Witness Name: Tilna Tilakkumar
Statement No.: 1
Exhibits: None
Dated: 4 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF TILNA TILAKKUMAR

I, Tilna Tilakkumar, will say as follows: -

Background and professional experience

1. I am a GP and a representative on the BMA UK Junior Doctors Committee. I attended medical school from 2009 to 2015 at Barts and the London School of Medicine and spent my foundation years training at I&S and I&S Hospitals. I spent two years working as a locally employed doctor in geriatrics at a I&S hospital before beginning GP training in August 2019 at the same hospital. In February 2020, I started a six-month rotation within a community adult mental health team at a local mental health Trust. Mental health forms a large part of my practice as a GP and the training experience of treating patients in the community was vital.

2. The community adult mental health team was multi-disciplinary, and staffed by a psychiatry consultant, psychiatry registrar, two Senior House Officers, including myself and a psychiatry trainee, mental health nurses, therapists and social workers. Before the pandemic started, I saw patients in clinic or on home visits if they were unwell, discussing issues and treatment with the consultant during weekly supervision meetings. Each week, I had half a day for supervision/teaching with the consultant, another half day for group psychiatry teaching and a third half day for group GP teaching. The focus was on gaining experience and teaching, and it was not a stressful role.

My experience of being redeployed

3. Initially, the community adult mental health team adapted to the pandemic by moving to telephone calls with patients, rather than having patients come into the clinic, and limiting home visits. We were organising laptops, hand gels and preparing to work from home. We also began to receive emails from the team leads in the mental health Trust advising that we might be redeployed. These emails were sent to all members of staff, clinical and non-clinical, although I was the only person to be redeployed in my team and of all the Senior House Officers at my site of work.

4. On Wednesday, 25 March 2020 while at home on a week of annual leave, I received a call from a consultant within the Trust asking me to attend a continuing care adult ward the following day. I was told there was Covid on the ward and they needed more hands on deck. The ward sat on the same site as an acute hospital of another Trust, and it homed 20 long-term residents who required inpatient hospital care for life because of their complex and enduring mental health needs. The ward functioned more like a care home than a hospital ward, with very little medical involvement other than a once-a-week ward round by a consultant psychiatrist. The patients were not usually visited by a GP.

5. I was told I was chosen to be redeployed because as a GP registrar I would have the best experience to care for physically unwell patients, rather than psychiatry doctors. I did not question the decision that I should be redeployed. It made sense that it would be me as the GP registrar. I was aware that colleagues in my home Trust were being redeployed, for example to ICU, and I felt this was the least I could do. My only concern at the time was that I was living with my parents, although they were also key workers.

6. I joined the ward on Thursday, 26 March 2020. The ward had suffered an outbreak of Covid after six patients were transferred from an acute old age psychiatry ward that had Covid. However, it became apparent that at least one of the patients had already contracted Covid at the time of transfer. When I arrived on the ward on

Thursday, 11 of the 26 patients were showing signs of being unwell; by the following day, it was 12 and by Monday, the number had increased to 15.

7. By this time, many staff had become ill and were off work, including one of the two consultants. The other consultant was on leave prior to retirement, although during the five weeks I spent on the ward, they returned to provide leadership and support to the team. Of the two regular psychiatry ward doctors, one had not attended the ward since the pandemic began, and the other – having worked on the ward all week – showed signs of illness when I met them on Thursday, 26 March 2020. They went on sick leave the following day.

8. I am aware that concerns were raised with Trust management before I joined regarding the outbreak of Covid on the ward. After one of the initial four patients that were transferred from the acute old age psychiatry ward was showing signs of suspected Covid, a request was made that no more patients be transferred. However, two further patients were transferred as the reports of illness were considered 'unconfirmed'.

9. Before attending the ward, I had no information, guidance or communication on how to treat patients with Covid. There was no information at the time. Staff did not know what to do, and there was not enough staff on the ward. When fully staffed, the ward should have had a ward manager (senior nurse), two mental health nurses and four/five healthcare assistants (HCAs) as well as occupational therapists and other therapy staff. Because of staff illness, there was one nurse and community staff members had been drafted in to help. There was no plan for monitoring or isolating patients, and there was no leadership because there was no consultant presence. It was very disorganised.

10. I spent Thursday, 26 March 2020, being shown around the ward and reviewing the unwell patients. The following days, Friday, 27 March 2020 and Monday, 30 March 2020, I was the only doctor on the ward. I finished three hours late on both days and made myself available by phone to the on-call doctor over the weekend.

11. I spent Friday trying to make a day-to-day plan for the ward, creating a spreadsheet of all patients, and observation charts for monitoring. I conducted clinical reviews on all 26 patients. Basic checks on vital signs and physical observations, such as blood pressure and oxygen levels, should be done four times a day for patients showing signs of illness, with the results plotted on a NEWS chart (National Early Warning Score). The nurses were mental health nurses and they had limited training in physical health. It took a long time to conduct observations on all patients (there was only one machine for 26 patients that had to be fully wiped down between each patient) and to plot the results on the charts. The nurses were not aware of what was considered out of range or concerning. That day, I recall asking one staff member to transcribe observations I had taken for all twelve patients with Covid symptoms, and realised after they had gone home that the NEWS charts were filled out incorrectly and had to be redone. I made protocols for the ward that I printed and stuck up on the walls around the ward to help support the team.

12. I considered whether we could move patients so that those who did not have Covid were in the same section of the ward. However, this was not a traditional ward. As the patients were mainly long-term residents, they all had bedrooms that were personalised with their belongings. They had a dining hall and a living room with a television. They continued to move freely around the ward, as they were used to. We tried to keep patients isolated to their rooms as much as possible, but because of their mental health needs, they could not appreciate the importance of this, or they forgot.

13. I spent the weekend deeply concerned about the position on the ward, for patient and staff safety and wellbeing. We did not have enough staff to keep patients under one-to-one observations. Although community staff had been drafted in to help, it was difficult to work out who was who on the ward or what their skill set was. There was no warning of how many people would come or who would come, so it was impossible to plan. Also, as volunteers, they were under no obligation to stay for any length of time, which meant it was very difficult to rely on their assistance throughout the day. Moreover, we had six patients who had come from the other ward who were acutely mentally unwell and needed psychiatry input, which I did not have.

14. I thought about how best we could protect and monitor patients and realised that the corridor of bedrooms could be sectioned using fire doors. I proposed that one staff member sat at each section of the corridor, with a few runners who could offer help when required and deliver food at mealtimes. For physical health, usual staffing is one nurse and one HCA to six patients. I tried to think about how many staff we needed and considered that in addition to the two nurses, the number of additional staff needed to be ten. This would allow the nurses to complete their duties, plus medications, and the staff member in each section to do physical observations four times a day (although they would need training on how to do this properly). We also needed an additional observations machine, so that one could be used for those patients with symptoms, and the other for those that were asymptomatic.

15. I raised my concerns with Trust management, as set out in more detail later in this statement. I do not think they realised how unwell patients were, how the virus was escalating with no way to contain it, and the extent that staff were going off sick. The following day, Tuesday, 31 March 2020, two additional doctors were redeployed to the ward. I continued to raise concerns throughout my time on the ward, although I did not feel that my concerns were properly listened to.

16. I stayed on the ward until Tuesday, 29 April 2020, when I was moved back to my previous community job. The two other doctors that had been redeployed stayed on the ward.

Impact on patients and provision of care

17. I did not know the patients, who were already mentally vulnerable before the pandemic, so I was not familiar with their behaviour before I joined. There were two broad groups of patients, one that was subdued and able to follow instructions, but they sat in their rooms with no interaction which was not good for their wellbeing or mental health. However, I cannot say objectively whether the pandemic made their conditions worse because I was not there before it. The other group was very

agitated, and I believe they were more agitated because of the restrictions. Their usual activities, such as attendance by occupational therapists, had stopped.

18. As I mentioned, in an effort to contain the spread of the virus on the ward, we sought to isolate patients to their bedrooms, which I believe had a detrimental impact on their mental health. Patients who did not comply required one-to-one observation to keep them in the room, which required more staff. Some patients could be physically aggressive to staff, break the 3-metre distance rule and spit. Visors and goggles were not immediately available to staff.

19. There was no treatment for Covid – only supportive measures such as paracetamol and monitoring. We had oxygen cylinders if needed, but no piped oxygen supply. We were not expected to manage anyone who became very physically unwell, and the normal approach would have been to transfer very ill patients to hospital. We were on the same site as an A&E of another hospital Trust, but I knew from colleagues there that the hospital was overwhelmed, and patients were dying in A&E. I also knew that the ambulance service was under huge strain. I was concerned about what would happen if any of the patients on the ward should require hospital admission or emergency services call out.

20. There were a lot of daily phone calls from families, especially for patients showing signs of Covid. I updated a lot of families by telephone. At that time, we did not have iPads for video calls - I think there was Skype, but it was before Zoom and Teams became commonplace. I remember some relatives asking if their loved one could come home, but they did not have the set-up to support them outside the ward.

21. Almost immediately on joining the ward, we began to have conversations over the phone with the families of vulnerable patients who might not survive severe illness with Covid due to their comorbidities. Although this is not the way we would have liked to have these discussions, we discussed what would be in the patient's best interests if they became very unwell, including whether their relatives would prefer that they died on the ward if it seemed unlikely that they would survive. When I arrived on the ward, two patients had a do not attempt resuscitation (DNAR) order

already in place, and after conversations with patients and/or their relatives, and with consultant input, we put in place DNAR orders for a small number of additional patients. It is difficult to remember, but I think there were no more than ten patients, out of 26 on the ward, that had DNAR orders in place.

22. I liaised frequently with the relatives of patients, and with consultants and specialist teams, such as community palliative care and infection prevention and control (IPC). All the conversations I had with relatives went fine. They knew what was going on, and they just wanted the best for their relative. For those patients for whom it was appropriate, their relatives were content for them to stay on the ward if they became very ill, provided they were kept comfortable.

23. One of the psychiatry doctors spoke for over one hour with the daughter of a bed bound patient who was fed through a tube in her stomach, at the end of which, they acknowledged that CPR would not be in their mother's best interest and, if it came to it, they wished for their mother to die in her own bedroom with Bach playing and a staff member who she knew.

24. On one occasion, I consulted with the family of a frail, dying patient who had contracted Covid but had significant comorbidity. We agreed the patient would not be admitted for treatment at the overwhelmed acute hospital; his wishes would be to die in his bedroom around familiar staff rather than alone on a trolley in a busy A&E department. To comfort his family, who could not visit, I walked across to the hospital's A&E department and sourced equipment to slowly give fluids through the vein (cannulation set, IV fluid bag and giving set) holding up the bag myself as we had no 'drip stand' to hang the fluid bag from.

25. A mental health support worker on the ward, who had known this patient for years, was in denial that he was dying, stating that this was sometimes his behaviour and that all he needed was some encouragement and motivation. It was heartbreaking to see him speaking to the patient and trying to feed him as normal. The patient died the following day.

26. We were unable to source a syringe driver or a trained nurse to set one up, so the patient received near hourly injections of palliative care medications to keep him comfortable. His family arranged for his hearse to come by the hospital so staff could say goodbye.

27. One patient was transferred to the main hospital for a surgical complaint (but this was not related to Covid).

Infection Prevention and Control (IPC), Personal Protective Equipment (PPE)/Respiratory Protective Equipment (RPE), and Testing

28. At the start of the pandemic, there was a lack of testing and we relied on clinical signs and symptoms in identifying Covid. At the very beginning, the signs included travel from Wuhan, although this was removed as Covid spread. There was no consideration given to close contacts or asymptomatic transmission. When the four patients were transferred from the other ward, one had a fever and was isolated in their bedroom on arrival, but the three other patients who had travelled with that patient were free to move around the ward. There was no consideration given to pre-emptive isolation.

29. Patients began being tested on 8 April 2020, although by this time we did not have many patients still showing signs of Covid or within the two-week isolation period. Only five were showing clinical signs and of the 20 patients that were tested, 18 were negative and two returned as 'not clear'. We suspected that the testing had been arranged too late as many patients had recovered or that some of our patients had not fully cooperated with the invasive testing. There were patients showing signs of Covid that had tested negative.

30. There were efforts by managers to deescalate the ward from a 'red' to a 'green' zone (i.e. a non-Covid ward) so that the ward would require less PPE and Trust management could divert the few staff available to other areas of need. I recall a nursing manager coming on to the ward in the first week of April 2020 saying that we were not a Covid ward anymore, and there was no need to wear any PPE.

31. When I arrived on the ward, the standard PPE was full PPE at all times – that meant gowns/aprons, shoe covers, gloves, normal surgical masks (not FFP3) and a 3-metre distance. I asked for goggles and visors because patients often came up very close. A lack of PPE meant staff (who were predominantly from Black and ethnic minority backgrounds) had to source their own PPE. I sourced scrubs from another Trust and offered it to ward staff. We bought goggles off Amazon. This resulted in a feeling amongst staff on the ground that we were not being heard and we did not feel safe.

32. For the first two weeks I was on the ward, there was no hand sanitizer or 'gowning station' for donning and doffing PPE at the entrance of the ward. There were no orange clinical waste bags meant for infectious clinical waste, so there was a risk that PPE was initially disposed of inappropriately or mishandled. There were no showers or changing facilities accessible to staff at this site, so we had to go home in contaminated clothes. When a gowning station was set-up, it was often not replenished; the bare minimum was that masks were available, but the hand gel would often be empty. I advocated for sufficient and appropriate PPE for staff, for shower facilities and for appropriate training on IPC.

33. In the early weeks, there were regular - sometimes daily - changes in the rules about what PPE/IPC was required. I expect the changing guidance was circulated in Trust wide emails; however, staff working on the wards relied on word of mouth or team talks for information to be communicated. We didn't have time to review emails, clicking on links to relevant guidance, etc. In the early weeks, changing PPE/IPC requirements were often communicated by ward managers verbally, but there was always a delay.

34. Shortly after arriving on the ward, advice came that we should only wear PPE (apron, mask, shoe cover, gloves) if in direct contact with a Covid-positive patient. Then on 2 April 2020, we were advised that we should be wearing surgical masks at all times on the ward. At that point, we were trying to keep patients in their rooms, however, as I mentioned this did not work for all patients. There was one resident in particular who was very unwell and very agitated. They would spit and shout and often wandered around the ward.

35. Mask fit testing took place on Friday, 3 April 2020 although on attending I discovered it was carried out using the wrong face mask. It was an FFP2 mask, when it should have been an FFP3 mask. After I raised this, FFP3 masks were tested at some point in the following weeks, but I failed with the two types of masks available at the time because they were not airtight. I passed fit testing for a third type of mask on 28 April 2020, immediately before I returned to my community role.

36. FFP3 masks were required for seeing Covid patients, or for CPR in line with Resuscitation Council Guidance. As I had failed fit testing with the two available FFP3 masks, I remember asking if anyone else was CPR trained because I was worried about my exposure to the virus if I was called to do CPR. My worries were never realised, thankfully. I wore the FFP3 masks that did not fit me when seeing Covid positive patients, until the third type of FFP3 mask that I passed on was made available.

37. The Trust started doing antigen testing for symptomatic staff in April 2020, but they only had capacity to do 35 tests a day. I was never tested as I never showed symptoms of illness. However, I received a PCR antibody test in May 2020 arranged by my home Trust and tested positive for antibodies, confirming that I had in fact caught the virus (likely from working on this ward).

38. I did not have a risk assessment during my time on rotation with the mental health Trust.

39. We had a lot of visits in the first weeks from Trust staff members, particularly non-clinical managers, who came to the ward in normal clothes, with no PPE and no masks. This did not seem right to us – they were visiting multiple sites and offices. While we were already exposed because there was Covid on the ward, they risked spreading infection to other sites across the Trust and to their families. It is likely they were visiting the ward to assess the situation given the Covid outbreak, and to consider staffing requirements, but I don't believe they understood the severity of the illness having not witnessed it first-hand.

40. I also recall one incident when a visiting manager pulled a plastic apron from a HCA because the PPE requirements had changed and at that time, full PPE was not required unless with a positive patient. The HCA was terrified about contracting Covid and had continued to wear full PPE. The Trust was a mental health Trust and not used to dealing with physical illness or infection prevention, and there was a lot of stress and anxiety. There was also the background of national PPE shortages, and it seemed that the Trust was trying to limit the amount of PPE being used.

41. Because the Trust was a mental health Trust, there was a lack of IPC training for staff on the ward. For example, there was only one machine to take vital signs for patients and staff did not know they needed to wipe down the observation machine between uses. I remember we ran out of thermometer probe covers after one week of doing observations, and I had to take some from the acute hospital across the site.

Changes to working conditions and impact on healthcare workers

42. I have detailed above the changes to my work and conditions as a consequence of the pandemic and redeployment. I didn't know what I was getting into until I was on the ward. At the time, my husband and I were living with my parents and after a couple of weeks I asked to be allocated hotel accommodation, which was organised through my home Trust (where my husband was also employed). This had a significant impact on my wellbeing.

43. During my time on the ward, I felt anxious about working on a ward with Covid but also on edge, fearing that these vulnerable patients could have a cardiac arrest at any moment. I was worried we would not have the support we needed to help with resuscitation and as mentioned above, because I originally failed FFP3 mask testing, I was concerned about not having the right protective equipment to participate in the resuscitation of a Covid patient during an on-call shift where I would be the only doctor.

44. Increasing staff sickness added to the pressures and annual leave was cancelled. Although volunteers from community teams were asked to attend the ward, due to lack of inpatient experience and clinical experience, and the challenging environment on the ward, they often did not have the skills to provide the support that was needed and found the experience upsetting and did not return.

45. The death of one of the ward's long-term patients had a significant impact on staff. I did not know the staff members before my redeployment, and I had no contact with them afterwards. However, it was clear they knew their patients very well, because it was more like a residential care home. Having a death on the ward was very traumatic for them. I asked for staff to receive bereavement counselling, and I understand that someone from the psychology team came to talk to them.

46. Hearing of deaths of colleagues across the wider Trust also had a significant impact. Although these were not colleagues who we knew, it was very scary. The majority of staff were from Black or minority ethnic backgrounds. I am unsure when we came to realise that Covid was affecting Black and Asian people more, but it became obvious and it increased anxiety. This prompted me to move out of my parents' home.

Concerns about lack of resources

47. I have detailed above the various concerns I had on joining the ward, and throughout my time there I raised these issues with Trust management on a regular basis, particularly: the urgent need for more resources given the lack of staffing on the ward (not just numbers of staff, but staff with the correct range of skills); the need for training for staff (including physical health training, specialist Coronavirus training and training in IPC); sufficient and appropriate PPE and appropriate equipment for staff (for example, eye protection, scrubs, a gowning station, orange bin bags for infectious material, showers and better rest facilities); more equipment (for example, an additional observations machine).

48. We were under pressure as a team throughout the time I spent on the ward. For example, although it was recommended that vitals be done four times a day,

because of staffing and the need to prioritise feeding patients and attending to their personal care, they were often not done that frequently. Given these circumstances, I did not insist on it and often did the observations myself, but I recall feedback from a Trust manager that the team was working too slowly, which was not helpful. We could perhaps have met this frequency had a second observations machine been provided.

49. Although Trust management acknowledged my concerns, I felt that little was done to properly address them. I was referred to a Trust Freedom to Speak Up champion and we spoke on 27 April 2020 regarding the lack of accessible PPE (often they were locked away), lack of a second observation machine, lack of syringe driver, lack of shower facilities/scrubs, lack of training for new staff, and food and drink delivery for staff. On the morning of 29 April 2020, I received brief instructions by phone to go back to my previous team. I was not told the reason why my redeployment was ended so suddenly, when the other two doctors stayed on. I had no chance to say goodbye to the ward staff or patients.

General Practice training

50. When I left the ward, I returned to my previous role in the community. We conducted everything by telephone, and when lockdown eased by the summer, we started to do home visits again, wearing aprons, gloves and surgical masks. Teaching schedules resumed however it was all remote. In August 2020, I returned to my previous hospital for a rotation in obstetrics and gynaecology. This was an acute hospital with much more resources – scrubs were provided and washed for us; there was a canteen with 24-hour access to free food for staff.

51. However, a significant impact on patients was that they had to attend antenatal appointments alone and were only allowed one birthing partner in the birthing suite only and not on the postnatal wards afterwards. Not having someone with them had a big impact on patients, and it was extremely difficult and sometimes traumatic for them.

52. In March 2021, I rotated to general practice for the first time in my training, working at a suburban GP in I&S I worked 40 hours per week, Monday to Friday, including half a day for group GP teaching remotely, half a day for direct supervision (where my supervisor observed my patient consultations), and half a day for self-directed learning. Having never worked in a GP before, I started on 30-minute appointment slots initially and worked down to 20 minutes, 15 minutes, then 10 minutes by the end of training (this is standard in GP training).

53. In March 2021, all appointments by default were telephone or video for GPs, and if required to bring a patient in, there was one designated room allocated to all GPs to use in turn by pre-booking the room. Most appointments could be conducted effectively on telephone or video. We would often start by calling, although if it was something had to see, we would ask for a video call or for a photo to be sent. I conducted all appointments with children on video. Patients who could not manage technology to send photos by text or to do video calls found the remote consultations difficult. This was the case for some elderly people, and if needed, they were invited to in-person appointments. We could see patients very quickly if needed. I moved to a different practice in August 2021, and before I left, we had resumed in-person appointments.

54. The IPC measures were the same as in the hospitals - we wore surgical masks at all times, kept a 3-metre distance and wore aprons and gloves when seeing all patients. We did lateral flow tests once a week at the practice and logged the result into NHS system. I wasn't aware of any specific issues with IPC measures or access to PPE at this practice, although I was not working there in 2020. I am aware that supply of PPE to GPs improved as the pandemic went on. I can't recall whether we had FFP3 masks, although I don't remember bringing anyone in to the practice who had symptoms of Covid. In August 2021 I moved to a different practice. We continued to wear masks and keep distance, but as Covid restrictions relaxed, we moved back towards offering more face-to-face appointments.

55. Whilst we returned to in-person teaching in August 2021, Part 2 of the GP exams are to-date still being conducted remotely. The exam was usually circuits of stations of actors and real patients examined by GPs. However, when I did the exam in April 2022, I had to submit audio or video recordings of my consultations

with real patients. This was much more time consuming and labour intensive and the change of exam style was stressful to GP registrars and their trainers. Although patients were happy to be recorded, it added a lot more time to the normal consultation.

56. During a group GP teaching session in 2021, we were offered a breakaway session with a psychologist to have a Covid pandemic debrief. When I spoke of my experiences at the mental health Trust and how I was still affected by it, I was advised to seek psychological support through occupational health, as I was told I might have post-traumatic stress disorder. However, when I attended an initial assessment with a psychologist at my home Trust in June 2021, this was dismissed as a potential diagnosis, and I was advised to self-refer to Care First "*the Trust's counselling service offering 24/7 in-the-moment support*". I did not do this. By November 2021, I was finding working in a primary care setting isolating and I was diagnosed with depression. I took sick leave and applied to complete my training at 60% less-than-full-time. I completed a course of psychological therapy through the NHS Practitioner Help Programme in May 2022.

57. I qualified as a GP in December 2022. I am currently working as a locum GP in I&S I still see the impact of the pandemic on patients today, whether it be delayed presentation of illness, a build of multiple complaints, the effects of long-Covid, or the impact of lockdown and the pandemic on people's mental health and wellbeing. Some patients have experienced symptoms for some time, and they refer to the pandemic or the perception that primary care is overwhelmed, as reasons for not seeking medical advice. There has been an increase in demand for appointments since the pandemic, and there's a shortage of qualified GPs, which means that some patients find it hard to access their GP. Instead, they go to A&E or urgent care, which can overwhelm those services and leads to a lack of continuity and patient follow-up. I continue to conduct telephone and video consultations with patients, which can be more convenient for them, although about two-thirds of my practice is in-person appointments,

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: 04 July 2024