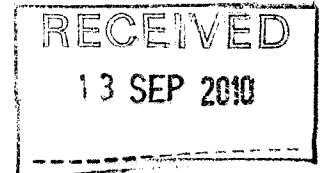


**WITNESS STATEMENT TO THE PUBLIC INQUIRY INTO THE OUTBREAK OF  
CLOSTRIDIUM DIFFICILE IN NORTHERN TRUST HOSPITALS**

WITNESS NAME: DENISE MARSHALL



**STATEMENT BY DENISE MARSHALL**

I Denise Marshall say as follows:

1. My name is Denise Marshall and I live at an address that is known to the Inquiry Team. I am the daughter of Samuel Brown who died at Antrim Area Hospital on 21<sup>st</sup> February 2008 aged 73 years.

**Admission to hospital**

2. My father was admitted to Antrim Area Hospital on 12<sup>th</sup> February 2008. He was examined by a doctor at his home who said he should be admitted to hospital. An ambulance was called and he was taken to the Accident and Emergency Department where he was examined and then transferred to Ward B. My mother went with him in the ambulance.

He was in Ward B for about two days and then transferred to Isolation Ward A where he died on 21<sup>st</sup> February 2008. He was only in hospital for about nine days. The Isolation Ward was a small room with its own toilet facilities.

## **Visits**

3. I visited my father every afternoon and evening with other members of my family. Visiting hours were restricted to I think from 2.30pm until 5pm in the afternoon and from 7pm to 8.30pm in the evening. My mother was always present but you were only allowed a maximum of four people in the isolation room at any one time.

## **Care**

4. As for medical care I do not think my father was ever told what was happening. No doctors examined or spoke to him in my presence.
5. The nursing care was deplorable. On several occasions my father rang the bell so that he could be helped with his toileting but no-one came. The family were having to renew his bottles and food trays were not taken away after meals. On a few occasions a nurse came in and handed him a bottle, pulled the curtains and left.
6. He also had to use a bedpan and sometimes the family had to deal with this themselves. It was disgusting and degrading for my father. The family also had to wash my father and look after his personal hygiene.
7. He had to wear an oxygen mask and so he could not have got to the toilet unaided.
8. Urine bottles and bedpans were not emptied or replaced properly.

It appeared to the family that there were not enough staff on duty.

9. He started to get diarrhoea and was sometimes soiling the bed. We also had to take his pyjamas home on a daily basis for cleaning. We were not told until days later that the hospital had special bags for use in the washing machine. Our washing machine had to be disinfected after every wash.
10. My father was very upset. He was a proud man and did not like what the family was having to do for him. I do not think that he received proper care or attention from the staff. Some staff were good but some were very bad and unhelpful. They seemed to have time to talk to themselves but when the family asked for help they said "yes in a minute" or "I'll get there". This happened on several occasions.

We had very little dealings with the doctors or staff.

11. It should also be noted that my father was on a drip in the isolation room for dehydration and I had to ask and remind staff on several occasions that his water jug should be placed closer to him so that he could reach it.
12. Staffing care was atrocious and we maybe had to ask once, twice and three times before anything was done.
13. I also noticed nurses coming into the room and not adhering to procedures. They were not wearing a mask, apron or even washing their hands. They would for example take his blood pressure and then leave.

I do not think the staff attended to my father's needs on a proper basis and I would consider the attitude of staff as unhelpful.

## **Cleaning**

14. The family did not receive any brochures, pamphlets or any other written documents about C difficile or anything else. The procedures on the Isolation Ward were explained to us by a nurse and the family stuck rigidly to the precautions regarding the wearing of aprons and gloves and the washing of hands. However they were surprised to note that not all of the staff followed the same precautions.
15. We were not impressed by the staff and even when my father moved to the Isolation Ward the staff could not fit his oxygen to the wall and this had to be done by a family member.
16. I only saw Ward B being cleaned on one occasion and although I saw the cleaners cleaning a bed and locker, it was done using a bucket and one cloth. I did not consider this as appropriate cleaning.

I was also appalled to note that there were bloodstains on my father's bed for over 24 hours which meant that the bed linen had not been changed during that time.

17. In relation to the Isolation Unit I could not comment as I never saw it being cleaned although I have already criticised the fact that urine bottles and bedpans were not emptied or changed in a proper fashion and were left sitting around for far too long.
18. I also noticed on one occasion that there was a very large spillage on the floor which was black in colour and it seemed to cover a large section of the floor. The spillage was still there the following day. Various members of the family saw it.

I did not notice any odours or smells in the hospital.

19. I was washing my father every day as I did not think that the staff were doing this properly or on a regular basis. I was only aware of my father getting a shower on one occasion during his time in the hospital.
20. There was also a shortage of disposable aprons and gloves and I remember on one occasion that we could not enter the Isolation Ward until they were replenished. These aprons and gloves were then disposed of in a bin. Although his visitors adhered to the procedures staff did not always do so.
21. I remember a doctor coming into the room with gloves on one day and then taking them off in my presence before he dealt with my father.
22. I also remember one nurse actually sitting on the bed.

There were plenty of gel dispensers in the hospital.

### **Communication**

23. Family did not receive any leaflets, brochures or anything else in writing in relation to C difficile, personal hygiene or anything else. We did not see any notices on the notice board or any notices on the ward door or on the isolation room.
24. My father was informed that he had C difficile while he was on Ward B. My mother and sister in law were present but no proper explanation or advice was given to him. The communication was very matter of fact. There was a complete lack of information, sensitivity or advice. I had to go and speak to the Ward Sister for a proper explanation and she

told me that he must have brought the infection into the hospital himself and that the antibiotics were to blame.

25. No compassion was shown to my father or to the family. My father was very upset and disturbed. He did not really discuss it with us. We all knew that he was sick but we did not think that he could die. He told me not to allow the grandchildren to visit so he must have known that it was serious.
26. No proper explanation, diagnosis or prognosis was given to us by the hospital. I was appalled that I only heard after my father's death that a doctor had informed my brother that "your father only has a couple of days left in him". If I had thought that there was a possibility that he might die then I would have taken time off work and been with him full time. I would not have left him on his own.

#### **Food**

27. My father was on a drip. He was dehydrated, weak and even had difficulty lifting a water jug. I am not sure what he was eating but I think he was losing weight. I can make no comment regarding the food.

#### **Death Certificate**

28. On 21<sup>st</sup> February 2008 my mother, father's brother and his wife were visiting my father when they found him slumped on the bed. They immediately knew that something was wrong as his false teeth had fallen out and his oxygen mask was lying at his feet.

29. They tried to revive him but there were no obvious signs of life. My father's brother went to the nurses' station where there were three or four nurses standing about talking. He approached the desk and said to them that he needed someone to come down to the room immediately at which stage they just looked up at him, nobody answered on the first attempt and so he said it again and one of the nurses said they would be with him shortly.
30. It took another two or three minutes before a nurse entered the room. She approached my father and then asked my mother if she wanted him resuscitated as he had passed away.
31. The nurse then indicated that the time of death was 7 o'clock to which my aunt disagreed as he had already passed away when they had entered the room which was at 6.45 pm.
32. The family are appalled and still distraught by their experience at Antrim Area Hospital. It is disgraceful that staff were not aware that my father had passed away and allowed my mother and other members of the family to enter the room and find him for themselves. We found our experience of Antrim Area Hospital absolutely horrendous. There was no care or compassion whatsoever and the family are appalled by their treatment.
33. It was a good hour before a doctor was found who took my mother and my brother into a side room to deal with the Death Certificate. It was then that the doctor said to my brother that "my father only had a couple of days left in him". I have been very distressed and upset by this comment as if the doctors had known this then why were we not informed at an earlier date.

34. The Death Certificate was put into an envelope which we took home but did not open. The following morning I was phoned by the hospital and a Doctor (whose identity I have made known to the Inquiry) asked me to check the Death Certificate basically because the junior doctor who had signed it was not up to date with procedures for Death Certificates dealing with C diff patients. The Doctor then asked if my mother and I would please come back to the hospital at which point I informed the doctor that my mother was not in any state to come back and so I informed her that my brother and I would do so.
  
35. When we returned to the hospital, the initial doctor who had pronounced my father as dead was still on duty. We were however taken into a room at the back of the nurses' station by the doctor who had phoned me who basically started to talk to us about the Death Certificate and what was written on it. During this conversation she had to leave the room to take a phone call and when she came back in I was extremely agitated and upset as I could not understand why someone would leave a room to take a phone call when they were dealing with such a sensitive matter.
  
36. Just as that doctor was talking to us again the door opened and another lady came in. She did not introduce herself and I had to ask her who she was as I had never seen or met her before.
  
37. The outcome of this meeting was that my father's Death Certificate was changed to include C difficile and a new Death Certificate was completed and given to us.
  
38. I have to say that I was extremely upset and annoyed by the completely indifferent and insensitive attitude that the doctors and staff

showed to us at Antrim Area Hospital. They were completely insensitive to our feelings.

We left the hospital in disgust and have not been back since. We have not had any further communication from the hospital.

### **Conclusion**

39. The family have had no contact whether written or verbal from the hospital since my fathers' death nor have they received any apology.

His overall care was horrendous, absolutely horrendous. I mean, there was just no communication, no care, no cleanliness nothing. It was atrocious in every way.

I confirm that the contents of this statement are true and correct to the best of my knowledge and belief.

Dated this 7<sup>th</sup> day of September 2010

Signed 

Denise Marshall