Witness Name: FIDELMA MALLON

Statement No.: 1

Exhibits: 2

Dated: 22.07.2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF FIDELMA MALLON

I, Fidelma Mallon, will say as follows:

Background

1. I have been asked to provide a statement to the Inquiry in relation to my experiences relating to the care and treatment of my husband, Michael James Mallon, who passed away on 24th February 2021 after contracting Covid 19 in hospital.

2. I will finish this statement with some words about Michael, our life together, and the impact of his loss on all our lives. At the outset though I would emphasise that, although Michael was 70 when he died, he was still a big, strong, man. He took good care of himself and had never touched a drop of alcohol in his life. He was a happy man, always singing about the house and lifting the mood of others.

3. He was only seventy years old in February 2021, and despite his liver disease he was not on the list of those particularly vulnerable to Covid, had not received any notice to attend for the vaccine at that stage, I assume because his age category had not yet been reached.

Hospital Admission

4. Michael had liver disease and had been on hypertension medication for some time. In or around 1st February 2021 he had pain which we believed was due to a gallstone. During the night of 1st-2nd

February he developed a fever, became cold and was in pain. My daughter is a I&S and has some medical knowledge, and we believed he had developed an infection such as cholangitis as a result of the stone. We were concerned at how unwell he was and so contacted the GP who arranged for him to be admitted to the local hospital.

5. We were concerned about his being admitted there due to the risk of him acquiring Covid 19 in hospital. One reason we were so aware and concerned about this is that one of Michael's family members had been admitted to the same hospital with an infection, contracted Covid 19 there and ultimately died there only 5 weeks previously. Despite this, we thought Michael was so unwell that he required medical care and observation that a hospital could provide.

6. Michael was admitted to hospital on 2nd February 2021. On arrival at hospital we had been informed that Michael was diagnosed with a suspected infection due to cholangitis, which is what we as a family had suspected. Upon arrival my husband was kept in A&E for approximately 36 hours, before he was moved to an Orthopaedic ward. I was not made aware of any other diagnosis at this stage.

7. I understand that Michael was put through various diagnostic procedures, including an MRI, a CT scan and an MRCP to examine the stone. I spoke with hospital staff by telephone and was assured that my husband had only an infection due to a gallstone, and that, once it was removed, he would make a full recovery. We were also told that he was moved wards on a number of occasions, which does not appear consistent with a strategy of protecting patients from Covid.

8. Although we as a family believed that they had scheduled an operation to remove the stone a number of times, and he was made to fast from 6pm in the evening on a number of occasions as a result, he had still not had the operation by 10th February 2021, which was 8 days after his admission. This meant he simply received treatment for the cholangitis at that stage.

9. We had not understood that the procedure would take so long at the time Michael was admitted. I am aware from my daughter that patients with impaired hepatic function (in this case due to the gallstone blocking the biliary duct) have a greater risk of dying with COVID-19. My husband had other risk factors, including having liver disease and being on hypertension medication. I believe that these risk factors should have meant that removing the stone was a matter of utmost urgency, in order to limit both his risk from the stone, and also to limit the length of his hospital stay. If it was not possible to remove the stone due to unforeseen circumstances and pressures, say for example staff off on leave, or sicker patients presenting, then I do not understand why was he not discharged on IV antibiotics and seen by the acute at home care team, which would have cut his risk of developing COVID-19. He could then

have been seen as an outpatient at a later date, at a time when the virus was less prevalent and the risk of hospital acquired infection was reduced.

10. If we would have known that the procedure that Michael required would take this long to arrange, we would have resisted hospital admission, particularly given our concern at what had happened Michael's family member. It also does not seem to us that it made any sense to admit Michael to hospital in circumstances where they could not do any more for him than could have been done in our home for the week, particularly where this was simply exposing him to an unnecessary risk from Covid 19.

11. We later submitted a complaint letter to the Trust in March 2021 in relation to Michael's treatment, and received a response to that only in February 2022. A copy of that complaint FM/01 [INQ000494733] and the response FM/02 [INQ000494734] will be provided with this. In their response the Trust suggested that the day after his admission (3rd February) an MRCP procedure was arranged with the intention that it would take place on 9th February. There are two issues with this. Firstly, if it was known that the MRCP would not take place for 6 days, it is unclear why Michael was required to remain in hospital. Secondly, that correspondence suggested that it was only on 9th February that the medical staff knew that the issue was a gallstone. That is not consistent with our understanding that procedures were cancelled on Michael on a number of occasions. Our belief is also supported by the fact that Michael was made to fast during the evening on a number of occasions. It may be that it was only following the MRCP that there was confirmation of the gallstone, but my understanding was that everyone knew that this was the most likely explanation from his admission, and this was effectively the working diagnosis.

12. I would add that during his stay in hospital, Michael informed us that a doctor had advised him to stay in hospital despite the delay to his ERCP to remove the stone, because if he went home he would not get the stone removed for at least 2 years. That made no sense. Either he required the stone removed as a priority or he did not. It did not make sense to artificially make himself a priority, whilst simultaneously exposing himself to a risk of Covid 19 by remaining in hospital.

13. Michael was tested for Covid on a number of occasions during his time in hospital. We were advised by the Trust that he had been tested using a Lumira test on 2nd February, and using a PCR swab on 3rd and 7th February, all of which were negative. As a result Michael had been placed on an apparently Covid free ward. This appears to be where he contracted Covid. I am concerned that this must have meant there were insufficient precautions to protect those on the ward from Covid 19. This was particularly poor as I believe Michael was at high risk of serious illness if he contracted Covid due to his liver issues and the gallstone. I do not believe he was treated by the hospital as being someone with such a heightened risk and therefore requiring a greater level of protection from Covid than the general population. I do not know how he was permitted to acquire Covid on the ward, but I do know that

Michael would have worn a mask on the ward to protect himself from Covid, and despite this he was informed by nurses that he should remove this. On one occasion, when he was asleep in the Orthopaedic ward, he was woken by a nurse removing the mask off his face as he slept.

14. Michael also told us he had asked for a new mask each day to help protect him from Covid. This was initially refused, as he was advised by a nurse that the masks lasted 3 days and he was not entitled to new PPE. My son had to ring and ask the nurse to give him a new mask. The Trust later accepted that he should not have been told that he was only entitled to a mask every three days.

15. On the night of the 9th of February, Michael was moved ward in the middle of the night from the Orthopaedic ward to I&S (time of move was apparently approximately 01.30am). We as a family have never received an explanation as to why he was moved ward that night at this time when he was asleep. It also seems to me that such movement to a different ward would have increased my husband's risk of acquiring Covid 19, as it necessarily meant exposure to a greater number of patients and staff. Following our complaint about Michael's treatment to the Trust they asserted that the move had been due to Michael testing positive to Covid, however we are certain in our minds that this move took place the night before the positive Covid result. One reason (though not the only reason) we are sure about this is that Michael was moved again the afternoon after he tested positive, and that move was apparently the result of the positive test. Although at this point we do not recall the precise date of these moves or the positive Covid test, we are very clear about this sequence of events and always have been.

16. Michael had been due to have the gallstone removed on 11th February 2021. He did a further pre-operation PCR test on 10th February, and the result came back positive for Covid. Michael told us that the Doctor who was attending on this date told him that he thought this was a false positive, as Michael had absolutely no symptoms. Despite this he was not re-tested but was moved to a ward with Covid positive patients. He continued to have no symptoms for the first few days. If there was in fact the possibility of the covid test being incorrect and being a false positive, then I do not understand why was he not re-tested, or why he was immediately moved to a Covid ward rather than placed in isolation. This meant that even if it was a false positive, Michael would inevitably contract covid on the covid ward.

17. The fact that he had tested positive for Covid was very distressing to Michael and all our family. At this point Michael just wanted to get home to see me and our children, particularly because a member of his family had died five weeks prior as a result of acquiring Covid in this hospital. We were all terrified that this would recur for Michael. Sadly these fears were in fact realised.

18. On Sunday the 14th of February I first noticed my husband to be confused. I reported this to the nurse on duty that day. For example, he seemed unable to answer his phone, and prior to this he had had no issues with his phone or his state of awareness. This caused me great concern. The nursing staff did not seem to notice any issues, which did not allay my concerns but heightened them. The next day it seemed clear that Michael was repeating himself and not realising this. He also seemed to be having problems using his phone, and even turning on the radio. My daughter, who is a pharmacist, rang him that day and also described him being confused.

19. On the morning of 16th of February my daughter contacted the hospital and got speaking to a nurse to raise concerns about him being confused. The nurse said that it was her first time in caring for Michael and that she had not noticed anything wrong with him but then she didn't know him. The nurse later told my daughter that a fellow patient had said that my husband had went very downhill over the weekend. I was shocked that it took another patient to identify that his condition had deteriorated. I was also shocked that our family could tell this through occasional phone calls, whilst the medical staff charged with caring for Michael full time, in whom we had placed our trust, had completely missed this.

20. It was even more concerning that hospital staff not only did not notice this deterioration, but also did not act on what they were being told. Instead, on 15 February 2021, a doctor determined that Michael was now fit for discharge. My daughter got speaking to a ward pharmacist who was apparently preparing his medication for discharge, and she raised concerns about delirium. After that she managed to get speaking to a doctor and raised her concerns. I spoke with the same doctor and informed him that I did not understand how he could think Michael was fit for discharge as he had called me multiple times that day without remembering the other calls, and had sounded confused on the phone. Following the discussion with us the doctor went back to examine Michael. He contacted us a short time later and said something to the effect that Michael was completely "out of it" and confirmed that he was not fit to be discharged.

21. I later raised a complaint with the hospital in relation to much of the decision-making and treatment of Michael, and my complaint letter exhibit **FM/01 [INQ000494733]** and response **exhibit FM/02 [INQ000494734]** will be provided to the Inquiry. One significant feature of the response was that, in relation to the query as to why he was determined fit for discharge, we were informed that "*it is not uncommon for the clinical picture to change. When this occurs, it is important for the medical team to reassess the situation and revise the decision if appropriate. This is what occurred in this instance.*" I believe that this response was not true. The clinical picture did not change, as my husband had deteriorated and had been confused on the phone in the days and indeed hours before he was found fit for discharge. This had been recognised by myself, my daughter and my son. All of us had calls with him and had discussed afterwards how confused he had been. My daughter would describe

him repeatedly calling her, and how he was having difficulty turning on his radio. This was also sufficiently marked that another patient had alerted staff to the deterioration. My concern is not only that the care and attention he was receiving was deficient, as it failed to notice such significant deterioration and level of confusion, but also that a response like this seeks to cover up those failings rather than acknowledge and address them. Failings of this nature appear to be more systemic and cultural, and in the long term present a greater risk to health and life. If failings in care at this hospital had been identified and addressed much sooner then Michael may not have lost his life. Instead it seems that the Trust they have simply tried to explain away their failings in relation to his care rather than address them in practice.

Medication

22. My husband was on morphine 10mg bd and gabapentin 300mg started by the pain team due to pain resulting from an unsuccessful hip replacement. The doctor queried hepatic encephalitis and constipation but also said it could be covid related. My husband had stated, before he became confused, that a doctor had stopped his morphine but a pharmacist said that this would not have had time to work and she had got it restarted again.

23. Before his admission to hospital my husband did not take pain relief medication at the level which was administered to him in hospital. Even though he was prescribed such medication, he did not take it at the level prescribed. For example, he would have only taken one or possibly two co-codamol per day, and although he was prescribed amitriptyline he tried it and it did not agree with him so he very quickly stopped it. I am therefore concerned at the nature of the medication that was administered to him during his time in hospital, as this suggests that this context was not taken into account. For example, my husband was on morphine for over 10 days, however he had also been found to be at risk of precipitating hepatic encephalopathy, which suggests he should not have been receiving morphine, at least for such a period.

24. The pharmacist, when going through discharge information with my daughter on the 15th February, advised that Michael had duodenitis, colitis and a peptic ulcer and had a high risk of GI bleed. This was the first time these diagnoses were relayed to my family. We are concerned that these complications could have been a result of increasing his medication for fatty liver. The Trust response now suggest that these were not proper concerns. That does not assist the family. If in fact these were not concerns, this merely serves to show that there were failings in communication, with the family being worried about issues unnecessarily. I would also find it surprising if the pharmacist had raised those concerns in circumstances where they had no basis.

25. During the evening of the 16th February we were informed that Michael had crashed and needed oxygen. When this occurred his medication was reduced and his condition improved dramatically. The

doctor then informed my daughter that in his view it looked likely that the medication caused the collapse, as he had recovered 'too quick' for it to be Covid. We understand that within 6 hours Michael was back to normal.

Communication and Michael's Death

26. I found the communication received from the hospital generally and the Covid ward in particular to be extremely poor. At times my daughter, my son and I had to ring numerous times (54 times on one occasion before anyone answered the phone) to get an answer to the direct lines to get any sort of communication out of the staff caring for my husband.

27. It was not simply that the attitude of staff made it difficult for us to communicate or receive updates. At least one member of staff was actively hostile to our efforts to maintain contact with Michael and to receive updates about his condition. On the night of the 17th February 2021 a call was made by my son at 20:45. During this call, the nurse who was at that time charged with the care of Michael could be clearly heard on phone saying something to the effect of, "*I'm sick of your family calling the hospital and annoying me the nurses/sisters with asking questions about you.*" We heard this comment as, when the nurse arrived to get Michael set for bed, he put the phone on his hospital bed. We then heard this exchange occur. A number of members of the family heard this comment clearly, and I emphasise this was said in what sounded a serious manner, and was not jocular or tongue in cheek, as was subsequently suggested. It was extremely distressing for us as a family to hear this conversation, as it showed disrespect to both my husband and our family at such a vulnerable stage in my late husband's life. We as a family strongly feel this could have been avoided. We found this incident extremely distressing, especially with COVID-19 restrictions keeping us from seeing my husband. We do not want this treatment to happen to any other sick or elderly patient, when there is no one there to comfort or stand up for them. We do not believe that the Trust's response on this issue, or the account of the nurse in question, is consistent with what we heard this nurse say to Michael.

28. A further call took place on 19th February 2021, when my son spoke with the sister on the ward, who refused to provide details of the current health/state of my father. She advised my son that she was not looking after his father, and added that the nurse who was in charge of his care was too busy to speak with ourselves and update us as a family. As a family we believe this to be totally unacceptable. I stress that we were not calling excessively, we simply wanted a single update each morning and evening. This was particularly important to us as we were refused permission to visit.

29. We were later informed that we should have been permitted to visit him in at least one of the wards he was in under the rules in place at the time. This was particularly distressing to discover, as my husband and ourselves as a family queried on many occasions why we were not allowed to visit him

when he was in this ward. Our requests were rejected, and we were informed that this was due to COVID-19 restrictions. We were told that visits were only permitted when a patient was deemed "*end of life*", and such a visit would have been only for 60 minutes. Despite this information, my husband was able to tell me that other patients in his room were receiving visitors weekly, including one gentleman who had been a member of the armed forces. This suggested that there were different rules for different patients. I do not believe this could have been justified.

30. Subsequently, when my husband was moved to a different ward, a doctor who looked after my husband confirmed that when he had been in the previous ward he should have been entitled to visitors, as it was not deemed as a red covid ward. She advised that the decision from the nurses & sisters of the ward to prevent our family visiting my father was wrong and that her colleagues on the ward were at fault. This was extremely distressing to hear, particularly after Michael had passed away, as we had all wished we had been able to visit him, support and comfort him in hospital.

31. Following our complaint to the Trust, they advised in correspondence that such visits had not in fact been permitted in this ward. If that was correct then we do not understand why we had been told that the visits should have been permitted. We continue to believe that visits were allowed given that other patients on the ward in fact benefitted from multiple visits, as noted above.

32. Our isolation from Michael at this point was even more concerning given the failures in the care shown to him. For example, we are aware that fellow patient in the ward on one occasion had to get up from his hospital bed at around 3:30am on night in order to go to the reception desk and seek medical attention urgently for my husband. On that occasion Michael had not been seen by medical staff since early evening.

33. Two other incidents demonstrate the detrimental consequences in practice of Michael's isolation from us and the problems with communication with medical staff. Michael had recently undergone a cataract operation, and since his operation was prescribed daily eye drops known as "Hylo-forte", which were to prevent dryness in his eyes. When we contacted the hospital about this we were advised that they did not store this medication on site and it may have taken 2 days to obtain the eye drops. As a result members of the family drove to the hospital and provided the medication. When we subsequently phoned the ward to check they were administering the eye drops to my father, the nurse who spoke with us asserted that they could not as it was not the proper medicine for his eye. This was despite the fact that they had been on his medical history since the operation.

34. That suggested that there was no proper reconciliation carried out in relation to my husband's medicines, otherwise it is not clear why his eye drops were omitted. Michael would complain about his eyes being dry every day, and told us that he had requested the nurses to insert the eye drops without success. He would tell us that dryness in his eyes occurred as a result, and caused haziness in his eyesight. Eventually my son spoke to a nurse and insisted she contact the I&S Hospital eye department who had prescribed them.

35. The day before Michael died, our daughter was allowed to visit Michael. Even at that point he asked her to get his eye drops as he hadn't received any. His eyes were blinking and couldn't see properly. Cathy had to ask a nurse called I&S for his eye drops and administered them herself. We found this all very distressing as a family, that Michael would be left in discomfort simply because the hospital refused to administer his own medication.

36. In response to our complaints about the failure to administer eyedrops, the Trust advised that they had been identified as Michael's medication and had been administered on two occasions. This did not make sense to us. If they had been considered necessary they should have been administered daily, particularly as Michael was in discomfort. It is also not clear to me whether my daughter's administration of these eyedrops were included within the two instances identified. Even if the Trust's response is accurate (and it is not accepted), this still suggests a breakdown in the systems used to care for patients, and suggests that these breakdowns were reinforced by the isolation of patients such as Michael from their families, and the apparent refusal on the part of medical staff to listen to and act on information provided by family members.

37. There were also comments made to us which were hurtful. For example, my husband never drank alcohol in his life (he was a pioneer), however he did have liver trouble. Despite this background, on several occasions during his time in hospital 2nd of February- 24th of February we were told *'your father must have been fond of the drink'*. We could not comprehend that medical professionals could make such statements. They were offensive, as they sounded critical of his personal behaviour, and also demonstrated a failure to consider his previous medical notes, which made clear that he had not drank alcohol and his liver issues were entirely unrelated to such a source.

38. The conclusion that his medical notes were not considered by those professional caring for Michael was reinforced by other comments made. For example, I had been speaking to a doctor in I&S who told me that markers relating to Michael's liver function were raised. I was surprised and responded to advise that he had only just seen his doctor, about his liver a few weeks ago, and queried how it had gotten so bad so quickly. The Doctor then advised that he would check those notes, following which he advised me that I was right, and that it was only the level where the stone is that was raised. As a result he assured me that my husband would be ok.

39. This was very distressing in the circumstances. It was not merely the inability to contact Michael and to ensure he was receiving proper treatment which was frustrating, but also the failure to provide us with information in a timely way.

40. For example, on the 19th February a doctor informed my daughter for the first time that Michael had decompensated liver cirrhosis with biliary hypertension, which was identified on a scan taken on the 4th of February. This was the first time we were made aware of how serious Michael's condition was. We were aware he had fatty liver. After this date he was only allowed 500mg of paracetamol to bring down his hyperpyrexia due to COVID-19.

41. Our concern at the failure to provide us with proper information is not some isolated complaint but is inherently linked to the care that was provided. By way of example, if we had appreciated the liver cirrhosis which had been identified on the 4th February, we would have questioned the administration of morphine and gabapentin at the doses provided. It is not clear to us whether these doses were a feature of Michael's decline, but it seems to us that they may have been, and that the doses were not appropriate in the circumstances. Even if we are wrong about this, we were entitled to have informed input into his treatment, and the lack of information provided prevented this in practice.

42. I note that many of these complaints were put in correspondence to the Trust. The answer to the failures in communication appears to primarily have been based on other pressures on hospital staff. That suggests there were insufficient staff for the work which was required, as patient updates must be regarded as a necessary part of proper care. Although there was an apparent acknowledgement that on most occasions we did not benefit from twice daily updates, the nurse lead nurse from the ward about which we had greatest complaint gave only a conditional apology in that correspondence, to the effect that she was "*sorry if communication was not at the level expected.*" That apology should not have been conditional and to frame it in this was disrespectful. For the avoidance of doubt, communication was not in fact at the level which was expected, or at the level which should have been considered appropriate and necessary. I find it shocking that this nurse, and the Trust, did not immediately accept this and provide a proper apology.

End of Life

43. On Friday the 19th February, Michael was told that he was to get a chest x-ray. This was not in fact carried out until the Monday 22nd February. At this stage Michael had been moved to a different ward. We were never given an explanation again why he was moved ward. If it was this case that his condition had deteriorated over the weekend, then we also do not understand why there had been a team of

health care professionals with him, including consultants, on the morning of Monday 22nd February, apparently still reviewing whether the gallstone could be removed.

44. My daughter Cathy was permitted to visit Michael that day. We were told that they would only let one person in and so it was Cathy who went. Cathy was saying goodbye to him, but at that stage it was not clear whether he could hear her. He was making comments that showed he remembered things, such as "*make sure you keep the good brand tablets for me*", which was a family in-joke. At least he was talking, though we did not appreciate how bad he was. After the visit there was very little compassion. Cathy was told that here would be no more visitors permitted as he had had his visitor. This was very hard to hear.

45. That evening my daughter received a phone call from a doctor who advised that Michael's condition was on a "knife edge".

46. The next day Michael called my daughter to advise that they were considering an experimental drug on him, and asking for an immediate decision about whether he should take it. She advised to do what the doctors advised, but there was no time at all for us to consider the possible impact on him of such a medicine. That evening my son Aidan had spoken with Michael, and told us that he had been in pain. We knew his condition had worsened, but we just did not know he was as bad as he was.

47. I then had a call with Michael on the Wednesday morning, but we did not subsequently receive a proper medical update until Wednesday 24th February 2021. On that date we received a call from the hospital late in the afternoon approximately 3pm. This was to inform us that the medical team on the ward had inserted my husband with a syringe driver, and that he would very shortly be dead, Michael passed away at around 7:30pm that night. The syringe driver had been inserted 2 hours before we as a family were made aware. We believe ultimately that this was the end of his life, and that we should have been notified in advance of the decision to use the syringe driver.

48. In response to a complaint about this, correspondence from the Trust confirms that the Palliative Care team met with Michael on 24th February and that this decision was taken with him without the family being consulted or informed. This was despite his history of appearing confused as an apparent result of Covid. I should have been consulted before this decision. I do not believe it was acceptable that none of our family found out about the decision until after it was implemented.

Information after Death

49. Michael had been under the care of a gastrointestinal consultant, and last had an appointment with him in late 2020 (Nov or Dec 20). Michael came home to say one aspect of his liver function was raised, but that he had just been told to increase his ursodeoxycholic capsules. We do not know the reason that his liver function indicator was raised, including whether this was indicative of a gallstone. We are concerned that steps could have been taken to identify this at an earlier stage, which may have allowed for the stone's removal before any infection requiring hospital admission.

50. We note that on the Michael's death certificate, his primary cause of death was Covid-19 and his secondary cause of death was as a direct result of liver cirrhosis although this diagnosis was never noted to the family or my husband prior to his death. We do not understand why we were not advised of this. We believe that ultimately this was a major factor in the death of Michael, because, when required, could not receive ICU treatment. We were later informed that the act of sedating Michael during ICU treatment would effectively cause his death with immediate effect due to the health of his liver.

51. As indicated above, we also wrote a letter of complaint to the Trust following Michael's death, which outlined many of our concerns. Some of the contents of the response to that complaint has been outlined and addressed above. I do not intend to go through the response line by line, as I appreciate that the Inquiry will not be investigating the specifics of what did and did not occur. However I would emphasise that much of this response appears inaccurate to me. The description of the communication and advice between the medical professionals caring for Michael with myself and my family simply does not accord with reality. To the extent that is purported to be based on medical notes, including for example, the detail provided around 14, 15, 16 and 17 February, I am very concerned that those notes are inaccurate and do not accord with the information or level of contact with our family during this time. It is not clear to me how such inaccuracies would have occurred without the mistakes being deliberate.

General Concerns

52. The fact that Michael contracted Covid in hospital and on a supposedly Covid-free ward was particularly concerning given that Michael was admitted to hospital around a year after the government knew Covid was coming and knew that those in hospital would be at particular risk from the virus. It was also concerning that he contracted Covid five weeks after one of his family members died from it in the same hospital. This suggested that there was no long term or even short term learning. We entrusted Michael to the hospital to care for him. Instead through their apparent carelessness or ignorance they effectively killed him by exposing him to Covid 19.

53. We also believe that there was neglect in caring for him, and that this may have contributed to his deterioration and death. The updates we received from the hospital were simply not consistent with what we knew simply from speaking to Michael. I do not believe this was acceptable. It seemed he was simply abandoned once he contracted Covid. This demonstrates a lack of leadership among those in the hospital to permit such failing to occur. That concern is reinforced by the contents of the response to the complaint we received, which simply attempted to explain all these failings away rather than to confront them and ensure they did not happen for any other families.

54. We are also extremely concerned at the failures in communication with us about Michael, including the failure to provide updates and at times hostility to us seeking updates. As noted above, these concerns are significantly reinforced by the apparent failures in Michael's case. These are failings in themselves but we believe they are also interlinked. As a family we had a significant level of knowledge about Michael's medical history. It would therefore have assisted in his care and treatment if we have been kept informed and consulted. We believe that Michael being isolated form us ensured that his treatment was less likely to be informed, particularly given the pressures that hospital staff were operating under.

55. The long term effect on us as a family has been terrible. We miss Michael every day. We all feel guilt, in particular at the fact that we let him go into the hospital to obtain treatment, rather than just trying to treat him at home. It is terrible that we put this person we loved so much in the care of the healthcare system, and he and we were ultimately so badly let down.

56. I would like to finish on a positive note to highlight the love which I and many others felt for Michael. I believe this is important information for the Inquiry to have in order to bring home the very real and lasting sense of loss we all feel at his treatment and unnecessary death. I believe this information may assist the Inquiry to appreciate the long-lasting impact caused to myself and our family as a result of what we believe was an unnecessary death due to Covid 19, but also emphasise my belief that these experiences and sense of frustration and loss are not at all confined to our own case.

57. Michael James Mallon fondly known to me, his friends and our family as 'Micky'. Michael was born on 17th June 1950. We married on **31 July 1982**, and were happily married for 39 years, during that time we were blessed with 4 wonderful children (Michael Og, Sean, Cathy and Aidan) who brought him and us so much joy. Michael was not only loved by his family, he was extremely well thought of among our wider community circle. Michael was a loving grandfather to his 3 grandchildren, and he lived for his children and grandchildren. His final words in our family home were to his youngest granddaughter

"*what am I going to do without my little girl*" a testimony to the love he had for his family. Since Michael has passed, 3 further grandchildren have been welcomed into the world. He has been absent for family celebrations such as birthdays and Christmas and very deeply missed. For our family this has not only been a lasting loss, but has felt like a nightmare. We feel tortured that we were unable to be with Michael in his final moments, as he passed away alone. It has caused further lasting grief that we were unable to see him before his burial. This sense of loss, and deprivation of a wake or funeral he deserved, has made it very difficult to cope with his loss. I feel like at any time he could walk through the door.

58. My family continues to grieve every day for our loss, our hearts are broken.

59. I wish to provide evidence to the Inquiry to bring some light to the circumstances which surrounded his death so lessons can be learnt. I hope the Inquiry can bring us, and others in our position, some comfort in the turmoil we feel.

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: 7/22/2024