Witness Name: Katherine Poole
Statement No.: 1
Exhibits: 0
Dated: 22/12/2025

UK COVID-19 INQUIRY - MODULE 10

WITNESS STATEMENT OF KATHERINE POOLE

I, Katherine Poole, c/o Broudie Jackson Canter Solicitors will say as follows: -

1. I am a member of CBFFJ UK and make this statement in relation to Module 10,"Impact on society", in response to the UK Covid-19 Inquiry's Request for Evidence under Rule 9 of the Inquiry Rules 2006.

Introduction

2. My father, John Hoare passed away from Covid-19 on 31st March 2020 aged 62. He passed away in hospital where he was transferred from a mental health unit after being sectioned under the Mental Health Act.

3. My father was a lovely man, born to my granny, a nurse, and grandad, an engineer. He was loved by all who knew him. He was quiet and kept himself to himself but loved his family and when they were alive, he would regularly visit his parents and family with me. He loved music and would spend a lot of time watching the music channels on his television. He was the person you would want on your team in a music quiz! He was also very knowledgeable about nature; he could give David Attenborough a run for his money. He had a real sweet tooth and loved it at Christmas when he would get many tubs of chocolates. My father negotiated his mental health struggles in a very admirable way enabling him to live independently with a little support. Prior to his mental health diagnosis, he worked as a warehouse man for a newsagent.

4. My father was first diagnosed with a mental health condition in 1985 when he was given the diagnosis of schizophrenia, in 1997 he was given the diagnosis of

schizoaffective disorder. In January 2020 he was moved to a Rehabilitation Care Home on the advice of the hospital social worker after he had been in general hospital with acute kidney injury and hospital acquired pneumonia which had been treated successfully but effected his mobility. The hospital social worker explained that the rehabilitation care home would only be for a short stay of up to 6 weeks where my father would be able to receive 24/7 care, including visits from physiotherapists and occupational therapists to help improve his mobility. As I had two young children, we agreed this would be the most appropriate place for him to be discharged to. We thought that this would be the best place for him to recover and give him the support he would need, and we believed it would only be a short-term placement. Unfortunately, he was allocated a care home at the other side of town to where I live but we visited him every day until the 5 March 2020.

5. My father was detained under the Mental Health Act whist in the short stay rehabilitation care home. His detention was due to his psychotropic medication, lithium, which was used to treat his schizoaffective disorder, being inappropriately stopped. His medication was stopped by the GP. When he was discharged from the general hospital in January 2020, his discharge documents had lithium on them, and he was sent to the Rehabilitation Care Home with lithium as part of his discharge medications. Because the care home was at the other side of town the care staff there somehow managed to change his GP Surgery unbeknown to me, when I did question why this happened and without consent, I was advised this is usual practice and to allow home visits. During this time my father was left without a mental health care coordinator as his long-term care coordinator moved job roles, and he was awaiting the allocation of a new one.

6. The lithium (discharge medications from hospital) was administered up to 24 January but then it was decided by the GPs that a blood test would be needed before continuing with the lithium prescription. A blood test was taken on 4 February which showed his lithium to be below therapeutic levels but there was then an oversight and a further prescription was only made on 5 March 2020. By this time his mental health had deteriorated so much that he was detained under section 4 of the Mental Health Act. I was unaware that his medication had been stopped and my father had no known health professionals in his care at this point which makes me question why they did not involve me more. Carers are experts through experience and can give valuable insight into their loved ones care. Their knowledge and importance should not be dismissed.

7. I was incredibly close to my father and had been his main carer and advocate for most of my life. My father was first ill when my mother was pregnant with me, so I cared for him jointly as a young carer throughout my life. When they divorced in around 2013, I became his main carer. Prior to being sectioned under the Mental Health Act I would have contact with my father daily. The last time I was able to see or speak with my father was when his mental health deteriorated dramatically on 5th March 2020, a lengthy 26 days prior to his death.

Communication Issues

8. When my father was sectioned on 6th March 2020, all forms of contact and any right to a family life was removed from him, myself and his family. Despite attending the Mental Health Unit to take my father's belongings and attend an initial formulation meeting, mental health staff refused my request to see my father by any means.

9. I made requests to the mental health unit for various forms of contact; seeing him physically, a telephone call, a video call if I provided an appropriate device, viewing CCTV of him to reassure myself of his wellbeing, all of which were denied. I called the mental health ward daily for updates but was not allowed any direct contact. Initially I was told it was due to his mental health presentation as it may upset me, something I disputed as I was with him on 5 March when he presented the same and had seen him previously unwell with similar presentation. Prior to 23rd March 2020, I asked again if I could see my father as I had heard through media channels that lockdown was imminent. Staff at the mental health unit advised that they had not been notified of lockdown, and I could see him once his mental health had stabilised. When lockdown was announced I was advised that I would not be able to see him until visiting was allowed again, which did not happen prior to his death as no alternative arrangements were made to enable contact with my father.

10. The only attempt at contact I was able to make was taking a handwritten card and photographs of family to the mental health unit for my father, although I could not go any further than the reception. It is documented that he hugged the photographs which indicates that despite his severe mental health condition, he still had that knowledge of who we were and wish for family contact. Despite his deterioration, the last thing I recall him saying to me was 'you won't leave me, will you?'. He still recognised and needed me.

11. Being unable to see or communicate with my father during his final days has had a major impact on me and my family. One of the hardest parts for me was being unable to see how he was for myself or provide any input into his care. Staff at the mental health unit did not know my father, so they were unable to make decisions based on his preferences and routine. One example of this was when they mentioned he had some anomalies in his kidney function and were trying to encourage drinking, they asked me what drinks he liked as they did not know. This showed how beneficial my consistent input would have been in advising of my father's norm as well as the importance of family in recovery. Given the obvious benefit of including me in his care, I find myself querying why there was such secrecy and what they were doing to my father.

12. When my father was taken to the general hospital on the same site as the mental health unit on 27th March 2020, communication did not improve. Not only were there issues with the communication I received from both the general hospital and the mental health unit, but there were issues in communication between the two departments.

13. When I got the call to advise of the move, I was told that I may want to go to the hospital to see him but was not provided with any further detail. I rushed to the hospital and was hopeful that I would be able to act as his Independent Mental Health Advocate (IMHA) to support him as he did not have the capacity to effectively communicate. Upon my arrival, I was once again turned away, and it was only then that I was advised my father was being tested for Covid-19.

14. I went to the mental health unit for an explanation and was advised that my father had become physically unwell, his oxygen levels were low, and he was not responsive, causing his transfer to the general hospital. As I was not permitted to see or speak to my father, I was unaware of his decline in physical health, despite asking for regular updates, I was unaware that my father was approaching the end of his life.

15. Whilst in the general hospital, updates were not detailed at all, and I was left in the dark. The day before his death I called to ask how he was and was told that the staff could not update me and likely would not be able to update me if I rang later. The next contact I had was very early the next morning when I was told he passed away.

16. As I was unable to attend to be my father's advocate, I was concerned that there would be no one present with him at the general hospital. I asked who would be with my

father and was advised Mental Health staff would stay with him as he was still under their care and on 2:1 care, this did not happen as the mental health staff left on the evening of the 27th of March 2020. I was caused incredible distress by the thought of my father, who was vulnerable, mentally unstable and lacked capacity due to a relapse of his mental health condition, being left with no support or IMHA for a significant time. It was during this time that decisions around the ceiling of care and DNACPR were made, yet no best interests or mental capacity tests are documented.

17. Lack of communication between the general hospital and the mental health unit led to a misunderstanding of my father's needs, no multidisciplinary meeting took place to discuss his current care or medication which may have helped with the decisions made by the general hospital. Doctors in the general hospital did not understand the extent of his medical history, they blamed his mental state on his Covid-19 infection and placed a DNACPR upon him as he was drowsy despite it being well known that the sedatives he was given for his mental health condition would make him drowsy.

18. I and the mental health staff were not made aware of my father's DNACPR or the ceiling of care until after his death. If I would have had contact with him and the general hospital staff, I could have queried this at the time, I was not given the chance to ask for a second opinion on my father's behalf or discuss the reasons for the decision. I would have suggested a multidisciplinary meeting as I feel such a large decision should have been made jointly rather than by one consultant from the general hospital.

19. Had there been a multidisciplinary meeting with no input from me, I would still have been unsure about the level of detail that could be provided as the staff at the mental health unit did not know my father too well. This would however have been more valuable than no meeting at all as my father's hospital notes state that general hospital staff are not mental health specialists, so insight from mental health staff would have been beneficial. Significant periods of no contact with the mental health unit and myself meant missed opportunity for the general hospital to understand my father, which may have impacted the treatment he received. In the absence of an assessment of his capacity to refuse treatment, there was nothing general hospital staff could do to ensure he took his medication. However, if we had been contacted I or the mental health staff could have encouraged him to take his medication. My father's notes document him to be 'coughing in nurses' faces on purpose with no mask', this is not something he would do when mentally stable, and I think this shows the lack of

knowledge the general hospital staff had of severe mental impairment. I would like to note that I am aware coughing in nurses' faces is not acceptable, particularly with Covid but some understanding of mental health would have been advantageous and multidisciplinary team work to support those with severe mental impairment.

20. I feel that communication issues further affected my father's health both during his time at the mental health unit and the general hospital. My father's mental health notes document that he had signs of acute kidney injury, the notes advise that bladder scans and intravenous infusion would have been beneficial, however physical health refused to admit him and mental health staff stated they did not have the skills or equipment to deal with such physical health conditions. There were issues with administering mental health medication in the general hospital, staff did not do this as they stated they were unable to get them from the pharmacy, despite the building being on the same site as the mental health unit and my father being sectioned. I feel that both issues could have been assisted with proper communication and coordination between both services.

Funeral and mourning rituals

21. Following my father's death, I requested to view his body in the hospital, I was advised he would be taken to the hospital mortuary after an hour, although when I called them, they also did not allow me to see him or say goodbye. I have struggled with the entire period I was unable to see my father, but I have particularly struggled with being unable to see his body. This has led me to question whether it was even him being held in the mortuary as he was taken to the mental health unit from a rehabilitation care home, then to the general hospital. At no point was I allowed to see him, he was simply identified by hospital wristband, which I never saw, how can I be sure it was him?

22. The Covid-19 restrictions massively impacted my father's funeral and my experience of mourning rituals. When my father's care was passed to the undertakers I again asked if I could see his body to say goodbye and reassure myself that it was him, this was denied. I asked if I could have a picture of him so I could see it was him, again, this was denied. I asked if I could order fingerprints, as I had with the same undertaker when my Granny had passed, this was denied. I asked if I could put items in the coffin with my father, this was not allowed. I then asked if my father could be driven over the moor, an area in which he grew up, again, this was not an option. We had no option of a family funeral car and many florists refused to provide funeral flowers. It was not the

send-off my father deserved.

23. The funeral itself was extremely limited, 10 mourners were allowed to attend but were required to be stood outside, socially distanced. We could not comfort each other or celebrate his life how we should have been able to; we couldn't even have a wake afterwards. We went from standing outside socially distanced, watching a closed coffin arrive, not knowing whether it was him inside, to going home. Family who lived further away were not allowed to attend and there was no live stream offered. I was not allowed to see him while he was alive, I could not see him when he was dead, and I was unable to mourn him in the traditional sense.

24. At the time of my father's death, my children were aged 2 and 4, this was their grandfather and their first experience of a funeral. This is not how a funeral should be, stood outside so many metres apart; but this this is now all they know of a funeral. They are forming memories, and this is what they will remember of their grandfather's celebration of life.

25. The time following his funeral felt rather surreal, like an added grief on top of the grief I was already experiencing, it did not feel like my father had a proper send-off. I did not experience the closure that funerals would usually give, and I held a lot of guilt that I could not give him the send-off he deserved. The ongoing guilt of not being with him in his final month of life or after his death is something that I believe will stay with me. The fact he could not be driven over an area he loved was very upsetting, I had to wait until I received his ashes to do this, but it was not the same as it being part of his funeral. I feel like this has affected my grieving process as nothing seemed final following my father's death, it was hard to understand how that was it and he was gone. Returning back home to lockdown was difficult as nothing was as it usually would be, there were condolence cards and messages but face to face human contact that would act as a comfort during the time following death was missing. It made me feel isolated and I know that having people check in on me in person would have helped with this.

Post death administration

26. As my father was detained by the state at the time of his death, a coroner was instructed by the doctor at the general hospital to hold an inquest. This was one of the few exceptions to obtaining an inquest following a death from Covid and was not the

case for a lot of people bereaved to Covid-19. During the inquest however, the coroner did not consider Covid in detail and left a lot of questions unanswered surrounding my father's experience with the virus. Instead, they focussed on the circumstances leading up to my father being sectioned.

27. The aspects relating to Covid that were left out of my father's inquest have left me with a lot of unanswered questions. I had many questions around the care my father received and whilst I have been able to sit with mental health services to ask questions the general response has been 'it was unprecedented times' which does not provide clarity to me as a bereaved family member. Obtaining answers from the general hospital has proven difficult, partly due to my father's death becoming part of a legal process through the inquest. I was advised that any questions should be addressed by the coroner, even though this was not done in relation to Covid. I have been told since by the hospital that as it is so long after the event, staff have left or cannot recall events. Although I acknowledge that I have been able to attend an inquest where others have not, in terms of Covid grief, it has not helped me to move forward due to the number of questions that are still unanswered.

28. As it took three years, seven months for the inquest to take place, a lot of post death administration was delayed. This was difficult because although I was pleased that my father's death would be investigated, it prolonged the process for me and I was left waiting for answers, many of which I still don't have. I feel like my grief was further prolonged as I have had to look back on my father's story in pre inquest documents and inquest proceedings. I feel that I am still awaiting closure as I attempt to tie up all loose ends, some of which may never be finalised.

29. When I was able to carry the post death administration out, I found some of this quite difficult as it involved attending in person which I was not able to do with the risk of contracting Covid myself.

30. There were issues with submitting an interim coroner's death certificate and whether this would be accepted by certain organisations. The interim certificate was provided to be used prior to inquest as the final registrar death certificate is only issued by the registrar following inquest. A bank was over cautious in accepting this stating that a full certificate was needed, this caused complication in an already stressful process.

The Impact of Covid Bereavement

31. Being bereaved by Covid has impacted all aspects of my life greatly. I have experienced severe anxiety in relation to Covid-19 and health in general, for example I have found it hard going out in public, particularly to busy places and have needed to take small steps to gradually re introduce myself. I am still rather cautious in busy places opting for quieter places and times. I also continue to wear masks when attending venues such as medical practices where I may come in to contact with viruses. I have found my pre-existing IBS symptoms have become more prevalent following my father's death.

32. My confidence in health and social care services has been impacted as I now find myself being cautious of professionals, often advising friends and family to query resuscitation status and ask for documentation when they attend hospital. I have gone from being very pro NHS having worked and qualified in healthcare to not trusting the healthcare profession. I feel like this leads health professionals who do not know me or my experience to feel I am a bit overzealous. I do question a lot, but I feel that the lack of candour when losing my father has led to a breakdown in the trust I once had.

33. There is a lack of understanding of the impact of losing a loved one to Covid-19 and comments in relation to decisions made often lack compassion. One statement written by a consultant as part of the inquest causes me a great deal of anxiety and concern, he stated Irrelevant & sensitive Irrelevant & sensitive Irrelevant & sensitive As the daughter of such a patient I find this quote extremely insensitive and read it as though my father was seen not worthy, as though the doctor had already decided he would die and his life was not valued.

34. As a result of my father's death, my children have been left with a lot of anxiety around hospitals and health care as they saw their grandad taken away were not allowed any contact to understand what had happened, then he was dead, at the age of four this is hard to comprehend. My two-year-old just kept telling everyone grandad was in

hospital, finding it hard to understand that he will never come back. In 2020, when my husband, their father, was admitted to hospital with kidney issues which at a later date the GP notified us was in fact Covid, this caused my child a great deal of anxiety. My husband now has Long Covid and has been in hospital for a range of issues since that can be linked to this. The first time he was in hospital following my father's death, my eldest child asked if daddy was going to die like grandad.

35. My children were the people who kept me going through everything, it feels like my concentration moved to them and my own grief still hasn't been fully processed. I feel that my priority was to get through what happened as best I could which meant my own physical and mental health were not my priority.

Bereavement support

36. I and my family received some but very limited bereavement support following the death of my father. We found you must fit into certain criteria to access support and where support was offered it was generally through voluntary sector, offering a limited number of sessions. Where sessions were offered it was with organisations who appeared to have a limited knowledge of bereavement by Covid and the complexities surrounding this.

37. I found my GP very supportive and understanding however they were limited in terms of availability, the support they were able to offer and how this could be offered, for example appointments moved to telephone. It is important for someone bereaved in such circumstances to have healthcare professionals known to them, with whom they have a rapport to talk to and trust.

38. I received support from my Family Support Worker, from a local Mental Health Charity whom I have known for years, they ensured to be available for me whenever I needed support. This was helpful, but again it was not the Covid specific bereavement support that I needed.

39. I received a limited number of sessions with a well-known bereavement charity over telephone with a volunteer. I found that they failed to account for my anxieties around Covid, for example, I mentioned I was isolating to protect myself and family, yet the volunteer councillor said how they couldn't wait for restrictions to be lifted in their area as wanted to go out. This was wholly inappropriate for me and again, I found this

insensitive.

40. Family therapy with another organisation was good but again, limited in the number of sessions allowed. I felt that they were only just starting to 'scratch the surface' when sessions came to an end.

41. Due to my father's inquest certain organisations refused to offer me sessions. I was initially advised that starting it while the inquest was still open may not be the best time, then after the inquest I enquired and was advised that to access the therapy through them I would need a GP referral to secondary mental health services which I would not be likely to get.

42. My eldest child has been left with a lot of anxiety for which the GP and school nurse have been involved, however, finding Covid bereavement support has proven almost impossible. Charities for child bereavement advised that all they could offer was Live Chat, email or helplines to give support and ad hoc advice. My children did not meet the criteria for secondary health care, CAMHS services so the help they have received has been limited and their anxieties persist.

43. I have felt that being bereaved by Covid can be very isolating as professional support available appears very limited. For myself I found the best support to be from professionals I already knew, and close family and friends. However, I also found that certain family and friends disappeared as though they were avoiding the situation around Covid grief, people have become impatient and have stopped contacting me as I navigate a world following my father's death.

Ongoing impact

44. Every day I miss my father, and I am left with a huge number of questions that are unable to be answered. I regularly find myself questioning what happened to him as his post infection review showed that he was infected during his time in the mental health services. I feel that from spending most of his time in his room, on 2:1 care and experiencing safe holds the most likely source of infection was from asymptomatic staff. Staff had no PPE, no testing and rapidly changing guidelines. I question regularly why more was not done in mental health units particularly as staff are required to be within close proximity to patients.

45. I have found it difficult to deal with the public attitude to Covid. Comments like covid is just a cold/flu are hard to listen to. When I wear a mask if I feel it necessary to protect myself in certain places, I am told by strangers that Covid is over, and they hope I do not become too dependent on my mask. I have received more personal comments such as 'if your father died of covid he must have been ill anyway'. This can be mentally draining having to justify myself and my father to people. This is not something that is generally questioned when people die of other conditions.

46. Following the pandemic I often try to stay in quieter places where possible as the thought of somewhere overly crowded feeds my anxiety which is enhanced by my experience, I try to reduce risks to my family and myself where possible. Due to ongoing anxiety around Covid and my wish to continue to isolate to protect myself and my family longer than others did, I was unable to return to my job in a front facing role whereby I would be in contact with up to 3000 customers every shift. I was ultimately sent a P45 in the post with no warning and I have been unable to return to work. Whilst everything else continues in the world, I feel my life as it was stopped, I am not the person I was before the Covid-19 pandemic.

47. Whilst the experience has changed my view on health and social care making me more critical and questioning, one thing I aim to do is make people aware of the inequalities surrounding mental health, particularly in healthcare. I have used my lived experience to inform and improve practices in the future and make sure lessons can be learnt from what happened to my father and that his death can inform future decisions and care for other individuals like him. Following the Mental Health serious incident Review I was asked to assist in creating a system learning event around the wider healthcare system and need for a more integrated and joined up system based on what had happened to my father. This was in the form of videos of myself with senior leaders from general hospitals, primary care and GPs, local authorities and mental health services being invited. I would discuss the care my father received in every organisation, identifying learning and improvements needed in the healthcare system. I also became an Involvement Partner in our local Care Trust; this is a patient or carer who shares their lived experience to shape and improve health services. Providing this witness statement for the Covid Inquiry is also pushing me out of my comfort zone.

48. These are all things that people would not have expected of me, but I must do to ensure my dad is not a lost statistic and that his death informs future practice for mental health service users, who must not be forgotten. People with severe and enduring mental

health conditions are unlikely to speak out due to barriers such as stigma, fear and communication challenges so I felt it is something I must do for those who cannot have a voice themselves.

Recommendations

49. My experience in losing my father and his experience in relation to his mental health is not something I would like anyone else to experience in a future pandemic. There are a number of recommendations I would like to make to assist the Chair in preventing another person from having the same experience as my family.

50. There must be a much more integrated multidisciplinary working system in place with mental and physical health specialists able to provide holistic, appropriate care to individuals with severe mental impairment. There will always be questions in my mind of whether my father would still be here if physical health staff had assessed and treated him while in the mental health unit and if mental health staff and I had been involved in decisions around his care in the general hospital.

51. I feel like those with severe mental impairment were unfairly discriminated against during decision making in the pandemic. People detained under the Mental Health Act are entitled to an Independent Mental Health Advocate to help making decisions about care and treatment, my dad did not have one and decisions were made when he was unable to understand and have input into his care and treatment, this is wrong and is something I think about regularly.

52. There should be integration of physical and mental health care and multidisciplinary teamwork. It is known that those with mental health conditions are also likely to experience physical health symptoms, so such integration is vital.

53. Patients with complex medical needs should not be treated in a disadvantaged way due to being medically complex, there must be a much more robust and integrated system in place to care for these individuals. Being medically complex should not mean they are denied care and treatment, they have as much a right to life as anyone else. Carers and loved ones must be fully informed of care and treatment and be included in all care and treatment plans alongside the whole multidisciplinary team.

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: 08/01/2026