Clostridium Difficile Public Inquiry
Premier Business Centre
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Statement of Purpose

The panel appointed to conduct the Public Inquiry into the outbreak of *Clostridium Difficile* (*C. difficile)* that occurred in hospitals of the Northern Health and Social Services Trust between 16 June 2007 and 31 August 2008 has been given terms of reference in two parts: -

(1) to establish how many deaths occurred in Northern Health and Social Care Trust hospitals during the outbreak, for which *C. difficile* was the underlying cause of death, or was a condition contributing to death; and
(2) to examine and report on the experiences of patients and others who were affected directly by the outbreak, and to make recommendations accordingly.

We intend to fulfil these terms of reference through an inquiry that will allow us to hear the views of the greatest number of people. Our process will be essentially fair, inquisitorial and not adversarial in nature. Our overall objective is to contribute to restoring and increasing the confidence of the communities served by the Trust in the safety, effectiveness and sensitivity of the services provided, especially in the care of frail and vulnerable members of the community.

We see a clear link between the two terms of reference. We intend our review of the number of deaths in which *C.difficile* was either the underlying or contributory cause to provide publicly accessible information on the nature of these infections. Our aims will be to increase understanding of the relative

risk infections pose in hospital care and to challenge unnecessary or exaggerated apprehensions.

Similarly, by listening to patients, relatives and staff affected by the outbreak and drawing on their experiences, we hope to increase understanding of the impacts of hospital acquired infections and point to changes and improvements that can lessen or ameliorate them.

Since its appointment by the Minister for Health, Social Services and Public Safety on 31st March, the panel has met twice. We have reviewed our terms of reference and received reports relevant to our purpose including The Regulation and Quality Improvement Authority (RQIA) review of the outbreak. Our remit precludes us from reopening the issues covered by that review.

Our initial work will be concerned with collecting and reviewing records and documentation concerning this outbreak and similar outbreaks in the UK and internationally. We will commission more detailed and comparative reviews of the mortality ascribed to *C.difficile*. We will explore how best to make ourselves as accessible as possible to those who experienced this outbreak and capture their testimony in a constructive way. We will seek to make recommendations on effective and sensitive care and, where relevant, on enhancing communications with and between patients, relatives, staff, management, the public and the media.

Our website www.cdiffinquiry.org will keep the public informed of the progress of the inquiry.

The success of the Inquiry is clearly dependent on the cooperation of the communities served by the Trust. We hope that as many people as possible will contact us to express their views.