Witness Name: Nathalie MacDermott

Statement No: 1

Exhibits: 11

Dated: 4 July 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF NATHALIE MACDERMOTT

I, Nathalie MacDermott, will say as follows: -

1. I make this statement in my individual capacity. I am however also a member of CATA, and that is how I came to be asked to provide this statement.

My background

2. I am an expert in epidemic and pandemic diseases, having spent a significant period of time responding clinically to cholera outbreaks and Ebola outbreaks, as well as responding to disaster settings in which disease outbreaks are highly likely and need to be prevented. My PhD, awarded by Imperial College London, investigated genetic susceptibility to the Ebola virus disease in Sierra Leone and involved the study of disease transmission in communities throughout Sierra Leone and the recruitment of over 2500 people to my study.

3. In 2011, I answered the call for a disaster response to the Cholera epidemic in Haiti, where I was the lead paediatrician on the paediatric ward in the Cholera treatment centre in the largest slum in Port-au-Prince. In late 2013/ early 2014, following Typhoon Haiyan, I deployed to work in the Philippines and treated child outpatients in a field hospital for

infectious diseases and malnutrition, as well as being part of a mobile medical team to communities cut off by the aftermath of the typhoon.

4. In May 2014, I deployed to Liberia to work in an Ebola treatment facility in Monrovia to address the alarmingly high incidence rate of Ebola. I was asked to lead clinical care in the facility, due to circumstances at the time this eventually led to an entire change in staff management at treatment facilities for Médecins Sans Frontières (MsF) and oither non-governmental organisations (NGOs). When I had arrived in Monrovia, MsF had no policy in place for testing staff for illness when attending work at treatment facilities, and because of my involvement with two of my senior colleagues contracting the disease, MsF implemented an organisation-wide screening policy of testing healthcare workers for symptoms upon attending work at Ebola treatment facilities.

5. In October of 2014, after returning home and quarantining for three weeks, I redeployed to Liberia, in order to continue to provide clinical care for the Ebola outbreak response. While back in Liberia, I oversaw the construction of and managed four Ebola treatment facilities, trained all the healthcare workers within them and developed the IPC protocols and patient management guidance. Alongside the Ministry of Health, I was involved in developing a rapid intervention and treatment of Ebola program to be utilised in rural areas, where there was little to no ability to transport patients to urban areas with more healthcare resource, as well as training the county health teams in implementation of the strategy.

6. Finally, in October of 2018, I was deployed to South Sudan to carry out an Ebola preparedness program due to the outbreak that had begun in North-Eastern Democratic Republic of Congo and threatened to materialise in the border communities that were run by the South Sudanese anti-governmental opposition party. I developed a training facility and programme to train South Sudanese healthcare workers in PPE, donning and doffing, management of Ebola patients and Ebola treatment facilities, including IPC protocols. I trained community outreach workers in community sensitisation and awareness of Ebola, and I also assisted with development of laboratory protocols, contact tracing strategy and IPC in rural health facilities alongside the Ministry of Health of South Sudan.

7. My deployments to the various aforementioned overseas disease outbreaks have been entirely on a volunteer basis, all through the Samaritan's Purse International Relief (SPIR) organisation, motivated by my passion for assisting the ill and the healthcare

workers that care for them. I have seen countless patients and many healthcare worker colleagues perish as a consequence of the deadly infectious disease outbreaks that I have been deployed to manage.

8. I have trained hundreds of healthcare workers in Liberia, Sierra Leone and South Sudan on personal protective equipment, how to appropriately don and doff PPE, when PPE is necessary, the quality of PPE that is necessary and how to care for people with highly infectious diseases. I have developed PPE guidelines, as well as guidelines for the management of high consequence infectious diseases. I have also worked alongside the World Health Organisation, UN organisations, DfID (now FCDO), USAID and the US OFDA, as well as many non-governmental organisations.

9. I was awarded a medal from the UK Government for my service in West Africa when David Cameron was Prime Minister, called the 'Ebola medal for service in West Africa'. I have also been awarded the Student Award for Outstanding Achievement from Imperial College for my work in Sierra Leone and Liberia, as well as a Deanery Award from the Wales Postgraduate Deanery.

10. I am trained as a team lead for the UK Emergency Medical Team (part of FCDO and the WHO emergency medical teams system).

11. I am currently an NIHR Clinical Lecturer in Paediatric Infectious Diseases at King's College London.

12. Due to my expertise, during the first 2 months of 2020, I undertook repeated media interviews to warn of the potential risks of Covid-19 and to discuss what we knew of the disease and its mechanisms of spread. These interviews are still widely available, one of which featured in the Sky tv series, 'This England'. In February of 2020, during the outbreak of Covid-19 on the Diamond Princess cruise ship docked in Japan, it became apparent to me that the spread of Covid-19 likely had an aerosol component as too many of the new infections on board the ship could not be explained through droplet or fomite transmission and I explained this position to many media outlets.

13. In March 2020, I was invited by the UK Research and Innovation (UKRI) Covid-19 funding panel to join their 'College of Experts'. I would assess applications to scrutinise and recommend for funding for Covid-19 research.

My clinical experience during the Covid-19 pandemic

14. In March 2020, I began work at a hospital in England as a Paediatric Registrar (ST-7) and as part of the Paediatric Infectious Diseases Specialty Training Pathway. Within the first month, I had contracted Covid-19. Shortly before I started working at the hospital, a senior surgeon returned from Italy and refused to self-isolate, despite government advice. A wave of infection commenced within the senior executive team, which then spread down through the consultant teams to the junior doctors, because at that time we were not permitted to wear any form of face mask in our offices. Our offices were also not appropriately ventilated. Several doctors were sharing very small offices and the disease spread easily. After contracting Covid-19, I was off work for 10 days, but after 4 weeks had made a full recovery.

15. When I returned to work in April 2020, I went to work on a Covid-19 ward. This ward was a repurposed ward, which was originally designed to be a private day-case unit and was not designed (nor appropriately ventilated) for the management of cases of infectious diseases, especially not those spread through aerosols. On 23 May 2020, I developed symptoms of Covid-19 again. This time I did not fully recover and did not return to work at this hospital.

16. During my work on this ward, I would routinely treat children who were hospitalised due to Covid-19. This involved assessment and examination of children transferred to my hospital for inpatient admission, including obtaining observations, inserting intravenous lines and arranging investigations and commencing treatment. To undertake good clinical care it was not possible to maintain a distance of 1-2 metres from my patients. It was at this time that we started to recognise the first wave of multisystem inflammatory syndrome in children and teenagers as a result of COVID-19.

The RPE/PPE provided during my time working during the pandemic

17. On my first day working on the repurposed ward in April 2020, I was surprised to discover that I was only permitted to wear a surgical face mask ("FRSM"), a flimsy plastic apron and a pair of gloves, despite working with children and their parents who had tested positive for Covid-19. I was often within 1 metre of my patients as it is not possible to examine a child at a great distance. We were also at the beginning of the first wave of multisystem inflammatory syndrome following Covid-19 infection and so many of our patients deteriorated rapidly and needed urgent resuscitation. These patients were not on ventilators so they were coughing, shouting and crying, as afraid children often do. On

the ward, we were only allowed to wear visors if we were performing Aerosol Generating Procedures ("AGPs"). I was so concerned that my team were only wearing fluid resistant surgical masks and were not protecting their eyes, that I recommended they wear visors during all patient interactions.

18. In March of 2020, staff had been complaining about the lack of fit testing and so the hospital agreed to fit test staff. The fit testing felt like a token gesture, as it wasn't carried out thoroughly. I failed the fit testing on the only two masks I was tested on. The fit testing exercise became redundant anyway though, because only those working on the Covid-19 intensive care ward, and so not the ward I was working on, were provided full PPE/RPE. The only mask I was permitted to wear was a fluid resistant surgical mask.

19. My colleagues and I were not aware that the national Infection Prevention and Control ("IPC") guidance had changed in March of 2020, namely that FFP3s were only required for those healthcare workers performing an AGP on Covid-19 positive patients. There was no hospital wide announcement and so we just found out on site that RPE/PPE protection had been downgraded. Most of my colleagues were not aware of this, they assumed that full PPE/RPE was being worn on the COVID wards, it is only when they attended our ward to assess patients or conduct investigations that they discovered we were not permitted to wear full PPE/RPE.

20. I challenged my hospital's IPC team and said that the 'PPE' provided was inadequate for the disease we were dealing with and that they were putting healthcare workers at risk. I attempted to show the early evidence for aerosol transmission and work with the IPC team to develop PPE protocols/guidance which would optimise safety while balancing the limited stocks of PPE/RPE. I repeatedly tried to explain that the distinction between AGPs and non-AGP's for the purpose of access to RPE did not make sense in practice and, in the absence of evidence to the contrary, a precautionary approach should be taken in order to protect staff **[NM/02-NM/07 - INQ000480633, INQ000480634, INQ000480632** INQ000480636, INQ000480643, INQ000480641]. I could see that these policies were putting staff at risk. My lobbying for greater PPE and improved IPC guidance was not borne out of a desire for self-protection, but rather to ensure that my colleagues were adequately protected.

21. In April 2020, I was told by a member of the IPC team that there were 20,000 FFP2 masks on site at the hospital, and a large stock in the cupboard on our ward, but we

were not permitted to wear them in case the Trust ran out of FFP3 masks on the Covid-19 intensive care ward. This was the only ward at the hospital whose staff were allowed to wear FFP3 masks, or RPE in general. I believe it was in the first week of May of 2020 that somebody senior in the hospital's executive team sent an email to all staff stating that the issue was not about availability of PPE - but that they were following the national guidance and full PPE/RPE was not needed. The email informed us the trust had discussed this with an IPC expert and they were confident they were providing the correct level of protection to us. I looked up the expert they mentioned, but it turned out their area of IPC expertise was in surgical site infections and prevention of transmission of multidrug resistant bacteria in intensive care settings. I believe that the Trust were just covering themselves and backtracking because, just prior to this update, the Chief Executive had referred to a shortage of PPE/RPE in a virtual team meeting with junior doctors.

22. In early May 2020, I sent an email to my Trust's IPC team offering to share with them a link to a retailer with a large stock of cost-effective FFP2/3 masks **[NM/01 - INQ000480637]** never received a response to this email and they never took me up on the offer. I ended up ordering a batch of these FFP3s for myself and other colleagues regardless, but I never had a chance to use them, because they arrived after I had contracted Covid-19 for the second time and couldn't return to work.

23. I was repeatedly rebuffed by my Trust's IPC team in conversations and email correspondence, when I raised the issue of Covid-19's aerosol spread and the need for proper respiratory protective equipment **[NM/02-NM/07 - INQ000480633, INQ000480634,** INQ000480632, INQ000480636, INQ000480643, INQ000480641] . I was continuously told that they were 'following the guidelines' and I was referred to in a private email that I was shown as just an 'anxious registrar' who was causing other staff to become concerned about the level of PPE provided. All my suggestions were dismissed.

24. In a meeting on 21 May 2020, with the lead IPC nurse and the head of the paediatric infectious diseases department, I was shouted down and told the evidence I had provided regarding aerosol transmission was just "my opinion" and was not scientifically robust enough, despite no evidence being provided to the contrary and only the national PPE guidance flowchart being provided again. Roughly three days after this meeting, I became symptomatic with Covid-19 for the second time.

25. It is my view that both the IPC team and senior management at my Trust had some concerns about the availability of PPE at a national level, even if there was no official admission of this. The IPC team appreciated that FFP3s were necessary for intensive care units and so applying the precautionary principle, should have afforded the same level of protection to all staff working with Covid-19 positive patients. I believe that the reluctance to provide better PPE/RPE and protection was in my view driven by an archaic understanding of the transmission of respiratory diseases, as well as a general attitude that exists within the NHS which disregards the need to protect staff. Within the NHS, healthcare workers are considered more likely to contract disease from the community, than they are from work. This was quoted to me as a reason for us not requiring a better level of PPE/RPE, despite the UK being in lockdown at this time. This latter perspective is in stark contrast to the positions taken by other industries, and I cannot understand it.

26. Despite my Trust's opposition to adequately protecting staff working on my ward, I saw that many registrars and consultants from other wards who, when working on my ward, would take FFP2s from the cupboard to use, and in some instances colleagues and consultants would bring FFP3s from the intensive care ward. Multiple colleagues insisted on wearing full PPE and outright refused to attend my ward unless they were allowed to do so. This included a senior consultant who was cognisant of the emerging evidence of the disproportionate impact of Covid-19 on those from the BAME community. However, if anyone from my team was caught wearing FFP3s or gowns on our ward or taking them from the intensive care ward or elsewhere, they were reprimanded and told to remove them. Physiotherapy colleagues on my ward were the only staff permitted to wear full PPE/RPE as their national body had issued guidance stating physiotherapists should be provided with full PPE/RPE due to their close proximity to Covid-19 patients in the course of carrying out therapies. As the therapies they were carrying out on my ward were not considered AGPs, this was inconsistent with the information/guidance provided to other healthcare workers. Nursing colleagues who carried out nasopharyngeal aspirates (NPAs) to test our patients for COVID-19 were permitted to wear full PPE/RPE when conducting the procedure as NPAs were considered an AGP. The advice was then to close the door to the patient's cubicle for 20 minutes afterwards and nobody was to enter. Thereafter healthcare workers could enter just wearing FRSMs, despite the cubicles not having adequate ventilation for respiratory infectious diseases.

27. My colleagues and I became exceedingly frustrated at both the dismissiveness of senior staff relating to our raised objections with guidance/policy, as well as the outright hostility

we would be subjected to if and when we chose to further protect ourselves. When the IPC team eventually attended the ward in person, staff did not wish to even meet with them due to the tensions stemming from this.

28. By the end of March of 2020, an email was sent to all staff at my hospital informing them there were roughly 300 members of staff at my hospital who were off work with Covid-19. A whistleblower leaked this to national media. In mid May 2020 the lead nurse for my department died of COVID-19 after a month in intensive care, and the matron remained in intensive care for two months and hospitalised for several months after.

29. I have no doubt that the patients on my ward received a lower standard of care as a result of our IPC policy. As staff did not feel adequately protected, they felt reluctant to have physical contact with patients, and reluctant to spend the time necessary with patients to carry out the best possible treatment. Staff would also be mentally distracted due to the stress and fear of being infected, which even further eroded the level of care provided to patients. Play specialists would not attend the ward at any point due to concerns with the IPC policy and psychologists would only interact with the children in the ward virtually through an Ipad.

The impact of contracting Covid-19 and then developing long Covid

30. Two weeks after I contracted Covid-19 for the second time, I developed neurological symptoms, which continued to get progressively worse. I was diagnosed with a Covid-19 related myelopathy in September 2020, in other words damage to my spinal cord secondary to Covid-19.

31. This form of long Covid affects my mobility, my bladder and bowel function and leaves me with constant pain and fatigue. I walk with crutches and require a mobility scooter to travel longer distances. I am registered as disabled, hold a blue badge and am awarded personal independence payments (PIP). Other symptoms of my long Covid include the development of an inflammatory skin condition, rosacea, and the initial stages of autoimmune thyroiditis as well as chronic urinary tract infections, which could lead to further kidney issues.

32. I returned to clinical work in March of 2022 with several adaptations in place and provision of a mobility scooter and minicabs through Access to Work. My previous intention was to blend a career in academia with clinical work, however I struggle with

executive functioning and as a result I now find it extremely difficult working in a clinical setting. The additional physical demands of clinical work and the impact on my health have made me realise that a full-time and even possibly part-time clinical career is now not possible for me.

33. Finding employment within clinical work is almost inaccessible for me now, as despite the NHS in principle not openly discriminating, when I attend an interview in my mobility scooter or on crutches it becomes evident that I would be unable to attend the wards in the same manner as other candidates. In practice, there are insurmountable hurdles that I do not feel I am able to overcome regardless of there being reasonable adjustments in place.

34. Even within academia, I feel as though my long Covid has resulted in me being perpetually behind my peers. I am unable to work at the rate I did previously, and feel exhausted mentally and physically after even short periods of working. In such a competitive field, I am at a significant disadvantage now.

35. My passion still lies in responding to disasters and epidemics, and while I am determined to try and return to this line of work, the practicalities of this are difficult due to my disability. I know that many agencies will now be reluctant to deploy me.

36. The NHS and the NGO sector have as good as lost a highly trained consultant in paediatric infectious diseases and an expert in epidemic and pandemic diseases, all because the NHS and UK government were unwilling to provide respiratory protective equipment to me on the front line, which should have been demanded by applying the precautionary principle.

37. My long Covid has already had a huge financial impact on me due to the costs associated with my disability. Now that I face employment insecurity and uncertainty, this financial impact is likely to become even more significant. I currently work at just 0.5 FTE as this has been the only research funding I have been able to obtain. This funding will end in February 2025, and so far I have been unable to find other sources of funding or employment. The financial insecurity has had a significant impact on my quality of life and causes substantial additional stress, as well as the loss of identity that I feel in not being able to continue in a career I loved and was passionate about.

38. Despite my best efforts to remain resilient, my mental health has been impacted by my experience of contracting Covid-19, developing long Covid and the manner in which the NHS responded to both. Although I never returned to work in the same hospital after contracting Covid-19 for the second time, I was never contacted by anyone from senior management at the hospital, despite them being aware of the ill health and disability I was suffering. I was diagnosed with post-traumatic stress disorder after my traumatic experiences from when I was deployed to Liberia during the Ebola outbreak. My PTSD very specifically relates to healthcare worker colleagues being put at risk and contracting the infectious disease they are treating, after watching so many healthcare worker colleagues die from Ebola due to the lack of PPE they were provided with. This was triggered during the first wave of the Covid-19 pandemic and at one point, I even contemplated suicide as I was so frustrated and overwhelmed at not being listened to regarding the PPE/RPE.

39. In August 2020, I became aware of the RIDDOR Regulations. I had not been aware of reporting under the Regulations before this point. Shortly afterwards, I approached my Trust, and formally requested that they RIDDOR report my two Covid-19 infections to the Health and Safety Executive ("HSE"). The principal reason that I decided to request a RIDDOR report, was to try and influence the Trust's policy regarding the provision of PPE/RPE. I hoped that this report would prompt an investigation and change within the organisation.

40. After making the request, it took roughly a year for my Trust to make a decision about whether to RIDDOR report my Covid-19 infections. I had to constantly chase them, even though my health was deteriorating at that time. I had to routinely check that the information they were using was correct, as it often was not, and that they were following the correct procedures **[NM/08 - INQ000480635; NM/09 - INQ000480640]** It was incredibly frustrating and demonstrated to me very clearly that they were not taking the issue seriously. I was so dismayed by the length of time that my Trust were taking to make a decision that I even tried to self-report my case under RIDDOR directly to the HSE **[NM/09 - INQ000480640]. I** understand from colleagues that there was a specific form for self-reporting under RIDDOR not long before I came to self-report, but when I tried to do so, that form was no longer available. HSE never responded to my self-report.

41. Before my Trust conveyed to me the final outcome of my request for RIDDOR reporting, I was notified that a consultant in occupational medicine, who the Trust had sought advice

from about my case, had concluded that my first incident of Covid-19 infection was RIDDOR reportable, but that the second incident was not, as I was not only unable to report exactly who was responsible for my infection, but also because I never received a positive Covid-19 test. I found this very puzzling as it was almost impossible in those circumstances to identify the exact person from whom I contracted the virus. Additionally, I presented with all the clinical symptoms of Covid-19 and, even with my expertise, this was not enough evidence for my Trust. Ultimately, my Trust declined to report either of the incidents in which I contracted Covid-19 to the HSE **[NM/10 - INQ000480642]**

42. I enlisted the support of one of CATA's member's, David Osborn, an expert in occupational health and safety, to write formal representations to my Trust as to why they were obligated to RIDDOR report my case, but again they declined **[NM/11 - INQ000480644]**

43. After David Osborn assisted me with my RIDDOR issue, I became aware of the work that he and others within CAPA were doing campaigning and lobbying the UK Government and other public bodies. I tried to use my expertise to assist CAPA with their campaigning where possible. I had been speaking out publicly since the outset of the pandemic and so was more than happy to continue to do so on issues relating to RPE/PPE and aerosol transmission. I also wrote an article in early 2021 called "*COVID-19 and workers' protection: lessons to learn, and lessons overlooked*", which discussed the impact of non-recognition of aerosol transmission and the inadequate protection afforded to healthcare workers.

Experience of treatment for long Covid

44. Initially, my GP was unsure where to refer me for my long Covid symptoms. I identified the neurologist I was eventually referred to through a journal article they had co-authored on the neurological impact of COVID-19 that I came across in June 2020. Initially he was similarly unsure how to diagnose me. I had been booked to see them both prior to the recognition of long Covid as a medical condition. However, due to the clonus (repeated muscle response when certain stimuli occur) apparent in my legs, I was able to be taken seriously. I know that others have not been so lucky. It has generally fallen to me to coordinate my own care among various healthcare professionals, due to the difficulties in diagnosis/recognition/management of long Covid.

45. My experience in the navigation of treatment for long Covid has been atypical. Due to my clinical experience and expertise, I have been able to explain my symptoms better than a

layman could. My experience is therefore not representative of the experiences of the general population. Indeed, it is not even representative of other doctors who suffer with long Covid as I have been very fortunate in the support and healthcare I have received.

Statement of Truth

46. 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: _______4th July 2024_________________________