Witness Name: CATHERINE TODD

Statement No.: 1

Exhibits: 0

Dated: 16.07.2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF CATHERINE TODD

I, Catherine Todd, will say as follows:

1. I have been asked to provide an account of my experience (which is inherently linked to my partner's experience), and the experience of our son, who sadly passed away shortly after birth during the pandemic.

2. In or around 12 July 2021, I was around 27 weeks pregnant with my first child, and I contracted Covid 19. At the time I had been due to attend a routine scan, and I called the hospital's maternity unit to let them know I felt unwell and had Covid. They did not do anything for me except cancel the scan and advise me to isolate.

3. I started to feel very unwell as a result of Covid, but more importantly I became aware that Ziggy was not moving the way he had been. I made phone calls to the maternity unit what felt like almost every day that week out of concern for him. Every time I called they advised that they would not bring me in for myself and my baby to be checked because I had Covid. I was very sick, I was very worried, and I did not know what to do as the people I had been advised to rely on for help were effectively saying they could not and would not assist me, even to check that all was ok.

4. On Friday 16 July I went to the Emergency Obstetrics in the Hospital. While I was there they did not do a full scan but just used a doppler to listen to the baby's heartbeat. This is something that continues to worry me, as I wonder whether a CTG should have been used, given how far advanced my pregnancy was. I also wonder whether, if it had been, it would have identified that there was a problem and possibly identified something that could have been done to save Ziggy. I understand that the Serious

Adverse Incident report which was later conducted suggested that a CTG should have been done but they had not appreciated the complications that Covid had on pregnancy at that stage. I find that surprising as it was more than a year into the pandemic and it was widely publicised that Covid was associated with risks during pregnancy.

5. After doing the doppler, the midwife told me that I was fine, the baby was fine, and that she had been there since 7.30am so needed to do a handover. I had to go to the car to wait to see her follow-up, and when she did come out she had changed into her own clothes already. I was sent home, feeling very ill, and still very concerned that something was not right with my baby.

6. On the 19th July I had even more difficulty breathing, and was having heart palpitations. I was getting very concerned for myself and for baby. My partner TJ phoned an ambulance, however it took around six hours for it to arrive, which was around 1am or 2am the following morning. They did an oxygen test on me and said I was fine. They did not check the baby. They just told me to take paracetamol and "Ensure", which is a nutrition drink, however I was already trying to take this but could not keep anything down.

7. I had made clear to them that my problems were not constant, but were intermittent, though frequent, however they had attended at a time when my breathing had gone back to normal. I was also concerned about the reduced foetal movement, however I do not believe they did any checks on the baby, only on me. Despite this they told me that all was fine.

8. On the 20th July I was still feeling very ill, had difficulty breathing and again was frightened for myself and my baby. I phoned the GP around midday and within a minute she said she was referring me to A & E and told me that she would fax them immediately to ensure I was seen, as otherwise I would likely be turned away. I was surprised that they were still using a fax machine.

9. I travelled to A&E, and was placed in what seemed to be a waiting area for people with Covid, however it also seemed to be used for people with suspected Covid. This caused tension among the other patients, including one patient who was shouting a lot because he believed he did not have Covid and he was concerned he would get it from being placed in an area with lots of Covid patients. It was therefore a stressful part of the hospital. Obstetrics did a liver function test. I was later told this had come back deranged. When I was in A&E they also did a scan and I could see Ziggy moving. As soon as obstetrics obtained the scan results I believe that staff were all called into a meeting. Afterwards they told me that everything was ok, the only issue was the deranged liver function test. At that stage a midwife came and took me to the maternity ward. I remember thinking that this was odd, as I had been told that the concern was for me and not my baby. I was taken to a room with five people, which I understood included two consultants. They scanned my bump, though after I contracted Covid my "bump" had significantly reduced in size, which was something else that had caused me significant concerns around this time. They told me that my baby had little or no amniotic fluid and immediately

prepped me for a C section, including attaching me to a drip. At that stage alarms went off and they just all left me lying there for at least an hour and what felt like more.

10. I feel very strongly that I should not have been left like this. I was told an urgent C section was needed and could not wait. Despite this there was a delay in carrying it out due to what must have been a lack of staff. I was later told that they had to operate on another patient, who had an 80% chance of survival whereas Ziggy had only a 10% chance. I do not know and have never been told how they calculated these percentages. I believe that the delay in carrying out the C section must have meant that Ziggy was deprived of even that 10% chance.

11. My partner TJ did not know what was happening at this stage as there had not been time to tell him properly. He only knew that I was getting a C section. When he contacted the hospital they advised him to ask me, but I obviously could not contact him when I was having the C-section. TJ was only permitted to attend much later, in the early hours of the morning when Ziggy was already in the Neo Natal Unit (NNU). This was a source of distress for us both.

12. When Ziggy was eventually born by C section he had to be brought straight to NNU.

13. Nursing staff tried to bring myself and TJ round to see Ziggy a few times during the night, though I emphasise that it was not at all clear to me that this is what was happening. Nurses would just get me out of bed and into a wheelchair, and then they would just get me to go back into bed. I did not know what was going on. I later found out that they were trying to bring us round to see Ziggy on each occasion I was put in the wheelchair, but they had to kept postponing the visit as Ziggy's condition kept suddenly deteriorating. I was told that he kept going into cardiac arrest.

14. When myself and TJ did eventually get round to see Ziggy the following morning we were made to wear full PPE. I found this inexplicable for a number of reasons. For one thing we later found out that the hospital had tested Ziggy for Covid and he had tested negative (though they did not ask our permission to do this). That meant there was no need to protect us from him. They also knew (though I did not) that he was not going to make it, and that they would be switching his life support off, so there was no need to protect him from us. Staff also knew that I had Covid at the time, so there was no need to protect me from him. I find this not just frustrating but heartbreaking. There was no need at all for me or TJ to be in PPE once we went in to Ziggy. As a result, in all our photos with Ziggy, we are in PPE.

15. Shortly before we were taken round to see Ziggy we had been told that his "obs" had picked up. We did not understand that this was a very minor and that he would still not survive for any length of time. When they brought us round they had not explained that they were removing life support. I initially thought when they were removing all the tubes that he must be getting a lot better. Then they just handed him to me and left us.

16. They left us with Ziggy in that room in NNU for 2 hours and no one came back in at all. The Serious Adverse Incident report later said that this was a long wait but explained that they were under-staffed. For obvious reasons I still do not believe this was acceptable. I would add that there was a window into the room from the main room or ward in NNU. There was a wee girl and someone I assume was her father, who watched the entire thing. I understand that hospital staff have now put up a curtain to prevent this happening again. I cannot understand why this would not have been done before.

17. I was kept in hospital for some days afterwards. Two days after Ziggy had passed I was with TJ in the hospital, when a midwife came in and sat in the middle of the floor, which I found very strange. She looked at TJ and said something to the effect of "*you can't be leaving this room.*" She then said something like "*that's ok as we've already bent over backwards for you.*" I thought these comments were rude and unnecessary. I did not see this rude midwife again. Although I complained I have been told the hospital were unable to identify who this was. I do not understand this, as I assume documentation of who went in and out of hospital was very important during Covid.

Post Mortem

18. I have been told that different factors caused Ziggy's death. I was initially told I had Covid placentitis, then pre-eclampsia, and this appears on Ziggy's death certificate. Despite this I was later told that the doctors do not any longer believe that I had pre-eclampsia, though I believe it remains on the death certificate.

19. We were told that Ziggy was to be sent for a post mortem. We wanted to know where his body was at all times. We had been told that his body would be collected on the Monday to be brought to a hospital the Liverpool area for a post mortem, and were told that we would be informed once his body was collected, and that his body would likely be returned two days later, on the Wednesday. I asked to be updated on everything, however no one contacted me on the Monday. When we contacted the NI hospital we were told that Ziggy was not there and must have been collected, although they also said they did not know whether he had been collected or not. It later turned out that he was still there.

20. I eventually contacted the hospital in England directly and they informed me that Ziggy had definitely not been collected. There was therefore a period when we had no idea where Ziggy was and it seemed he had been lost. Neither hospital knew where he was, although it seems he was still in NI. On Wednesday morning they finally found him. A girl from the hospital in England phoned me to advise that they would have two babies coming over from Belfast that day, but as they did not know names they did not know if Ziggy was one of them. The later confirmed to me that it was Ziggy and that he had arrived. He arrived at the English hospital on Wednesday and returned to NI that same day.

21. Following the post-mortem at the Liverpool hospital I was informed that they believed that I had Massive Perivillous Fibrous Deposition (MPFD), which I was informed is a condition where the placenta is taken over by fatty tissue. I am told it is so rare that no test can identify this. I had been told by a midwife that she had never seen a placenta like mine, and this may relate to that. The SAI report suggests that this was linked to Covid.

22. I was also told that Ziggy had some brain damage. I had not been told this before. I was told that this was caused by the small amount of amniotic fluid, and they told me that if I had not had Covid then Ziggy would have been stillborn. I was told this a couple of months after he was born. However I do not fully understand the reasoning behind this, particularly as I was primarily calling the hospital because he was not moving, not because I had Covid. If I had not had Covid I believe I would have been scanned much sooner and the risk to Ziggy may have been identified.

23. I do not know whether they could have identified MPFD if I had attended hospital sooner or if I had the CTG instead of Doppler. A paediatrician spoke with me and said that Ziggy would have died regardless, whether or not I had been seen earlier. I do not know if this is correct.

24. I have been told that they have now reduced the stage at which they use the CTG but I also know 3 women who have had Covid in and around the same stage of pregnancy, but they still have not had CTG. That concerns me as it suggests that what has been learned from my case (and other similar cases) is still not being acted upon.

Lack of Information post-death

25. When Ziggy was coming home to us we had not been informed that he had a negative PCR. We were told by the funeral home that he could not have an open coffin. We also did not know anything about a cuddle cot. This is a type of cot that has a cooling device, which preserves appearance and so allows you to spend more time with your baby.

26. It was only when we spoke to a woman who worked for the Snowflakes team who checked that he had a negative PCR, that we were allowed to have an open coffin. It was also only after this that were told about the cuddle cot, and one was provided by the hospital for us. Again it seems that these were fundamental failings in communication at an extremely difficult time for us, and this caused us unnecessary further distress. It is not at all clear to me why we were not simply provided with this information ourselves, or why it took the intervention of the Snowflakes team for us to be given this information and provided with a cuddle cot.

Information Retrieval

27. I later managed to get a a copy of my green notes from the hospital. This was very difficult to get. Myself and TJ had to repeatedly request them which took almost 4 months. One receptionist in the

hospital made a comment to say that she didn't really understand why I wanted them, which I thought was unfair and unnecessary. When we finally received them, we had to attend in person to copy them. TJ went in to the room and they would not let me come in. He went into a side room and agreed to photocopy them. Around half were missing. It was only much later that we managed to obtain the full set of notes. One reason we wanted these was that we simply wanted answers about what had happened to us and Ziggy. Instead of providing us with those answers, it felt like we had to fight every step of the way to get even the most basic information which we were entitled to.

Data Breaches

28. I have since given birth to a baby girl, I&S born I&S When I was pregnant with her I had booked a private ultrasound scan. The radiographer who did the scan commented that they knew who I was and made comments which confirmed to me that they knew what had happened with Ziggy and myself. They said my auntie told her, however I do not have an auntie. It later turned out they had been told about myself and Ziggy by a receptionist in the hospital I had been in.

29. When I was first pregnant with I&S I was told by my consultant that I could not get MPFD again. However I contacted a doctor working in a university in the south of Ireland and he later contacted my consultant to advise that there was a risk this could happen again, and that I should be on medication such as aspirin, and should be monitored. I was then admitted to hospital multiple times during my pregnancy with I&S so that they could monitor me.

30. When I was 34 weeks pregnant with I&S I caught Covid, was admitted to hospital around 18 July 2022. The hospital staff let me out on 20th July to go to Ziggy's graveside.

Concerns

31. I obviously have a significant number of concerns about all of the above.

32. I believe I should have been examined sooner, even though I had Covid, even if this required staff to undertake such examinations with PPE. I do not know why I was not seen sooner when I expressed concerns about Ziggy's lack of movement. At the time I believed I had done everything I could, but I am still left feeling that if I had somehow insisted on a proper scan as soon as I was concerned, then something could have been done to save Ziggy.

33. Myself and TJ felt strongly that we should have been asked permission before a PCR was carried out on Ziggy, and at the very least, we should have been informed about this and the result at the time. It was distressing to know that we were not asked, and then that the results were then not given to us. It made us feel as though we were not important at all in relation to this decision.

34. Incidents like this are reflective of the fact that the information provided to us was extremely poor throughout. Most obviously, it was extremely distressing to have a visit with Ziggy after believing he was doing better only to discover, when we were there, that they were taking away medical support and that he was about to die. This obviously should have been properly explained to us. We were not prepared at all for this.

35. It was beyond distressing that we were required to wear PPE to visit Ziggy, and to have photos with him taken while we were wearing PPE. I do not understand the reasoning behind this. This has obviously had a very lasting impact, and we are reminded of this every time we look at any photos with him.

36. The information provided to us afterwards, and the manner in which this was provided, has also caused additional distress. For example, myself and TJ should have been informed about where Ziggy was when he was sent for post-mortem. It was extremely distressing that, for a stage, nobody knew where he was at all, particularly as it turned out that he had not left the hospital in NI.

37. I also was extremely dissatisfied with the SAI report. I feel it did not answer any of my questions properly. It was also extremely delayed. I understand that an SAI is supposed to complete in a matter of weeks. Instead it was only completed around a year after Ziggy's death. That delay compounded our distress. I believe it showed a lack of concern about the seriousness of our case and the fact that we deserved answers. It gave the appearance that the Trust were trying to find excuses to explain away the inexcusable.

38. Overall I was left with some overriding impressions.

39. One such impression was that there were not enough staff, and those staff that there were had been simply unable to handle my case. That was the impression I got from the failure to scan me at the outset, the failure to see me every time I called, and the delays in seeing me and in carrying out the C-section when it became clear that this was necessary.

40. Additionally, the medical staff who did see me gave me the impression that they just did not know what they were supposed to be doing. I got this impression from the day I first contacted the hospital with Covid, when I called about reduced movements; when ambulance staff finally attended with me, when I called to A&E; even getting us to wear PPE when going to see Ziggy. It simply felt that staff were trying to deal with us but not at all sure how this should be done. I am concerned that this was the case so long after the Covid pandemic started.

41. The medical staff also did not pay attention to what we wanted, and frequently did not ask or explain things, and this significantly increased our distress. This includes the obvious, in that we were not told that Ziggy would not survive and they were withdrawing support, but also things that may seem relatively minor in comparison, but which nevertheless have caused us great frustration, such as doing

a PCR test on Ziggy without our knowledge or consent. It just made it seem like our knowledge, input or views did not matter, from the smallest matters up to the most significant.

42. My experience with the Health Care system during the Covid-19 pandemic and the loss of our baby son has deeply impacted myself, my partner and our wider family circle. I have significant concerns about the quality of the maternity services in Northern Ireland and how the standards of this service were allowed to plummet even further during the pandemic. I believe the care and treatment I received was unacceptable, I hope that changes are made to prevent this standard of treatment being provided again in the future.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed Personal Data

Dated: 7/16/2024