Witness Name: Mark Tilley
Statement No.: First
Dated: 14 June 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF MARK TILLEY

I, Mark Tilley, will say as follows: -

1. I make this statement in response to a letter dated 17 May 2024 sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the "Inquiry"), pursuant to Rule 9 of the Inquiry Rules 2006. This statement is made for the purposes of Module 3 of the Inquiry, which is examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 March 2020 and 28 June 2022 (the "relevant period").

A. INTRODUCTION

2. I am an ambulance technician, working in an NHS ambulance services trust in the South of England. I have worked in the ambulance service for over 20 years. In my role as an ambulance technician, I work on 'Single Response Vehicles' (SRVs), or 'Double-Crewed Ambulances' (DCAs) as part of an emergency team alongside paramedics. I respond to all types of calls, from the highest priority life-threatening 'C1' incidents through to Urgent Non-Emergency Transport incidents. I treat patients at the scene of an accident or their home, and decide if they should be transferred to hospital or another medical facility for further treatment. I am also a GMB union representative, which meant I had access to more information regarding the pandemic and the implications for the ambulance service than perhaps some of my colleagues.

B. IMPACT OF THE PANDEMIC

3. Through my role in GMB, pre-pandemic I spent a large proportion of my time working from home in a 'behind the scenes' role, rather than attending patients for the entire duration of my shifts. However, and despite the potential risk to me and my family, when Covid-19 hit, I could not just hide away and I wanted to assist my colleagues on the frontline, so I undertook a substantive patient-facing role for the duration of the pandemic, booking onto multiple shifts to attend patients.

4. The pandemic had a profound impact on our work. There were occasions during lockdown periods where we would wait in an area outside a hospital for hours, in case we needed to assist a Covid-19 patient, knowing that there must still be elderly people falling over at home or having other problems that were not associated with the spread of Covid-19. It was incredibly difficult dealing with the fact that there were patients waiting for a long time, 30 or 40 miles away who needed help that we were unable to provide.

5. When we did attend incidents, it was taking us much longer to actually treat patients. The national response time for C1 incidents requires attendance at a scene within 7 minutes, however, when we arrived we would have to then put on the necessary personal protective equipment ("PPE"). This involved donning white disposable coveralls, double gloves, a hood and a battery pack, a process that meant that even if we attended the scene within 7 minutes, the time taken on top to attend the patient increased significantly. It was horrible to arrive at a scene and see someone in cardiac arrest, with their loved ones attempting CPR and begging for us to enter, only to then have to spend time donning PPE rather than jumping straight in to help.

6. Most patients and their families would just be happy that we had arrived, but there were a few who abused and assaulted crews. I, like many of my colleagues, was often on the receiving end of people's anger and frustrations.

7. I was one of the roughly 40 ambulance staff who volunteered to move to Kent for 3 weeks in January 2021, to provide additional support to our colleagues in Kent. This was as part of the contingency preparation plans for the end of the EU transition

period, but in reality it was to increase resilience in the face of the pandemic. We were temporarily transferred to a hotel in Sittingbourne, along with some military volunteers, and the old ambulance station was reopened for us. We made up ambulances as best as we could, borrowing from around the organisation, often the oldest and most damaged. We had a team of people going well above and beyond leaving their families for 3 weeks minimum, to help others in an unknown area, with care networks that are different to those they are used to. I and others had to beg, borrow and steal oxygen, PPE and other essentials from wherever we could. Although we were in a hotel, it was certainly not home. The country was in the third national lockdown at that time, so whenever I was not working, I was effectively stuck in my room, eating microwave food as there was no facility to store fresh food. This period took a real toll on my mental and physical health.

C. INFECTION PREVENTION AND CONTROL ("IPC")

8. I was appalled by the lack of understanding of IPC and health and safety during the pandemic – airborne infectious diseases and cleaning of equipment are basic issues. For a number of years prior, I had highlighted the cramped conditions in the various office locations I had worked at. However, I was told that was the only space the Trust could afford. This obviously had implications when we entered the pandemic, with little ability to increase numbers or space, and multiple people squeezed into desks. Meanwhile, at some locations we were expected to eat our meals at a table with a white line through the middle, in an attempt to maintain social distancing between crews. However, there were no disposable plates or cups, often only dirty ones left over from the last crew who might have been dispatched to another location soon after starting their meal break. This contrasted with locations like the Emergency Operations Centre, where they were given disposable items even though there were dishwashers and multiple staff who could be tasked to clear.

9. When it came to the SRVs and DCAs, I had been raising concerns about the vehicles over the years. I had often complained that the air conditioning and heating systems did not work properly. During the pandemic, this became a real issue as the recirculation of air and lack of proper ventilation increased the risk of transmitting the virus, either between colleagues or between the crew and the patient. It also impacted

on the ability to look after patients for extended times in an ambulance in the cold of the winter or the heat of the summer. I had also complained about the storage of crew kit on the DCAs as there is limited space. This was not deemed to be an issue prior to the pandemic as it was only likely to hit a crew member or patient in the event of an accident. Now we had extra PPE to store, like powered hoods in a hard plastic box about the size of a person's head, which was a potential hazard. I understand that the Trust are now trying to address this issue following serious incidents.

10. The PPE itself was a recurring and significant problem, both in terms of suitability and supply. We had to use aprons on all calls that were not requiring a suit to be donned. These aprons are possibly suitable in a hospital or office space but when you are in a confined space, like an ambulance or a toilet in a house, they get caught up. When you are outside, for example dealing with a road traffic accident or a person who has collapsed on the pavement, the aprons just blew up with the slightest of breeze into your face, onto your hair. This completely undermined all the communication we were receiving about being strict with hygiene and what we were being told about transmission of the virus. I effectively accepted I was going to be covered by the virus.

11. Nevertheless, we did to try and protect the patient from what we may have been exposed to earlier in the shift. We gave serious thought to using bin bags with holes cut for the head and arms when we had a supply issue. Alcohol hand gel was in short supply, with the GMB at point using their own funds to purchase supply from a distillery in 5-litre containers. When it came to the end of the patient contact, we would wipe down the life pack, stretcher and other equipment with Clinnel wipes and replace our disposable masks. However, we had no mop and bucket available at hospitals to clean the floor, ramp or lift that may have had bodily fluid and other substances spilled on it. We had our kitbags loose in the rear of the vehicle as there was not enough space to store them in the cupboards and these were often not wiped down. When I highlighted to the Trust that we should have spare bags so we could wash them, I was told it was not necessary. These bags were possibly the most contaminated items on an ambulance, closely followed by our green coats or reflective yellow jackets.

12. We have camping cool boxes in the front of many of the ambulances and you would often find that this was where the disposable masks had been stored, getting cold and

damp. We therefore had concerns around their efficacy. Additionally, the FFP3 fitted masks were often out of date, with no guarantee of how or where they had been stored. These were split down and stored in takeaway containers, squashed in so they were out of shape, and we had no confidence that they would fit correctly.

D. LONG-TERM IMPLICATIONS

13. Some of the improvements made during the pandemic to increase space have now been undermined, reverting back to an approach of squeezing as much as possible into rooms, with just enough space to sit behind a desk. We are still using out-of-date consumables, such as gloves and masks. There are also many out-of-date items we use on patients, which is completely wrong and something I keep raising, but the service I work for either thinks it is acceptable or not happening. I am concerned that when senior managers are aware of issues, they too often allow the staff on the frontline to be used and abused.

14. I, like many others, have been deeply affected by the pandemic and my experience working on the frontline in healthcare. The issues continue to play on my mind – how many lives were lost waiting, how many were lost in us transporting them to hospital or a nursing home where they then caught the virus. I saw colleagues become severely ill and die. I may have got through the Covid-19 pandemic physically, and for that I am grateful, but it has taken its toll on me mentally and it will always stay with me.

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

Mark Tilley

Dated: 14/06/24