IN THE MATTER OF

MODULE 3 OF THE UK COVID-19 PUBLIC INQUIRY

WITNESS STATEMENT OF PATRICIA TEMPLE

1. I commenced my nursing training in the UK in 1965. I subsequently travelled to Rhodesia and qualified as a registered nurse there in 1972. I then worked in South Africa, Zimbabwe, Saudi Arabia and Kuwait, the latter two as a Director of Nursing for more than 10 years, returning later to South Africa, where I made the decision to go back to bedside nursing, as a Staff Nurse, in the UK in 2016.

2. During the pandemic, from March to November 2020, I worked as a band 5 staff nurse on permanent night duty on the Cardiac Care Unit ("the Unit") of an NHS Trust. In addition to personally providing bedside care for acute medical and acute cardiac patients, I also provided bedside care for both symptomatic and asymptomatic Covid positive patients as and when these patients were admitted to the Unit.

3. The impact of the pandemic on my daily working conditions was variable, as was the response. We didn't know what to expect from one day to the next. Everything seemed very disorganised, including management. We received many mixed messages about how we were to nurse Covid positive patients and how at risk we were. There was a lot of uncertainty and a lot of gossip and rumours. Everyone seemed to have different opinions on what we should be doing and how best to protect ourselves and our patients. There did not seem to be a structured and organised approach. It really felt as though we had been caught unawares.

4. In the beginning the pandemic was seen as a challenge. There was a sense of adventure to it. We were being called upon to step up, to meet the challenge and do what we could, and more, for our patients and the country. But gradually we realised the gravity of the situation. This was serious. Something not to be taken lightly. Outcomes could and would be bad.

5. Fearmongering was rife and a straightforward and consistent message from management would have made things easier. As it was, policies seemed to change daily and, at times, did not seem to adhere to the normally accepted Infection

Prevention and Control ("IPC") guidelines. By way of example, we were advised one Friday that we were to wear masks from Monday. I found this nonsensical and difficult to take seriously. It became more difficult to trust management, as decisions did not always seem logical. These would be disseminated by the Trust via the Intranet and by notices displayed around the hospital. Information was also given during handover but, as handover was time pressured, it was difficult to have a conversation or discussion on policies and the rationale behind why we were being asked to do something differently. It was simply a case of having to follow orders.

6. There was increasing concern that management were not sharing with us all the information that we were entitled to, and it felt like that there might have been deliberate concealment. This applied, for example, to how many Covid positive patients were being admitted daily. We felt the situation was being downplayed and some information was being withheld so as not to alarm us. There was disbelief and scepticism in the beginning. The dangers were also 'played down' and initially nobody appreciated the impact the pandemic was to later have, least of all how many nurses were going to suffer serious illness because of unprotected exposure to Covid. The message we continued to receive was 'Don't worry. Everything is under control'. No one would dare say that it might actually not be.

7. We were often told that all information and guidelines were coming from the NHS, and they had to just 'follow orders'. It felt like whoever were in charge, from top to bottom, were not willing to accept responsibility for whatever it was they were implementing and 'blamed the NHS' and the Government. 'We're following the rules' was a constant message, even when those rules did not seem to make sense and should have been challenged.

8. It was an extremely confusing time. I was unsure what to expect from day to day. Initially the Unit did not admit known Covid positive patients but increasingly we admitted patients awaiting confirmation of results and then transferred them to Covid positive wards when the results came back positive. However, the reality was that we often had to continue to nurse these patients as there were no beds elsewhere and our Unit had side rooms where they could be isolated. Whilst there was a Covid positive designated ward, if that ward was short staffed, nurses from our ward were called on to assist. I believe this happened all over the hospital as the search for available Covid beds continued.

9. I did encounter staff members who were reluctant to undertake lateral flow testing when they were asymptomatic, as they did not wish to be sent home and made to take sick leave, which was limited, as this might have had financial implications. Despite these worries, I was not aware of any staff who refused to be tested when requested.

10. There were a fair number of staff who were very reluctant to take the vaccine – including myself – and who were made to feel guilty if one did not. There was a sense of letting the side down. This also applied to staff who were Covid positive and were advised to return to work as soon as possible and made to feel guilty if they did not. There appeared to be variable guidelines regarding nursing staff who acquired Covid and when they were permitted to return to work, with staff shortages making it difficult for staff to remain off until they were fully recovered. Staff were also reluctant to remain off duty or shield as there appeared to be no definite guidelines as to what impact this might have on salaries. In addition, some people took full advantage of shielding but were mocked for so doing.

11. As time progressed and general concern and fear built, staff began to request to not nurse Covid patients on grounds of illnesses such as asthma and diabetes and because they had vulnerable family members or young children at home. This then impacted those of us who were able to nurse Covid positive patients and, for me, nursing Covid positive patients became a regular occurrence.

12. Covid regulations had identified vulnerable persons who could shield at home. As my only 'vulnerability' was my age and as staying at home for an extended period was not financially feasible and as no one could give me any specific guidance on what would happen to my salary and enhancements, I remained at work as I felt I could not afford to stay at home, either financially or emotionally and, in addition, my absence would have adversely affected staffing levels.

13. PPE guidance lacked clarity and changed regularly. When to wear masks? Which masks? When should we wear surgical masks and when should we wear FFP3? Full PPE for a Covid positive patient or only for Aerosol Generating Procedures? I had been fit tested for a mask in 2019 and wore these when they were available and when it was required according to whichever guidelines were in place at the time, which as previously explained were hugely variable. The adequacy of surgical masks for nursing all but for actively positive Covid patients was stressed all the time and we were told that surgical masks would offer sufficient protection. We were also advised to use FFP3

with care as supply was not reliable and stocks might not be readily available. There seemed to be no consistent guidelines on what to use and when. Even Infection Control Practitioners did not seem to talk the same language. As the pandemic progressed more emphasis was put on wearing gowns, gloves, and masks for the care of Covid positive patients, with visors being added for those patients on Aerosol Generating Procedures. One could question the risk of not having donned this type of protective equipment from the beginning and throughout the pandemic, particularly when one thinks of the suspected Covid patients we nursed wearing only surgical masks, only to have them declared Covid positive later.

14. I was on permanent night duty, and this made it difficult to attend for fit testing as staying after duty was not ideal and returning to the hospital during time off was not advised. I trusted that I was covered and used FFP3 masks when necessary. I then discovered in November 2020 that the mask for which I had been fitted was no longer available as it had been removed by the NHS and put into general stock. I was not informed of this at the time. I also discovered that four of the five masks for which I was tested in November 2020, and which were available on the Unit were not suitable for me and would not have protected me. The fifth mask was suitable but was not one I had ever seen on the Unit. This would indicate that I was probably at risk during this period.

15. Visors for nursing patients on Aerosol Generating Procedures were not available initially and some donated items were supplied. Whilst this was greatly appreciated, the quality was of a variable standard and often we would have to remove the visors because they would steam up. These donations applied also to scrubs, which we were advised to wear and send to the laundry to be washed. This was fine but, often, there were no appropriately sized scrubs available on the Unit and so people started taking scrubs home and washing them themselves, which made the policy irrelevant. It also impacted on our start and finish times. People would turn up early to shift simply to ensure that they secured scrubs that fitted. Scepticism ruled here as well and management did little to reassure staff, despite guidelines being issued, as these changed so often.

16. Whilst IPC nurses did visit the Unit to discuss guidelines etc, working night duty shifts made this difficult and we had to rely on information being relayed to us during handover or by email. When querying guidelines, there would be acknowledgement that these might be questionable but that the rules should be followed. I followed the

principles of Infection Control that I had learned during my training but also used my common sense, which it often appeared was seriously lacking in the management of the pandemic at Unit, Hospital, Trust, NHS, and Government level.

17. Social distancing measures made sharing facilities like the clean utility, nurses' stations, ward kitchens and staff lounges challenging, particularly at shift handovers and when patients required additional staff to provide care. Notices were put up in all areas detailing the number of people allowed in at any one time, but this was difficult to adhere to at times. How these numbers were calculated remains a mystery. Opinions differed as to whether wearing masks in these shared facilities provided adequate protection.

18. A particularly distressing aspect of social distancing was that relatives could not visit seriously ill and dying patients and this had a hugely negative effect on all nursing staff who had to provide care in these circumstances and organise the logistics of families saying goodbye to their loved ones remotely. It went against our nursing ethics and against our need to advocate for patients and their best interests. It was incredibly difficult and terribly sad for all who witnessed these heart-breaking scenes, and this has left a lasting impact on me and, I know, many others.

19. Being older and living alone made it both easier and more difficult to work and live during the pandemic. I did not have the fear of 'taking the virus home to family' but did not have anyone to share difficult experiences and fears with. It was a very isolating time. Having no family in the UK was not easy. Listening to Government announcements did little to reassure us, particularly when the Prime Minister played down the severity of the pandemic and the Health Minister appeared to have no idea what he was doing – particularly PPE wise. It was a very difficult time to be nursing but, as dedicated and committed professionals, we continued to provide the care that our patients needed, despite the risks. We expected the NHS and management would look after us as required. I fear they failed to do so.

20. This was confirmed when I contracted Covid at work in November 2020, having nursed Covid positive patients immediately prior to this illness. I believe that I caught Covid at work due to a lack of appropriate PPE and the lack of appropriate management support, such as a guided risk assessment that considered my age and clinical vulnerabilities and which actually asked whether I was aware of the risks and prepared to continue. Instead there was an assumption that I knew and was prepared to continue

implicit in my turning up for work when scheduled. I never imagined I would get Covid. I was doing everything I could to avoid it. A number of other nurses on the Unit contracted Covid at around the same time, an outbreak was declared, and outbreak measures implemented. Initially I remained at home alone for the first week of my illness, as the regulations at the time advised that Covid positive patients should not go to hospital and should rather remain at home. This was a difficult time as I lived alone, both my children and their families lived abroad, and I had to rely upon friends to deliver food to my door. It became increasingly difficult to look after myself and my condition became progressively worse until such time as I requested a Dr's home visit. An ambulance was immediately called as my oxygen saturation levels were alarmingly low. I was admitted to hospital for some 10 days and diagnosed with Covid pneumonitis and acute Type 1 Respiratory Failure, requiring non-invasive ventilation with high-flow oxygen therapy ("HiFlo") and continuous positive airway pressure ("CPAP") and narrowly avoiding intubation and ventilation. Following discharge from the Respiratory Unit in November 2020, I returned to work in January 2021. In March 2021, it became obvious that I could not continue and left work on sickness leave, being diagnosed as suffering from Long Covid.

21. This was a life changing and soul-destroying event and the losses were many and various, some temporary and some more permanent. All revolved around the range of symptoms produced by my Covid infection, the most disabling being the dyspnoea (difficulty breathing) and breathlessness, the variability of my Oxygen Saturation Levels, the dysautonomic (difficulties with the autonomic nervous system) effects including hypotension (low blood pressure) and dizziness, the intermittent and inappropriate tachycardia (fast heart rate), the temporary deterioration in cognitive function and the enormous weight of fatigue and weariness. These health issues were dismissed by many people, even medical and nursing personnel and I was often told that 'it was all in my head' and 'there is no such thing as Long Covid'. Thankfully, both my GP and the Occupational Health Department were supportive, and I managed to have the Long Covid diagnosis confirmed.

22. The losses accompanying this diagnosis were many and included the loss of:-

- My financial and personal independence and my ability to earn my own living and not ask for help, which had long been a source of great personal satisfaction and a much-valued achievement. The loss of this independence has had a profound effect on me and my psychological well-being.

- My work, my nursing record, my nursing identity and my nursing image, a most prized possession and one that I have fought hard to develop, improve, maintain, preserve and to role model, over many years. A hard loss indeed.

- My personal freedom and independence in terms of running my own life and managing activities of daily living, including household tasks, shopping, and self-care, to the degree that I had done previously.

- My 'normal' cognitive function, requiring an ongoing interruption to academic studies and any intellectual pursuits, an issue which has slowly resolved over time, but which has caused enormous frustration and an adverse effect on my life plan.

- My ability to continue to exercise to any extent and to maintain my regular health and wellness programme. My exercise tolerance levels are hugely variable and recovery from exercise being extremely slow at times. This intolerance persists and is further limiting all attempts to walk for any distance at all.

- My ability to enjoy outdoor activities with friends, this being a regular event in my life, the lack of which has impacted negatively on my mental health.

- The desire and inclination to interact socially, due particularly to fatigue and a lack of understanding by many as to the significant impact that Covid has on ones' ability to function as 'expected' and as I had previously, with even family members finding this difficult.

- My ability to interact physically with my grandchildren as I had previously, and to enjoy my life, as I once knew it.

23. Initially, there was absolutely no process in place to deal with those of us who were still suffering Covid symptoms after the initial illness and no one really listened. I never felt heard. I spent the time from March 2021 to September 2023 trying to recover and return to work. I had to fight for my rights every step of the way starting with financial issues including the retention of salary enhancements. This was finally resolved, and the now renamed "Covid full pay' was continued until 31 August 2022. Occupational Sick Pay was paid from September 2022 to March 2023, half pay from March 2023 to

August 2023 and nil pay from 1 September, 2023. I was discharged from service due to illness at the end of September 2023.

24. The next 'fight' involved the payment of a Temporary Injury Allowance ("TIA"). I had not been informed that I might be eligible for this payment and feel that this might have been a deliberate omission. My first application was declined on the grounds that I could not 'prove' that I had contracted Covid at work. I appealed on the grounds that I lived alone, did not socialise, and adhered to all lockdown precautions. With the help of the Royal College of Nursing ("the RCN") my appeal was successful, and payment of TIA commenced. This was only payable whilst I continued to be employed, but by this time I had realised that, despite having worked extremely hard to get back to work (with very little support from either Management or Human Resources) and to be provided with appropriate redeployment opportunities – two of which failed - and despite having fought very hard to recover my physical health at some cost to myself, this appeared to be a losing battle and one which was taking its toll on my mental and physical health. In my final case review, I admitted defeat and allowed for a dismissal on illness grounds. This has been a devastating blow as I was not in a good place either financially, physically, or emotionally and now had to rethink my whole life and how to manage to remain financially independent and continue to earn my own living, my plan for achieving financial independence having been rudely interrupted by my Covid encounter. Accepting defeat was extremely difficult and I still feel that, had management been more prepared to appropriately deal with nurses suffering from Long Covid, I might well have manged to not only return to work but to also provide ongoing value.

25. My issues with Long Covid persist to this day and I view with enormous dismay the ongoing dismissal from employment of nurses with Long Covid. The same people who made an enormous sacrifice, who put themselves at risk to care for others, are now being made to feel disposable. I feel that this is extremely unfair and that much more should be done to try and understand Long Covid and its effects and to provide a far more supportive environment for these nurses while they recover.

26. I have now had to reluctantly relinquish my clinical nursing roles and, to continue to support myself – which is essential – I am currently providing online coaching, mentoring, and tutoring support for student nurses and others who are studying for their degrees. I am also developing my own online programme, 'Finding Your Florence', a transformative programme designed to guide those compassion-fatigued,

disillusioned, and dispirited nurses on a personal journey of self-discovery, reflection, and renewal, back to their true authentic nursing selves. During my career, I have always walked alongside nurses and helped them grow. This I want to continue. I will now utilise my wisdom, my knowledge, my years of experience and my true passion for nurses and nursing to continue to walk alongside and guide, mentor, coach and help my fellow nurses.

27. I sincerely hope that something is learnt from the experience of this pandemic, that all that has been seen and experienced is used productively for the future. I also would make an urgent plea on behalf of those nurses who are being dismissed on grounds of ill health due to persistent Long Covid symptoms. Nurses should not be viewed as disposable and every attempt should be made to retain this valuable resource.

Statement of Truth

I can confirm that the content of this witness statement is true to the best of my knowledge and belief.

Signed **Personal Data**

Dated ……..14 June 2024…….