Scottish COVID-19 Inquiry

Statement of: Sharon Ann MCBRIDE
Born Personal Data

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1. Statement taken on 09 October 2023 via Microsoft Teams. Witness number HSC0076 refers.
2. Interview lead by Witness Statement Taker (WST) Name Redacted and noted by WST Name Redacted
3. Also in attendance was Name Redacted, Para-legal from Aamer Anwar and Co Solicitors.

CONSENT

4. My name is Sharon Ann MCBRIDE and I am 54 years old.
5. I have met today with witness statement takers from the Scottish COVID-19 Inquiry team and am happy to provide a statement about my experiences of the pandemic as it affected my now deceased mum, NR Name Redacted
6. I have signed the consent form provided. I am content about my information being contained within reports and published. I would provide evidence at any hearing if required.
7. I do NOT have any holidays booked for the immediate future so would be available to attend at the public hearing if required.

ANTECEDENTS

8. My name is Sharon Ann McBride and my date of birth is Personal Data My details are known to The Inquiry. I am employed as an Personal Data Personal Data

9. I stay at Personal Data

10. I have on older brother, NR and two younger sisters and a younger brother.

11. I wish to give a statement to The Inquiry about my mum. Her name was Name Redacted My mum died on 20 January 2021 whilst within Monklands Hospital (Airdrie).

12. Mum had many jobs in her life. She was born in Blantyre and worked various jobs in a factory, as a chef in the golf club and working with dad in the shop

13. My dad died in 2000. Dad had worked as a golf club steward, and we stayed in a house connected with the job. When he passed, we could no longer stay in the house, so we stayed in different places before mum eventually got her house at Personal Data This was through Lanarkshire Housing Association. The year was around 2006.

14. The house was an upstairs and downstairs with the toilet being located up the stairs.

15. She used to attend the local church and speak with her neighbours.

16. Mum was a patient of the Bruce Medical Centre in Bellshill. I think this is covered by Lanarkshire Health Board.

17. Before dad died, mum was very sociable. After he passed, she became more isolated. She did spend lots of time with her family and always enjoyed seeing me and my brothers and sisters and all her grandchildren.

MEDICAL BACKGROUND

18. Mum had a heart attack three months after dad died in 2000. This was probably caused by the shock of dad's sudden passing. She also suffered from angina and COPD. In the last few years, she stopped going out as much, because she suffered from vertigo. She felt sick when she was travelling so preferred to stay at home. Despite this, she was still mobile around her home. She used to like sitting in the garden enjoying the sun and doing her housework.

19. Mum had always been active and was mentally very sharp. She was a good conversationalist and used to enjoy doing crosswords.
20. Mum had a fractured back caused by osteoporosis and was in a great deal of pain. She used to sleep on a reclining chair downstairs with a mattress under it. We got her a bed raiser one year before she passed.
21. The occupational therapist had managed to get her a wheelchair and walking stick to help her. But she would not use these.
22. She also had a dietician who used to monitor her weight.
23. Mum did not have a care package in place. I very much organised things for her, as I was probably the closest next of kin.
24. Before Covid, I got a GP to come out and assess her as I thought her memory was declining, but she was not diagnosed as having dementia or Alzheimer's.
25. Mum used to get a blister pack for her weekly medication. This contained tablets for her backpain, stomach, vertigo, heart, and inhalers for her COPD. Mum managed this herself before lockdown.
26. Mum used to feel sick and say she did not feel like eating. This may have been caused by the co-codamol tablets she took for her back pain.
27. She used to have porridge every morning for breakfast and a sandwich in the afternoon. We were concerned about her weight loss and got a dietician involved. The dietician was concerned (about her weight loss) and put her on high calorie drinks.
28. However, mum started taking the drinks as a food substitute as opposed to a food supplement. This would have been about 2018.
29. She had frequent suspected UTI's (urinary tract infection). The GP was taking samples, but nothing showed up, so she was not prescribed any medication.
30. She was still showing symptoms, but we never got to the bottom of this before she passed.
31. Mum's toilet was located up the stairs. She could go up and down well enough, but she did fall at the top one night. This was about October /

November 2020. My older brother, Name Redacted, moved in with her a short time after this.

DURING THE PANDEMIC

32. Mum understood Covid and the impact of isolating. She was in the shielding category due to her health. We advised we could not visit despite her always telling us just to go in. She had to isolate alone in her house.
33. As she stayed on her own, she always liked the company and did not enjoy not seeing her family. She lived for her family visits and the grandchildren going in to see her. We used to call her on the phone every day. We also ensured we dropped food off for her. We used to have garden visits, but she used to get cold standing in the doorway.
34. The GP stopped coming out to see her when the lockdown started, and the dietician also ended. If we had to drop of any medical samples to the GP's surgery, it was always difficult, mainly due to the limited times they were open and the receptionists.
35. This was frustrating for my mum as she repeatedly said she could not get past the receptionist to speak with a doctor. She used to get annoyed and angry. I eventually got added as a point-of-contact so I could liaise with the medical staff on mum's behalf.
36. The problem with mum being on her own was that she would not eat properly. If we were physically in her presence, as we were before the lockdown, we would encourage her to eat. But as she was on her own and not being looked after, she would not do so herself.
37. She began to decline mentally. I personally think she had undiagnosed dementia. She would accuse us of stealing from her, despite the fact we had not been in her house. Then she stopped answering the telephone when we were calling her. We used to have to turn up at her door to ensure she was ok. This was difficult as there were restrictions on travel, and I stayed in a different area to her.

38. Lockdown definitely contributed to her mental decline. Before lockdown, physically, she was not great, but she was mentally sound. I think this was because she had nobody to talk to all day. She just sat and watched the news about Covid on television all day.
39. I could not tell you what mum's weight was before lockdown. This will likely be in her medical records. But she was extremely slim.
40. The occupational therapists did advise that mum had a condition. I cannot recall the exact medical term they used but what was essentially happening was her muscles began to eat themselves.

PANDEMIC

41. Mum was taken into Hairmyres Hospital in East Kilbride around October 2020. Doctors were not doing home visits at this time. The paramedics came out and advised it would be better if she went with them to hospital. This was because she was confused and had an underlying infection, which caused her to fall. Mum was put on antibiotics at Hairmyres.
42. I think the reason she went to Hairmyres is because there was no space at Monklands Hospital (Airdrie). She was in the Elderly Care Unit (ECU). It was not a Covid ward and in a different part of the building.
43. She was taken in the ambulance by the paramedics. Nobody else was allowed with her. They gave her antibiotics. As the ward was on the ground level I could visit and see her via the window or drop off clothes for her at the ward entrance.
44. I transported mum home from hospital.
45. Mum did seem better after her release (from hospital).
46. My brother Name Redacted was staying with mum in December 2020. He used to live in Personal Data but we asked him to return and stay with her as he was also shielding.
47. He called me one day, (19 December 2020), to say mum was complaining about pains in her back and stomach. I told him to phone NHS 24, which he did. I was not with them at this time. I was in my own house.

48. Paramedics came out and recommended mum goes to hospital. On this occasion she was taken to Monklands Hospital. The only people in the ambulance with mum were the paramedics. My brother remained in my mum's house.
49. Mum was tested for Covid on arrival at the hospital, and she was negative. This put her in the amber pathway. The only people who were given green status were those who had been isolating in hospital for a period before going for an operation. Otherwise, people were amber, unless they tested positive, in which case they were red.
50. I think a doctor called me from the hospital (Admissions Unit) and asked me for background information about my mum's health. I was the point-of-contact thereafter.
51. I can recall the ward doctor then called me soon thereafter. It was during this time that DNR was first mentioned. Even though mum was not positive for Covid.
52. Mum was put into ward 17. This was not on the ground floor. It was a mixed ward. It was not a Covid ward at this time (but subsequently became one).
53. We were allowed to attend at the ward door to drop off clothes and pick up her old ones.
54. On Christmas day we went to the ward door and could see mum from the top of the ward. We were waving to her, and she was asking when she was getting home. We handed in Christmas presents for her.
55. The only PPE we wore at this time were masks.
56. I was not aware of mum being tested for Covid between entry to the ward and her going for an endoscopy on 30 December 2020. This was something I raised in a subsequent complaint and was advised that, as per Scottish guidance, they should have tested her, but failed to do so.
57. The reason mum went for the endoscopy was to try and find out what was causing the pain in her stomach. Mum was refusing to have this procedure. The doctor asked me to speak with mum on the phone to try and persuade her (to have it done). I eventually did get her to agree.

58. The endoscope got kinked so they did not get much in terms of results. But they did a biopsy which was sent for analysis.
59. We never got the results until after mum passed. There was inflammation in her stomach and this was causing the pain.
60. Mum was returned to ward 17 at this point (30 December 2020).
61. I got another call advising that mum's markers were rising on her bloods, and she was cold. They were going to move her into a side room, away from the main ward, and test her for Covid.
62. The doctors advised she was having a bit of difficulty with her breathing, was cold and they were giving her blankets for her bed to try and get her warm.
63. I was called on 2 January 2021 and advised mum had tested positive for Covid and that there was a ward outbreak. I just started crying.
64. When I raised this matter with the hospital at a later time, they advised my mum was the index patient. I then questioned where mum had got Covid from. Was it from the staff? Whilst going for the endoscopy? Because she tested negative when she went into the hospital on the 19th of December. They said infection control could not clarify exactly where it had come from.
65. They did say somebody in the ward, or a staff member, may have been asymptomatic, and asked their staff members to voluntarily agree to be tested twice per week.
66. By index patient, I took that to mean that she was the first person in the ward to test positive for Covid.
67. Because of this positive test, mum was moved to ward 2. Ward 2 was a high dependency unit. But they said mum would get a certain level of care (more than in ward 17). The consultant from ward 2 called me soon after she was moved and said she was downgrading this level.
68. She said she would get ward care. She would not get ventilation or c-pap, as she was too frail and that DNR would be horrific for her.
69. Mum stayed in ward 2 until the 15th of January. The doctor explained that after about 10 days a patient is no longer infectious. Mum was moved back to ward 17 at this time.

70. She was not tested before she went back to ward 17. I asked that question and was told the only people they were testing were those going back to care homes.
71. However, when she went back to ward 17, she was actually tested and it was positive again (on the 15th of January 2021).
72. I actually got mum's test results for the 15th on my mobile phone app. It was a text message.
73. I could not understand why they were moving my mum, considering she was still positive. I questioned this and was told it was due to bed capacity. I asked if ward 17 was a Covid ward and they advised it now was.
74. We received conflicting information from the medical staff. I used to phone in three times per day. I was always asking their opinions. We were confused as a family because we would be told her markers (for bloods) were fine and then the doctors would say that things were not looking good for her.
75. She was still testing positive and yet they were moving her.
76. On the 18th of January, I called as usual and was told her inflammation markers were a bit high. The doctor was advising that it was coming (mum passing).
77. At 1am (0100 hrs, 19 Jan) I got a phone call from staff in the ward. I guess I was not really expecting this due to receiving conflicting information from staff members.
78. After receiving the call, I phoned my brothers and sisters, as only one person was allowed in (to the ward). They all agreed and said that I should be that person.
79. I attended at the ward. I met the doctor who met mum when she first entered the hospital, and he said he thought she might have made it (surviving Covid). I was told she may have beaten Covid, but she got hospital acquired pneumonia. He showed me pictures of her lungs and how they had deteriorated.
80. I had to decide whether she was to be treated (with antibiotics) or made comfortable (with morphine).

81. I asked if I could call my siblings, which I did. We agreed she should be made comfortable, and morphine was administered.
82. She was in a side room of ward 17 at this time.
83. When the consultant came in during the morning, I asked how long mum had left (to live) and I think she said about 12 hours. My mum was not really conscious at this time. Her breathing was laboured. I was holding her hand and talking to her. She would occasionally try and say something, and I could not understand, so I would nod and this seemed to settle her. I did this two or three times. At one point she became quite discomforted, so I called the nurses and they gave her more morphine.
84. By 6pm (1800 hrs) on the 19th of January, I was beginning to struggle a bit. I asked if there was anything we could do to give me a break. I was advised I could leave but only one person could replace me, and I would not be allowed back in thereafter. I was told I did not have to isolate after I left.
85. Again, I made the phone call to my siblings and my youngest sister, Personal Data said she would take over. I think she still struggles with this even to this day.
86. I took away all mum's stuff from the room, all her bags and such like.
87. My mum passed away about three or four the following morning (0300 to 0400 hrs on 20 January 2021). Personal Data was with her when she passed.

RESTRICTIONS ON VISITING

88. Whilst in ward 17 (originally) we were allowed to visit but only attend at the door of the ward. Mum stood at the top of the ward and we spoke to her from the door of the ward.
89. We were allowed to see mum when she was in ward 2 because they thought she was going to die. We wore extensive PPE and had to isolate for 10 days after leaving.
90. We were allowed to see her in ward 17 during her last few days before she passed. Me and my sister Name Redacted were allowed to go in and sit with mum whilst wearing PPE. We did not have to isolate after leaving on this occasion.

91. Mum struggled to use mobile phones and the hospital did not facilitate the use of an iPad, saying theirs was only used for admin purposes. Mum would also appear not to have been able to use the bedside phones, which meant we had very little communication with her.

INFECTION CONTROL

92. Regarding Hairmyres Hospital, I never visited mum in the ward. None of my family did. We only spoke to her through the window so I can't comment on this.
93. With regards to the paramedics who attended mum's house to transport her to both Hairmyres and Monklands Hospitals, I do not know what PPE they were wearing / used as I was not there and did not see it.
94. We did have ward door visits in Monklands. Whilst mum was in ward 17 at the end (of her life), PPE was basic: mask, gloves, hat and apron. I was made to put this on just outside mum's room. If I came out the room, I had to take all this PPE off. If I re-entered the room, I had to put new PPE on.
95. In ward 2 there was a lot more to it. They took us into the nurses' room and put all the PPE on: two masks, and a suit with a hat and gloves. It all had to be put on in a certain order. They would even tell us the order to take things off and how to wash our hands. It was very detailed and precise.
96. The staff in ward 2 certainly had a lot of PPE on. They also wore visors.
97. Staff in ward 17 did wear PPE but not to the same level as ward 2.
98. I did see porters wandering about the whole hospital. They did not seem to change their PPE each time they entered a ward.

TESTING REGIME

99. I cannot recall if mum was tested when she went into Hairmyres Hospital in October 2020, but I am sure she would have been.
100. Mum was tested for Covid on arrival at Monklands Hospital on 19 December 2020.

101. She was tested again on 2 January 2021 and was positive.
102. Then mum was tested again on 15 January and was positive again.

INSPECTIONS

103. I personally was not aware of any inspections in Monklands Hospital but they were mentioned to me when I was going to do the swap over with my sister Name Redacted when mum was passing away. I did not see anything as such but I know the staff spoke to a team of infection control people at this time.

ISOLATION

104. When shielding first came in, I thought it was the right thing for mum because of her lung problems. It seemed right for her.
105. In retrospect, I think we should have made a bubble sooner for her.
106. I don't know if it was right for her mentally, but we could not have lived with ourselves had we gone into her house and passed anything on to her.
107. We protected mum only for her to get Covid in a so-called infection-controlled environment.

DNR ORDER

108. DNR was first mentioned when I received the call from the ward doctor on 19 December 2020. This was before she had tested positive for Covid and before she had the endoscope.
109. The doctor called and said that they wanted to put a DNR on mum due to her frailties. I asked if they could do that, as we had not given permission and did not agree with it. They advised this was a medical decision and unless we had power of attorney, we could not dispute their decision. They then went on to explain that we would be putting mum through terrible discomfort to try and keep her alive for our own reasons.
110. They did explain what DNR involved and they would likely need to crack ribs if required and that it was not for the patients benefit to do so.

111. Despite this explanation, the rest of the family were still not happy and did not want this to be put in place.

112. I went back to the medical staff and voiced the family's opinions, but they advised this was purely a medical decision.

113. I believe the doctors did have a discussion with my mum about this and she accepted it. But I know from reading her medical notes they also told her she was going to die.

114. I have seen mum's DNR notice (in her medical file) but I can't recall seeing mum's signature on it. I think she must have given verbal consent.

BEREAVEMENT

115. The impact on the family of mum passing, as I said previously, is that we were surprised, due to the conflicting information we were given from the medical staff. Some would advise her blood markers were good but then we were told to prepare ourselves for the worst.

116. We were all isolated in different houses when we found out that mum had actually died. This was extremely difficult for us all. Even though we all had our own families, as a group, we could not get together to mourn. Everything was done over the phone.

117. My sister had to tell us all via an app that mum had passed away. That is how we found out. At 3 o'clock (0300 hrs) in the morning. I think we all took it in different ways.

118. My brother never had anyone to grieve with as he was still staying on his own in mum's house as he was still shielding. He took it quite badly. He wanted to get in and see mum, but this was obviously not allowed.

119. His way of coping with the news was to start saying he was not well himself. We had to cope with my brother, and how he was reacting to the news, in addition to trying to cope with the fact my mum had passed away.

120. My youngest sister, Name Redacted also took it really badly as she was the one who was with mum when she finally passed away.

121. The death certificate stated cause of death as hospital acquired Covid-19 disease with respiratory signs and symptoms; COPD, Ischaemic Heath Disease, frailty.

122. I received the death certificate fairly quickly from the hospital. They emailed me a copy. I was able to forward this to the Registrars.

123. They then issued the formal certificate promptly, so I was able to arrange the funeral service quickly.

124. The funeral directors advised, as it was a Covid funeral, it would need to be a closed coffin. We could not go and visit mum at the funeral parlour.

125. We had a service the night before the actual funeral with the closed coffin in the funeral hall. I think the maximum limit of people in attendance, was 20.

126. On the actual day, we had a service in the chapel with 20 people present. This was the maximum allowed. Some people stood outside. We were all wearing masks. There was no singing. You could go to the graveyard if you so wished.

127. We had to provide the names and contact numbers for everyone at the service.

128. There was no event after it.

129. The funeral was available on-line. I think it was Facebook.

130. We could not use chauffeured cars. We had to use our own personal ones.

COMPLAINTS

131. I filed various complaints to the hospital management regarding how mum caught Covid and various other concerns. I have them in a file if needed and can pass on if required.

132. We filed our original complaint in June 2020 and they did not get back to us until January 2021. I responded back, as I did not agree with what they said. They offered a meeting, and it did not take place until around the end of last year, 2022. The final result was that they admitted some degree of

failing with regards mum should have been tested again after she was originally admitted to ward 17.

133. There were eight medics at the meeting and me, which was quite intimidating. It was just me and my aunt.

134. One of my complaints centred around the staff giving mum an antibiotic which interacted with one of her heart medications. Within a matter of hours after this was administered, she was rushed for an ECG as mum's heart levels went through the roof. This happened twice. And after the latter, on 18 January, mum never recovered.

135. We also filed a complaint about the canula being dislodged from my mum's arm on the 18th of January. I picked this up after we obtained and read mum's medical notes. This point was raised at the meeting with the medical staff who advised this would not have been vital medication and she would have received this orally to replace. They said the canula could not be replaced until a specifically trained nurse came in the following morning.

136. My only option moving forward is to take my complaints to the Ombudsman, which I have now recently done.

137. I first heard of the Scottish Covid Bereaved group (SCB) through Facebook. I found the UK one first and then the Scottish group. This was how we got linked in with the lawyers.

LESSONS LEARNED

138. I know there were GP's visiting patients when mum's own doctor was not. This should have been uniform across all authorities. GP's need to learn that older people cannot always communicate by phone and need to be seen in person to understand what their issues are. Elderly people get confused and don't always express how they feel on a phone.

139.I asked, before mum tested positive, and whilst she was in hospital on the 19th of December, if they could give her the vaccine. This was refused. The vaccine was available for some but not for all at this time. However, they advised this was not standard procedure.

140.I appreciate capacity was a problem, but to put elderly people who were shielding, with everyone else, who may have been asymptomatic, seemed a recipe for disaster. Especially if they got Covid, which my mum did, and subsequently died.

HOPES FOR THE INQUIRY

141.I will be honest, having seen other Inquiries, I hope it does not become political and the truth does not get swept under the carpet.

142.I also struggle with the fact that nobody is held accountable. Although the findings may issue recommendations to health boards or the government, they are not enforceable.

143.I want the truth to come out and people held accountable for the mistakes they made as well as lessons to be learned. There should have been a degree of planning before this happened. It seemed like it was all reactive and haphazard. Guidance was changing by the minute, and nobody seemed to know what they were doing. The result was people ended up dying due to the lack of proper planning.

Signed

PD

Date...27/10/23