Witness Name: Rachel Ashton
Statement No.: 1
Exhibits: RA/01-RA/02
Dated: 1 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF RACHEL ASHTON

I, Rachel Ashton, of Personal Data will say as follows:

1. I make this statement in response to the UK Covid-19 Inquiry's request for evidence pursuant to Rule 9 of the Inquiry Rules 2006. Within this statement, I have set out my experience (1) as a general nurse working in the NHS during the pandemic and (2) as the family member of a patient (my brother) seeking healthcare treatment who subsequently sadly took his life own life on 13 February 2021.

2. I have prepared this statement in liaison with solicitors at Leigh Day who represent Core Participants John's Campaign, Care Rights UK, and the Patients Association in the Covid-19 Inquiry. They have asked me to address questions based on the Inquiry's Rule 9 requests via telephone and email. Except where I indicate to the contrary, I make this witness statement on the basis of facts and matters within my own knowledge. Where these facts and matters are within my own knowledge, they are true. Where the facts and matters in this witness statement are not within my own knowledge, they are true to the best of my information and belief.

Background and career history

3. I am a nurse with experience working in both hospital and care home settings. I qualified as a registered nurse in September 2005, and now have over 18 years of nursing experience.

4. After qualifying, I worked for 15 years at a University Hospital on an orthopaedic trauma ward. My role there was caring for patients who required orthopaedic care and treatment, pre- and post-surgery. In this role, I gained experience caring for patients with a range of serious and sometimes life-threatening medical conditions (including sepsis, diabetic ketone acidosis and acute kidney injury). I also gained experience caring for patients with dementia and took specialist dementia training during this time.

5. In 2019, I moved to a Nuffield Hospital where I cared for patients who required urgent biopsies and surgery. I worked there throughout the pandemic period and continue to work there today. I am responsible for providing care to and monitoring the condition of up to seven patients at any given time on the ward.

6. Alongside my work at the hospital, I also currently work as a nurse in a care home, which has given me further experience of caring for people living with dementia and other complex needs. I work as a 'nurse on duty' at an I&S I&S care home. I work with people with Alzheimer's and other forms of dementia and my responsibilities include ensuring they are given the right medication, liaising with the mental health team and other medical professionals, monitoring their behaviors and reporting any changes, preparing individualized care plans, escalating to other medical professionals when required and providing basic personal care including feeding and dressing patients. When I take the night shift, I am responsible for 40 patients. During day shifts I am responsible for 20 patients.

7. I am on a rota and so the days I spend at the hospital and care home are different each week. I started my work at the care home two years ago. I did not work there during the pandemic.

8. My extensive experience caring for people with a variety of needs in both hospital and in care home settings, alongside my personal experiences which I discuss further below, have shown me the importance of involving family members and loved ones in care where appropriate, and properly communicating with them about their loved one's condition and care.

My experience working as a nurse during the pandemic

9. As explained above, throughout the pandemic I worked at a Nuffield Hospital as a general nurse. My role involved caring for patients who needed diagnostic biopsies and surgery (for example to remove cancerous tumors).

10. From what I observed during my time there, I thought we managed the pandemic well and in the best way we could based on guidance from the government. We took all the steps we could to keep the ward free from Covid-19: we had access to and wore essential PPE; we maintained the two metre rule wherever possible (using tape to demarcate two metres in busy areas of the ward); and windows were opened for ventilation and staff took time off and isolated as required if they contracted Covid-19. Nonetheless, sometimes Infection Prevention and Control measures made it difficult to communicate with certain patients. For example, if patients were hard of hearing, then facemasks made communication more difficult.

11. The specific ward I was on was for elective surgery patients who would only stay in hospital for a few days and were not critically ill. Initially, there was a reduction in our work and we thought we might be redeployed but because of our specific work with cancer patients who are particularly vulnerable to infections such as Covid-19, it was decided it was best for the team to stay within our specific ward (and not be redeployed). The fact that we were an elective surgery ward meant that, unless there were specific patient circumstances which meant they required a known carer (such as disabilities or cognitive impairments), family members were generally less needed, because of the length of stay and the patient's general condition. Patients would use their phones to contact loved ones and we would call family members if they were needed. I do not remember any instances where patients needed help with this, nor do I remember any situations where a patient was considered to need a loved one to support them during their short stay with us. The general policy was that family members were not allowed in, and I am not aware of any exceptions being needed or made on our ward.

12. Overall therefore, from what I observed professionally during the pandemic, we managed as well as we could given the circumstances. I am not able to comment directly on the experience of NHS colleagues who worked in other areas, however I am aware that my experience as a healthcare professional was very different to colleagues who worked in areas such as critical care or emergency care. For instance, we wore basic PPE whereas in critical care full PPE suits with helmets might be worn – which would make communication for patients with specific needs more difficult. We also did not look after patients at the end-of-life, meaning we did not need to make the same heartbreaking calls to relatives who were unable to see their loved ones.

My personal experience during the pandemic

13. The pandemic impacted me in multiple ways, as I also experienced personal loss during the pandemic, when my brother, Christopher **NR** took his own life on 13 February 2021.

14. My brother had suffered from poor mental health from the age of 14. He struggled with anxiety which then later led to depression. As years went on Chris continued to suffer with his mental health, and he was prescribed antidepressants. He hit crisis point at the age of 21 when we had to get the crisis team involved. Around 12 years before he passed away, he was particularly unwell, anxious and depressed. He was suicidal and required interventions by the community health team (including several visits to his home when he was suicidal). He then slowly got better with the help of the crisis team, but it took time and an empathetic and dedicated team for this improvement to happen. Importantly, he felt understood and supported at this time and it helped him get better.

15. Chris' mental health declined again during the pandemic. His mental health was particularly bad in January 2021. I have set out below what happened after he hit

this 'crisis point.' I have drawn on information given to me by both Chris himself and that we later found out from the Serious Incident Report and information given to the coroner by the medical teams involved in his care.

16. On 9 January 2021, Chris rang me at work saying he needed help and that he was going to drown himself in the bathtub and put dumbbell weights over his neck. I went to him straight away when he told me this and rang the mental health hospital for an appointment. We went to the mental health hospital and after a 2.5-hour assessment, Chris was discharged with 10 days of community therapy. At this point Chris told the hospital he felt suicidal and did not trust himself to be alone. Chris explained he did not want to leave until he was well and stabilised, but the hospital insisted on community therapy and no other intervention. Our views as a family were not sought and I only found out about how clearly Chris had expressed his concerns for his own safety from the paperwork we were given after he passed away.

17. On 20 January, after ten days of community therapy, Chris was discharged from community therapy. This was at a point when he still felt very low, and he needed more support. Whilst he was receiving community therapy, I know that Chris also asked for additional Lorazepam, a medication used to treat anxiety and sleep problems because he felt this was the only thing that was helping him. He had originally been given a prescription of a few doses that had run out. He said he was having serious issues sleeping and that the Lorazepam was the only thing helping to calm his mind. The community health team doctor denied his request due to what they assessed as a risk of addiction, but they disregarded how serious the risk arising from the symptoms Chris was experiencing were. His risk of suicide was far greater than the risk of addiction but his pleas for help were ignored.

18. On 31 January 2021, Chris was experiencing suicidal ideation and took a medication overdose. It had been Chris' birthday on January 29th and my sister had driven to the house he was living in with his fiancé to bring him brownies for his birthday. His fiancé got in touch and said that he had asked her to 'give him some headspace' and she was now at her mother's house but unable to reach him. My dad and I therefore also went to Chris' house and spent time trying to get him

to answer the door. We called the police, but Chris eventually opened the door before the police arrived. When he came to the door, he was pale, visibly shaking and looked very weak. He admitted that he had taken an overdose.

19. My Dad and I took Chris to Accident & Emergency ('A&E') at the University Hospital where I used to work because he needed urgent medical care. The police followed us there after having arrived at Chris' home but then left. After we checked in, we waited for over an hour. At this point Chris was saying that he wanted to die and was looking pale and sleepy. I was concerned because Chris appeared to be deteriorating, so I asked at the desk when he could be seen or if at least some initial observations could be done to check on him. Nobody came until I asked to speak to a manager, at which point a nurse asked how she could help. I explained how worried we were about Chris and asked for him to be assessed.

20. At this point they agreed to take him for an initial assessment but told me that my Dad and I had to leave. I asked staff if either myself or my Dad could stay with Chris, because we felt it was important that Chris had someone who was able to advocate for him whilst he was so unwell; we would be able to explain recent events and Chris' mental health more easily to doctors, especially as Chris was still impacted by the medication overdose. We would also be able to ensure Chris felt loved and supported at a time where it was critical for him to feel this. The hospital staff refused to let us stay with Chris because of Covid-19 (even though we had already been present in A&E with him). We felt so helpless not being able to be Chris's voice and support him in his time of crisis.

21. I could not understand the hospital's decision not to let us stay with Chris, when it was clearly so important Chris had someone with him to provide essential emotional support and act as his voice when he was not able to advocate for himself. I felt alone, anxious and scared for my brother. To watch my brother being wheeled away in a wheelchair by strangers at his most vulnerable was heartbreaking. I just imagined how scared and alone he must have felt, as he was asking us to stay with him. Can you imagine hearing your loved one say they just want to die and not being able to be there for them to provide the love, care and support they need at such an important and dangerous moment. We knew Chris best and could have helped

staff gain a better understanding of him and his mental health. Being with Chris would have reduced stress and anxiety for him and us as a family. I felt a complete lack of empathy, reassurance, and support from staff – communication was non-existent.

22. After we were asked to leave, Chris was reviewed by a psychiatric liaison nurse; they agreed that he did not have capacity and that a Deprivation of Liberty Safeguards ("DoLS") should be put in place if Chris tried to leave. However, the next day Chris was re-assessed and just offered community therapy again. At this point Chris said that community therapy did not work and asked to be admitted for his safety. We found this out later from the paperwork we received after his death.

23. Despite Chris asking to be admitted and telling the hospital he would take another overdose in the future and that he had researched and would take paracetamol next time to ensure the overdose worked, he was discharged from the Emergency Assessment Unit as medically fit. The hospital did not communicate any of this information to us; we were only notified of Chris' discharge when Chris phoned us to collect him and later obtained further details as to what happened during his time in hospital from the documents we received after his death.

24. After Chris was discharged, he went to see my mother on 7 February. When he arrived, he seemed very unwell and withdrawn and said to her that he did not want to die but could not live like this. My mother felt very worried about him, so she made a call to the crisis team and told them that Chris was still suicidal, agitated and withdrawn. The member of the crisis team she spoke to stated it sounded like a withdrawal from medication but to bring Chris down if my mother wanted to. Chris had been offered no follow up care other than community therapy, and nobody thought to offer Chris additional support such as a home visit or medication.

25. Chris tragically died by suicide on 13 February 2021. He spoke to my mother that morning and said he was feeling very tired after a bad nights' sleep but said he would walk to her place to see her later. He never arrived and my mother knew something was wrong when he was not picking up his phone a couple of hours later. He hung himself at the home he was sharing with his fiancé whilst she was

at work. I still remember saying to him shortly before he died: 'please don't leave us' 'our lives will never be the same again.' He said he did not want to leave us, and I know he did not, but he just did not have enough support to fight the difficulties he was facing – it all just became too much.

26. After Chris passed away, we made a complaint to the Patient Advice and Liaison Service. When the ambulance came to pick up Chris on the day of his suicide, we said to them that we did not feel that he had been properly supported and that his death would not have happened if he had been listened to. They raised our concerns with the Trust, and this led to the hospital releasing a Serious Incident Report. This stated that there were missed opportunities to robustly assess Chris' mental health so soon after a significant overdose with the intention to end his life. The report found that because Chris had said to staff he had no remorse for his overdose and told staff he would take paracetamol next time, this would have warranted a second opinion from the crisis team about his care. The Serious Incident Report found that lapses in care and missed opportunities may have had an impact on the lead up to Chris' death. It also noted that the views of Chris' family should have been sought and that more proactive steps should have been taken to understand his condition and circumstances.

27. We are extremely frustrated as a family, that we did not have the opportunity to advocate for Chris and that more was not done to listen to him (and us). There are several medical professionals in our family (my sisters are both nurses too) and we feel that we have a good understanding of where help should have been available, but despite turning to these places for help, we felt that no one was listening.

Advocacy and campaigning work

28. After losing Chris so tragically we felt that we had to do something to campaign for improvements in the care and communication between staff, patients, and families. During the period leading up to Chris' death, we felt so alone with no support and did not know where to turn when we were not being heard. People should not feel alone in a time of crisis.

29. I wanted to make it publicly known how restrictions on my family staying with Chris during his hospital admission and the subsequent lack of communication, led to what I believe was an avoidable death. I believe that a risk assessment should have been carried out when we asked to stay with Chris in hospital, and that a family member should have been allowed to be Chris' voice. I feel during the Covid-19 pandemic it became too easy for staff to say no to relatives' requests to stay with their loved ones, without doing risk assessments and thinking of what is in the patient's best interests. I therefore shared Chris' story on the John's Campaign website in April 2022, and I exhibit that blog to this statement as **[Exhibit RA/01 - INQ000273413]**.

30. Chris was admitted to a general hospital to treat an overdose, but had staff communicated with us properly we would have been able to explain that it was Chris' suicidal ideation which was putting him most at risk. Because Chris was so unwell he was not able to properly explain how his mental health had declined to staff at the hospital. When Chris was admitted, staff carried out assessments based on what they thought they could see (for instance in Chris' notes it stated there was no evidence of self-neglect and no agitation). Had we been able to be with Chris we would be able to explain that what we saw was completely different: sad eyes, voice lower tone than usual, not speaking much, sitting in silence, no longer watching TV, or doing the things he once enjoyed, such as listening to music. If we had been present, we could have explained that Chris was not washing himself, was not sleeping and was experiencing significant weight loss. I have known Chris my whole life and I believe it would have made a difference if I could have highlighted how unwell I thought he was.

31. Since Chris passed away, I have therefore set up the campaign 'Chris's Voice'. This campaign aims to be the voice for patients by listening to families, escalating care requests, and liaising with health professionals to develop a plan of care for patients and ensure safer dischargers. The campaign is also encouraging health care professionals to speak up if they disagree with a decision made regarding patient care. My sisters and I have put together a training which we have been presenting to different hospitals and which we are encouraging them to adopt. I exhibit the slides we use for our presentations as **[Exhibit RA/02 - INQ000486002]**.

32. We recently had our campaign approved at two University Hospitals and an NHS Trust. We also presented at a Fundamental Nursing Standards meeting and delivered our presentation on Chris' story and what changes can be made to make patient care better. We had good feedback from the NHS Trust Director, who said the presentation got staff talking, motivated and inspired to make positive changes. We are working with the communications team to prepare a video so that we can roll out our campaign more widely, including to nursing and medical students.

33. We have further campaign presentations booked and we want to make 'Chris's voice' part of mandatory training for staff. Our campaign encourages staff to share patient information where life is at risk. We are determined to have our training adopted nation-wide at hospitals to ensure that what happened to Chris never happens again.

Conclusion

34. If there is one lesson I wish could be learned from my family's experience during the pandemic, it is that communication with family and loved ones is essential and can be lifesaving. I firmly believe that had we been able to stay with my brother and been properly communicated with, my brother would still be here today.

35. Throughout the pandemic myself and my sisters (who work in the NHS) worked tirelessly to provide the best care and treatment to our patients and their families in very difficult circumstances. Our family are so frustrated that, whilst we worked caring for others during the pandemic, we could not be there properly for our own loved one in a time of need.

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: 01/07/2024