not made worse.

118. Whether it was due to a lack of experience or genuine fear, it felt like there was no sense of real leadership. The tier system in my opinion was ridiculous because it had no real nuance for situations like my dad was in. Dad became vulnerable through circumstance. If he and my Mum had been able to access important care and support while at home we would not have had to react to a crisis incident with a hugely disproportionate impact on Dad's freedom and right to be in the care of his loved ones.

*[statement concludes]*

Signed .....  
Amanda Burnett

Date 02/12/2023 .....