

## **PRESS RELEASE**

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### **C. diff Public Inquiry Report is Published**

The Public Inquiry ordered by the Health Minister Michael McGimpsey into the deaths which resulted from the *Clostridium Difficile* (CDI) infection at hospitals in the Northern Health and Social Care Trust between 16<sup>th</sup> June 2007 and 31<sup>st</sup> August 2008 has completed its work.

The Inquiry, chaired by Dame Deirdre Hine, delivered its report to the Minister on 4<sup>th</sup> March 2011 and set out 12 recommendations based on its conclusions.

Speaking at the publication of her report Dame Deirdre Hine said:

“I wish to express my sincere condolences to the bereaved. I am aware that the process of the Inquiry may have been distressing for those involved and may have resulted in the reopening of memories they would prefer to have lain dormant. I apologise for this.

“This was not an Inquiry into fault, and while we have been rightly critical of the systems of the Trust, we have not lost sight of the fundamental cause of the outbreak which led to this Inquiry – it was *C. difficile* itself, the bacterium which is pictured on the front of our report. We know that *C. difficile* presents a constant challenge for all those who strive to combat its effects and its spread. The patients whom it infected in this outbreak, as in others we have studied, were mainly old, frail, already suffering from other serious medical conditions and had recently taken antibiotic drugs. This organism, and the particularly virulent sub type that was the commonest one that was detected, was the root cause of both the deaths and the distressing experiences during the outbreak. The condition it produced was painful, debilitating and degrading. It resulted in the loss of dignity and tranquillity for some in the last days of their life. It was indeed the real villain of the piece”.

“The overall objective of this Inquiry was to hear from the people who suffered as a result of the outbreak; that is, the patients who contracted the infection, their families

and the people who have lost loved ones. We provided them with the opportunity to have their voices heard so that we could learn from their experiences”.

“I wish to thank the patients, relatives, and staff of the Trust for their cooperation and goodwill in sharing with us their experiences during the outbreak. I know that reliving these experiences was difficult for many of them but we could not have undertaken our task without their help. I am also very grateful to our expert reviewers for their thorough and careful work and to all our expert witnesses.”

The terms of reference for the Inquiry were:

1. to establish how many deaths occurred in Northern Health and Social Care Trust hospitals during the outbreak, for which *Clostridium 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.

The Inquiry was conducted under the terms of the Inquiries Act 2005.

The Inquiry received 112 written statements of evidence from witnesses and 62 of these witnesses were then asked to attend oral hearings to clarify and amplify their written statements. The Panel's findings were drawn from the evidence presented by those directly affected, a review by experts of the medical records of 124 of the patients who died, and took account of the evidence presented by expert witnesses on the themes raised by those directly affected.

Addressing the key findings contained within the report, Dame Deirdre said:

“The Inquiry has accepted the conclusions of the expert reviewers appointed by the Inquiry and finds that the number of deaths that occurred in the Northern Health and Social Care Trust during the outbreak for which CDI was the underlying or a contributory cause was 31. A total of 124 clinical records were examined. CDI was implicated in 31 deaths either as the underlying cause in 15 deaths and a contributory cause in 16 deaths.

“The expert reviewers established that the majority of the patients were older people, very frail and dependent and many were seriously ill with other medical conditions. Even if they had not contacted CDI, only six patients were considered likely to survive beyond twelve months. They found that as many as 3 in 10 of the patients reviewed had already acquired CDI before admission to hospital”

“An expert witness confirmed that a prerequisite to a patient acquiring CDI was that they were being treated with antibiotics as it is the administration of antibiotics which exposes the individual to overgrowth of *C. difficile* in the colon.”

The Panel’s interpretations took into account the experiences of patients, relatives and staff. Commenting on the findings in relation to the experiences of patients and relatives, Dame Deirdre pointed to failures in effective communications:

“*C. difficile* attacked at a time when the Northern Health and Social Care Trust was in a vulnerable state having recently undergone major re-organisation. And this explains, to some extent, why systems and practices in the Trust, in particular those relating to communication, that should have operated to minimise the distressing experiences of the patients who caught the infection, either during their hospital stay or before their admission, were, as demonstrated by the evidence we were given, less than adequate.

“From the evidence, both oral and written, that we received we looked for the reasons why some of those affected became so anxious and distressed. In doing so we identified weaknesses or inadequacies in some of the management systems and services of the Trust that were in operation at the time of the outbreak and we have been critical of them. Without such a critical analysis we could not have arrived at our conclusions and recommendations.”

“We have made 12 recommendations. This is a modest number for such an Inquiry and we have deliberately kept them so in the conviction that they cover the most important areas of concern they and, being limited in number, are more likely to be accepted and implemented by the Trust and the DHSSPS“.

In making our recommendations we acknowledge that much has changed since the end of the outbreak and that many of these systems, for example those of environmental cleaning, have been radically changed and improved. The Trust is

now more mature and aware of the need to maintain effective systems to assure the Board that negative patient experiences are known and tackled. We are convinced that the Board and the staff are now better placed to provide an improved quality of communication and care and that if our recommendations are accepted and implemented the community they serve can have every confidence in the Trust.

“We hope that the process of the Inquiry has removed for the bereaved some uncertainties about the part played by C.difficile infection in the deaths of those who died. It has provided an the opportunity for patients staff and relatives to describe their experiences and the panel has heard expressions of satisfaction from some relatives both that their voices were heard and that they now have a clearer understanding of the disease.

“For the majority of those who have assisted the Inquiry by giving evidence their aim, like ours, has not been to attribute blame but to ensure that, as far as is humanly possible, others do not suffer the same distressing experiences as they or their loved ones have done.

“We expect that our recommendations, if adopted by the DHSSPS and the Trust, will help to achieve that aim. We hope that other trusts both in Northern Ireland and elsewhere in the United Kingdom will also learn from the experiences of this outbreak.

## **Ends**

For further media information, a copy of the report and interview requests please contact Maria McCann at McCann Public Relations on 028 9066 6322 or 07802 934246 email: [maria@mccannpr.com](mailto:maria@mccannpr.com)

## **Note to editors:**

- The Inquiry Panel has provided information on evidence provided to it throughout the oral hearings on its web site [www.cdiffinquiry.org](http://www.cdiffinquiry.org).
- The Inquiry report includes a CD which contains the written evidence of all witnesses to the Inquiry.