

## Scottish Covid-19 Inquiry

### Witness Statement

Statement of Diana Montgomery – Witness Number HSC0057

Statement taken at 0900 hours on Thursday 5 October 2023 on Microsoft Teams

#### **Introduction**

1. My name is Diana Hendry Montgomery. My date of birth is [PD]. [PD] I am 75 years old. My address is [PD]. [PD]. I am a retired teacher.
2. 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. I have provided them with access to my background meeting notes with Thompson’s Solicitors and I am happy that they be included to assist in forming my statement. I am willing to provide a statement, have my information within reports and, for my statement to be published. I have completed the consent form and confirm I would be willing to provide evidence at an oral hearing. I am happy for this interview to be recorded.

#### **Personal Data**

3. I wish to give a statement to the Scottish COVID-19 Inquiry about my husband. His name was [PD], and he was born on [PD]. [PD] [NR] died on 24 October 2020. He was 69 years of age when he died. [NR] died at home after arrangements had been made to have a hospital bed and carers put in place. Immediately prior to this he was being treated in Woodend Hospital in Aberdeen, part of NHS Grampian health board.
4. [NR] and I were married for almost 45 years. We had two daughters, [NR] who is 44 and [NR] who is 42. [NR] is a doctor and lives in [PD] [NR] lives in [PD]. [NR] was also a teacher, a Guidance teacher. He had an older brother and a twin brother. His twin brother [NR] use to stay in London but is now in [PD] and his older brother [NR] is in [PD].
5. [NR] had a very rare aggressive form of dementia, frontotemporal dementia, one of the worst ones. It is very difficult to diagnose, and he

had 3 brain scans before his diagnosis which was the day before his 65<sup>th</sup> birthday (August 2016).

6. I managed [NR] at home, I didn't want him to go anywhere else but home, but around Christmas 2019 things became very difficult. He took a phobia about water and getting him showered was difficult. The girls were concerned, he was very physically fit and much taller than me, bigger framed and accidents could happen.
7. [NR] was never violent, but he was agitated all the time. He would stay up all night and things became unmanageable at home for me. Around the end of January 2020 [NR] was admitted into a dementia ward at Glen O' Dee Hospital to be assessed so they could sort out his medication. I always thought he was coming home though, no question.

### ***Glen O'Dee Hospital – Pre-Pandemic***

8. Glen O'Dee Hospital is in Banchory and is part of NHS Grampian.
9. I used to go down every day to see [NR] when I was allowed. This was before covid and we could visit as often as we wanted, the whole family could go as often as they wanted too. We even took musical instruments in, the girls played the violin, I would play the piano and [NR] would take through his accordion. It was not stressful at all; the people were so nice. We were all happy with that arrangement. The nurses commented on how [NR] would change when he saw his family, how happy he was to see them. Friends used to say that too, his reaction when he saw his grandchildren.
10. Just before covid, we had a meeting with the whole team in the hospital. [NR] was there as well. The doctor had said to me that he was surprised I had managed to keep [NR] at home for so long.
11. The doctor said he had put a 'Do Not Resuscitate" (DNR) on [NR] and I was absolutely shocked. But [NR] was there, and she said it was absolutely the right thing to do. Dad was never going to die because his heart stopped, the dementia would kill him, but he was never going to be in that position because he was so fit. He was never going to drop down with a heart attack. The doctor explained that [NR] brain could not take the resuscitation.
12. This meeting would have been about February 2020, a few weeks after [NR] went into hospital. The first fortnight we couldn't go and see him because they were assessing him and giving him different drugs and things. We discussed it at the meeting and agreed to keep it in place. We didn't have to sign anything, but we did agree to it. [NR] was sure that was the right thing.

13. It was only then that I realised how ill he was, I had overlooked things. I was living with him every day.

***Glen O'Dee Hospital – During the Pandemic***

14. As soon as lockdown was announced in March 2020, we were not allowed to see [NR]. We never got to touch him for 6 months. We got to see him one time through a window, and he started to put his hand out, but he wasn't allowed to be touched.
15. It was months before we got to see [NR] again. We got to see him through a window at first when [NR] was in Glen O'Dee. We had to book it in advance. But that was no use to him, he had no spatial awareness because of the dementia, it was gone.
16. Seeing him through a window, it meant nothing to him. Facetime meant nothing to him either.
17. We weren't allowed into the hospital until July 2020 and then the hospital visits were twice each week with distance, and we were wearing masks. It was only me who was allowed inside, and I never got near him to touch him.
18. [NR] was at one end of the corridor, and I was right at the other end. It was a long corridor with a number of rooms in it. It was quite a long way, there were a number of rooms on the way down between us. It was far more than 2 metres, the distance away. It wasn't within touching distance at all.
19. I had to wear a mask but no other PPE. He still knew me though. The only thing that [NR] did need was the touch of his family and he obviously wasn't allowed that.
20. The girls were happy because they knew that I was getting to see him, he was getting to see somebody from his family.
21. So, at first it was complete lockdown and then they were talking about opening up and I wrote a letter then asking when that would be happening. I did get a reply that to time to say it would be happening quite soon.
22. It just re-opened not long before [NR] left. So that's when I could see him inside, but at a distance. At that point he was looking okay, and he smiled when he saw me.

23. I don't criticise the hospital. They were really fantastic towards [NR]. There was also a Community Psychiatric Nurse assistant, [NR] who had been assigned to [NR]. He would not want to do things for me but when [NR] came, he would do things for her quite happily like go out for a long walk. I knew that [NR] was happy there because he was getting attention from people he knew, and we knew as well.
24. The staff in Glen O' Dee hospital were superb; I would never criticise them. It had nothing to do with the staff and everything to do with the rules.
25. I continued to be allowed to see [NR] at a distance until he was moved to Deeside Care Home in August.

### ***Transferring to Deeside Care Home***

26. I had no involvement in the decision to move [NR] from hospital to the care home. I think he had just been in the hospital overlong. If it hadn't been for covid he would have been moved much earlier and the difference would have been that I would have been able to go and visit care homes and decide for myself what was suitable for [NR]. Get a feel for the place, the smell of the place. But I had absolutely no say in that whatsoever.
27. Before lockdown had happened, the actual social worker had had ideas of where he might go and how I would be able to visit him and so on. But that all changed with lockdown I had no say at all. The only say I had; I was told this day that he would have to move out of Glen O' Dee which I did understand. I knew he couldn't stay there forever because people with dementia are not treated like other people who are ill.
28. So, I was just told basically, by the Social Work manager, that [NR] would have to go to Deeside Care Home in Aberdeen. It was the only place because he had to have an EMI unit.
29. An EMI unit is a specialist unit for people with a specific type of dementia, it wouldn't necessarily be the older person. It stands for Elderly Mentally Infirm, and it is for individuals who have lived with dementia related conditions for a significant amount of time and who need 24-hour care as their symptoms become more severe.
30. It was just a question of can you pay £1850 a week. I did ask what happens if I can't pay that and the response was that [NR] would be sent anywhere. I thought that would mean at a distance where I could not see him. In my innocence I thought I would be able to spend a lot of time in the home with [NR]. As it turned out, I wasn't allowed to visit him anyway.

31. I met with the family to discuss my finances and it was supposed to be that you had to be able to pay £1850 a week for two years but [NR] and [NR] both knew [NR] wasn't going to live for two years.
32. But I had to be able to say that and then pay the first month up front before Ken was even near the place. If I had known that [NR] was going to live for such a short time there, I would have asked to have gone in with him as a patient. I didn't know he was only going to live for eight weeks. I would have paid the same amount to be with [NR] because it was the only thing that would have allowed me to see him. I'd tried various things, but nothing had worked.
33. That's when it really became bad because I had assumed I would go with [NR] to the care home, but I wasn't allowed to be near him.

***Deeside Care Home August 2020 – October 2020***

34. [NR] was transferred to Deeside Care Home around August 2020. It was in Cults Avenue, Cults, Aberdeen AB15 9RZ. The company was Deeside Care, and it was in the Aberdeen City Council. The local health board was NHS Grampian.
35. That's when it really became bad because I had assumed I would go with [NR] to the care home, but I wasn't allowed to be near him.
36. I wasn't allowed to take [NR] to the care home. I was shocked that I couldn't take him. I mean how can someone else take my husband to somewhere and I wasn't allowed to take him? I wasn't allowed to be with him at all, I wasn't allowed in the ambulance with him, but I was determined to see him going in, so I drove there and waited until the ambulance arrived.
37. [NR] was taken out in a in a wheelchair, and he was smiling. It just broke my heart because I waved to him, and I took the accordion out of the car and showed it to him and he just lit up. I just don't think they paid any attention to that and that was just heartbreaking.
38. [NR] would have been tested for covid all the time when he was in the hospital so he must have been tested just prior to going to the care home. He wouldn't have been allowed to go without being tested, but yet was put into isolation for two weeks.
39. As it was an EMI unit, Deeside had to have nursing staff as well as carers. I didn't meet any of the nurses, I only spoke to them on the phone or during outdoor visits at a distance with masks on.

40. I often couldn't get through to the nurses on the phone. I could phone regularly but I would phone and phone and not get anybody. But when I did speak to the nurses it was okay, they told me how [NR] was.
41. Sometime later, when the Care Inspectorate went to visit because of my letter, they found there was only one main phone, and they were pretty shocked about that.
42. Some of the nurses in the unit had accents I found hard to pick up. They were all wearing masks and for [NR] they didn't have the accents he was used to, he didn't know the person.
43. Deeside wasn't that far away from home, let's say about 20 miles, and I thought that's not so bad, I can drive and see him every day. I imagined driving down and having tea with [NR] I imagined all these things, but it was just in my imagination, it never materialised.
44. I never saw the inside of Deeside Care Home; I could just look through the window of the main room. I wasn't allowed to see [NR] at all in the first few weeks. He was in isolation.
45. I think that's why he deteriorated so quickly, he was kept in his room, confined to one room. For someone with dementia, who is used to walking around. Even when [NR] was well, he was always standing.
46. He spent two weeks in utter isolation away from absolutely everybody. We did ask them to do things with him, give [NR] exercises to do but I've no idea if they did.
47. He spent his 69<sup>th</sup> birthday in isolation and it was totally heartbreaking. [NR] came round here to speak to him on Facetime and he looked so different to what he had been at the hospital, not smiling, he looked awful.
48. I phoned [NR] his twin brother, and told him not to do Facetime with him because it would be too upsetting. Facetime just wasn't suitable at all for [NR] he just didn't register.
49. The whole time [NR] was in the care home I was never able to go and visit him inside. I have no idea about what PPE they were using or anything.

### ***Care in Deeside Care Home***

50. I have a photograph of [NR] the day before he left Glen O' Dee and he knew me then and he was smiling. The photographs we have after that when we did get to see him outside, he had deteriorated so much.

51. Then [NR] got the UTI (Urinary Tract Infection) and I swear if I had been there with him, I would have known something wasn't right earlier. I knew how he reacted to things so I would have known there were problems there. I always knew latterly when he was at home when he was distressed, and he needed the toilet and things like that. I just knew.
52. But, as it was, he got the UTI, I think towards the end of the period of his post hospital isolation, and then he got another one. I don't think the first one was properly cleared and that was the real deterioration. He lost weight and the home didn't seem to think that was a problem, which it obviously was. That was when the real trouble started.
53. [NR] never had a UTI in his life and UTI's, even in ordinary people, are known to cause mental disturbances. It's not just the waterworks it affects, it affects everything if it's not being picked up on.
54. If someone who had dementia was distressed, which [NR] clearly was when he got the UTI, you were supposed to be allowed to see them, but I was not allowed to go near.
55. I have no idea what life was like for [NR] in the care home. I know he was kept clean, and I know he saw the Doctor later, but I have no idea who gave him his tablets, what tablets he was taking. I just don't know. I have absolutely no idea what he did all day, I think he sat in his wheelchair. He had been eating though.
56. I was never in the home, not even on the day he got taken to the hospital, they were applying the rules so rigidly.
57. When we got the hospital report when he left, he had deteriorated a bit. [NR] picked up that he had a different eating dish, but he was feeding himself and everything.

### ***Deeside Care Home Visitation***

58. I found out that I could get a 15-minute slot to see [NR] outside and I could take [NR] with me. That would have been after the two weeks isolation.
59. There was also a further lockdown in Aberdeen just as [NR] was going into the care home because a football team had gone into a pub and had spread COVID everywhere. The people who were punished for that were not the ones who broke the rules; it was people like [NR]
60. The 15-minute visits were one visit per week, and they had to be arranged in advance. I usually emailed the manager to arrange them. During the 15-minute visits we were kept at a distance so we couldn't

touch. We were supervised just in case we reached out a hand. If we had touched him, [NR] would have been punished, he would have been put back into total isolation. We had masks on, but [NR] didn't.

61. [NR] came with me on the outside visit, she was in my 'bubble'. Because [NR] came with me it meant that [NR] would never be allowed to see [NR] as she was the third person, but they weren't counting me and [NR] as being in the bubble they were counting us separately.
62. We went to see [NR] outside. It was getting really cold, and he was wheeled out in his wheelchair with great big blankets around him and a hat on. [NR] is used to seeing things, in her job as a doctor, but when she saw [NR] she was in tears; she couldn't cope with seeing her dad like that. He had just deteriorated so much. It just didn't look like [NR]
63. We were kept at a distance where we couldn't possibly touch him; that's what we wanted to do. Everybody else could touch him but not us. We just felt, was this even worse than not seeing him at all? He was just a different person.
64. The week before [NR] went into hospital, I wasn't allowed to see him as the care home said I didn't have a slot, it was difficult for them to arrange, and they only had 3 days to do it. But we were paying £1850 per week, it didn't seem right.
65. I emailed the manager that week and said we were really concerned about what we were going to see on the Tuesday because we weren't allowed to see him for a fortnight. The manager kept saying he wasn't deteriorating but of course we knew he was.
66. That turned out to be absolutely right because [NR] phoned on the Saturday and was told that [NR] wasn't able to swallow. Because it was the weekend, the manager was probably off, but nobody phoned us to bring forward a visit, nobody phoned to tell us he couldn't swallow. When people are unable to swallow that's when things are really just at the end.
67. I don't think we ever had a phone call from the home. I used to email the manager and we phoned every day to speak to the nurses. [NR] emailed too to say that she thought I should be an essential carer because [NR] was in the last weeks of his life. The answer we got to that was that he was not deteriorating.
68. On the Friday before that Saturday the doctor was in the home, [NR] knew him and he phoned her and said that he would write a forceful letter to the care home to say that [NR] must be made a priority for essential carer status.

69. On the way in to see **NR** on the Tuesday morning, **NR** was driving, and I got a call from the nurse saying it was nothing to worry about, but **NR** wasn't well, and he wouldn't be able to come outside to see you; we were still seeing him outside at that time. This would have been about the end of September, start of October. She said they had called the doctor.
70. When we arrived, we went straight down and were met by the nurse. We were able to look at **NR** through glass. As soon as I saw his face, I could see he was distressed. **NR** saw his breathing. She said to me, "Mum, Dad's dying". A paramedic came and said to us that he really needed to go to hospital.
71. We were actually quite relieved to see him outside on a stretcher. Even in those circumstances, we were not allowed in to see **NR** even as ill as he was. I was never in the care home, not even on that day when **NR** was taken into hospital.
72. **NR** went downhill, big time, when he went into the care home. Some of it obviously would be because of his condition, it was an aggressive form of dementia, but the UTI's would have been the thing that set it all off. Being restricted to one room. **NR** was sociable and liked to chat with people, everybody liked **NR** he was just that kind of person and to be restricted like that. I don't even know if they played the DVD's I sent in or anything, I just don't know.
73. The last few weeks **NR** was in the care home I got a cushion made, it was of me and **NR** and I put "I love you" below the picture. I asked the care home if they would give it to **NR** and if they would send me a photograph of **NR** holding it. I felt that was the closest he could get to me. I didn't want him to think we had forgotten about him.
74. Of course, it was put into isolation to start with because I might have had bugs, even though I wasn't seeing anyone at all. But I never saw a photograph of him with it.
75. Everything was put in isolation, even birthday cards, but I don't know how long for. It was the rules, not just for that care home but for them all.

### ***Aberdeen Royal Infirmary/Woodend Hospital***

76. He was taken to Aberdeen Royal Infirmary (ARI), and he was diagnosed with aspiration pneumonia, which is when you can't swallow, and stuff goes down the wrong way. He was dehydrated as well so he was put on 2 drips – one antibiotic and one rehydration drip as well.
77. We were allowed to go into the hospital to see the consultant together to start with. It was only me after that to see the doctors. The consultant

could not have been more empathetic. He actually said to us "More people are dying in homes because they are not allowed to see their loved ones than are dying of COVID". I don't want to get him in trouble, but he actually said that.

78. That morning, the Care Inspectorate had phoned me, because I had contacted everybody I could about access to [NR]. They said they were going to visit the home that day and, coincidentally, I was given essential carer status that day. But it was too late because [NR] was in hospital - just following the rules.
79. I'm not sure who made the decision to give me essential carer status. I don't know if the doctor pushed it, or the Care Inspectorate but someone pushed it because I don't believe for a minute that it would have happened otherwise.
80. I don't know if [NR] was tested for COVID before being transferred to the hospital, but I assume he was getting tested all the time in the home.
81. The next day [NR] was getting tested for COVID. We were not allowed to see him until after he was tested. They were having difficulty testing [NR] and I said if they were finding it difficult, that I would be able to persuade him in some way. The Consultant actually agreed that was right and made sense if they couldn't get it, they would get us in to help.
82. Someone who understood. The Government never understood that actually, people need their loved ones. They can pick up on things that other people can't and that's especially true with people with dementia.
83. After [NR] was tested, we were told we could come into the hospital to see him. Of course, we were testing as well. [NR] was allowed to visit too so she came up from Glasgow.
84. [NR] was actually sitting in a chair, that was new because he had always been in the wheelchair. He was sitting up in the chair smiling away and, when he saw us, he just lit up. [NR] wasn't there as she had been working and the word [NR] used was 'euphoric' she said, "I'm actually euphoric, I've seen dad". And she could see he was happy to see us.
85. I don't think we were allowed to touch him that day, but we were allowed to sit very close to him in the same room. It made all the difference to [NR] because she had been told she couldn't see her dad through glass at the care home. She was never given any explanation for that; she was just told she couldn't. She was upset and angry about this. [NR] wasn't allowed to see [NR] through the glass either at the care home.

86. You see you had your 15 minutes outside and you were not allowed to just go and casually look through the glass, it didn't work that way. Rules.
87. **NR** came into the hospital to see **NR** with me at night. He wasn't looking as good as he had in the morning, but he was showing us how strong his legs were and stuff like that.
88. We then had a meeting with a nurse about what would happen to him, and we said we would like to have him home because, at that time he was bed bound and we wanted him to die at home, we didn't want him to die in hospital if that was possible.
89. I met with the doctors on my own after that because I was going in to see him all the time. A decision was made regarding them stopping his treatment and that he would be transferred to Woodend.
90. He was transferred to Woodend after well over a week in ARI and, I wouldn't want to get anyone in trouble, but we were all then allowed to go and see **NR** as a family. He was put into a side room and **NR** his twin brother, was able to see him for the first time which was great. He and his twin were so close. His older brother was allowed to come in as well. It was just the family all allowed in to see him. He was lying in the bed showing us how he could lift his legs and stuff, he had always been so healthy and strong. You could see he was happier just seeing us.
91. I couldn't say whether **NR** was happier in the hospital than the care home because I never got to see him in the care home, only for the 15 minutes outside. The manager would email me and say "he's looking happy today" or whatever and I did get some photographs of when he was looking happy, but I couldn't say because I never saw him.
92. He was moved to Woodend with a view to getting him home. He had had speech therapy, but they couldn't get him to swallow or eat. The decision was taken to withdraw the tubes and things, we couldn't have him suffer any more.
93. They managed to arrange a hospital bed and carers at home. This must have been the only time the social work manager replied to any of my letters because I wrote all the time saying how unhappy we were.
94. I wrote a letter to both Woodend and ARI thanking them for how good they had been, how empathetic they had been. I couldn't believe that after all these months people could be so kind.

**NR** *Coming Home*

95. The bed came and, the next day, [NR] was brought home and he was taken into the downstairs bedroom. It was great, he was at home and his grandchildren were able to come down and cuddle him and [NR] and [NR] played the violin. He was smiling, he was keeping time to the music as well with his hand.
96. Although he wasn't able to eat anything I gave him ice cream. He wasn't able to speak very well, he had developed aphasia, but said he wanted more, and he was smiling. We were thrilled that he was back home, and we could actually cuddle him and touch him; all the things you would expect to be able to do.
97. We knew he was going to die the next day or during the night and [NR] and [NR] got into the hospital bed with him and slept with him. We had to get the doctor in the middle of the night because he was in a lot of discomfort. He died in the morning.
98. A lot of people didn't have that. We always thought we were going to get a phone call one day saying [NR] dead, so we were extremely lucky. And that was down to the compassion of the hospital, that he was allowed to come home. The carers that came in were lovely as well.

### ***Bereavement***

99. [NR] cause of death was aspiration pneumonia and unspecified dementia. He didn't have COVID.
100. We knew for a long time that [NR] wasn't going to live. His death was almost a relief that he was at peace at last because he had not been at peace for a long time. The agitation, all that kind of stuff, he was a different person because of his particular dementia. And in a sense, we didn't have to worry about him anymore, the isolation, the months of isolation were absolute hell, and he wasn't isolated anymore.
101. We were allowed 20 people at his funeral which was okay for us, we are not a big family. Over 400 households watched the funeral online. I played the piano; the girls played the violin and did a lovely speech about him, and his twin brother did a reading. We had our minister, so he was able to tie in things.
102. I do think that human rights were completely obliterated during covid – no human rights. We would not want anyone to go through what we went through.

### ***Care Home Residents Scotland (CHRS)***

103. I managed to get into a Facebook group who were so supportive and understanding and other people had the same experiences as us. That's how I came to be doing this. I think I would have gone absolutely crazy without that group. I think that really kept me going. That was Care Home Relatives Scotland.
104. I could not speak too highly of that group because it was such a comfort to talk to people through Facebook and find out that other people were having the same kind of problems.
105. The whole situation was so desperate. Rules were rules and there was nothing you could do. I felt totally impotent. Even writing to people, rules were rules and there were no exceptions. My MSP did come to my door, he understood how bad it was but the rest of them, nothing.

### ***Impact***

106. The impact of the visiting restrictions at the care home on me and my family was pure hell.
107. It was awful for everyone, my daughters were crying all the time, my grandchildren were aware of it, sons in law. I was writing to everyone by email because it was absolute hell. I was sending emails to different people at different times, all desperate; but nothing was done.
108. I, personally, will never be at peace until I die because all the time it goes through my mind, what could I have done differently? The girls will say to me I did everything I could, there's nothing else I could have done.
109. The girls say, "but we got him home". I know other people were not as lucky, but it only happened because he got so ill that he had to go to the hospital. He could have died in the care home any time and we would never have touched him.
110. **NR** was always going to die; he wasn't going to live for a long time. He never really knew that because of the kind of dementia, he didn't have the insight. But he knew something was wrong.
111. **NR** was a family man, he loved being with his family, he was always with his family and the girls had such a good relationship with him. They loved their dad so much, and he loved them. So, he was deprived of the only thing that mattered to him, his family. The most important thing in his life was taken away from him for months and that just wasn't right.
112. People were allowed to go to beaches and meet up with people and yet people with dementia were not allowed to be near their family. How could that be?

113. We never wanted [NR] to go into a care home, I would have had him at home, but it just wasn't working anymore. I often had to phone [NR] to come and help me. Without that I wouldn't have managed as long as I did.
114. The girls hang on to the fact that we got dad home at the end, and that's the important thing. We were with him. We have film of him with the grandchildren cuddling him, the girls playing their violins. Some people did not get that, they got a phone call to say their loved one had died or a phone call to say come in.
115. I do think that human rights were completely obliterated during covid – no human rights. We would not want anyone to go through what we went through.

### ***Inspections***

116. I know that, after [NR] died, the care home had quite a few deaths from COVID, it couldn't have been taken in by relations because relations would be keeping themselves isolated, so it must have come in via staff coming in and then going back to their homes where other people were.
117. When the Care Inspectorate went to inspect the care home after [NR] had left, the grades went down considerably.
118. I don't know how many other people contacted the Care Inspectorate, but I had a few contacts with them. The Care Inspectorate told me that they were going back to inspect the care home on the day they went in when [NR] went into hospital.
119. I couldn't tell you anything about the standards in the care home, [NR] room or anything because I was never in the place.

### ***Lessons Learned***

120. One thing I would say is that "isolation" is a euphemism for solitary confinement for people who have never committed a crime.
121. What I would want is for the Government to recognise that one size does not fit all. Not everybody has the same illness they are not in care homes for the same reason, they are not all old either. For people with certain forms of dementia you cannot explain to them what is going on.
122. The only thing that matters to a person with these aggressive illnesses, the only thing that [NR] understood was the touch of family, the touch of

his wife and actually the voice as well, you know, because [NR] couldn't understand what was going on.

123. To understand that, if anything like this ever happened again you cannot say that everybody will be denied their family in the last months of their lives, rules cannot be applied uniformly. There has to be recognition that the people who have the most interest in making sure that their families don't become ill are the family members, nobody else can have that level of interest, and that was never acknowledged.

### ***Hopes for the Inquiry***

124. My hope would be that the Inquiry will take on board what witnesses are saying.
125. The fact that people don't pay attention to people in these terrible positions – just saying well rules are rules and we don't really care about you, they apply to everyone, no personal circumstances. I think that if something like this happens again, they will have to take a different approach.
126. I understand that they didn't want people to get covid, but the thing about it is that they didn't understand that some people would die, not because of covid, but because they were deprived of things they needed, not wanted, but needed. There were too many people left sad because they did everything they could but they couldn't do anything.
127. I think it would be nice if the Government gave an apology to people who were in that situation.
128. I was married to [NR] for almost 45 years and the rules took away my ability to touch him and comfort him for the last six months of his life. All of the care staff who were going home to their families every night, were able to touch [NR] but none of his family members, the people who were most important to him, were able to be near him. [NR] was dying of dementia and was totally isolated from everyone he loved most. My hope for the Inquiry is that they ensure that people living in care homes, like [NR] can never be completely isolated from their family again.

### ***Additional Correspondence/Documentation***

129. I wrote over one hundred letters complaining about hospital access and care home visiting. I wrote to the care home manager a lot, and my daughter wrote to them as well explaining why I should be an essential carer. We both asked for one of our letters to be forwarded upwards, but it was never answered. I was told whoever was dealing with it was on a break or something. I also wrote a number of letters to the Social

Department within Aberdeenshire City Council. I also wrote to the Scottish Care Membership Support Manager, the Care Inspectorate, Scottish Dementia Working Group, Alzheimer's Scotland and Public Health.

- 130. I tried to do everything I could to get right to the top to see if I could change anything. I did get a letter from a [NR] I think he was one of the Directors of the large company of which Deeside Care Home was one.
- 131. I also wrote to Jason Leitch, Nicola Sturgeon, Jeane Freeman, I wrote to the private care homes person as well and I wrote to my MP, my MSP. I can't tell you how many people I wrote to and felt totally impotent.
- 132. I have provided all of these letters to Thompson's Solicitors and would be happy for them to be provided to the Inquiry. Sending these emails to Thompson's took me back to the time and all the awful things that happened.
- 133. My MSP, as I said, took it on board and Andrew Bowie, the MP, he wrote a very empathetic letter.
- 134. The next thing we, as a family, were going to do was get a solicitor because that's the only way we were going to be able to see [NR] It probably wouldn't have made any difference anyway.

Signed .....

Date .....