

Witness Statement to Clostridium difficile (Cdiff) Public Inquiry provided by -

Dr Michael Devine, Consultant in Communicable Disease Control, Public Health Agency, County Hall, 182 Galgorm Road, Ballymena, N. Ireland BT42 1QB

When the Clostridium difficile outbreak at the Northern Trust was declared on 7th January 2008, I was Consultant in Communicable Disease Control at the Northern Health and Social Services Board (NHSSB), County Hall, 182 Galgorm Road, Ballymena, N. Ireland BT42 1QB. The Public Health function of the NHSSB was incorporated into the Public Health Agency from 1 April 2009 as part of the Review of Public Administration.

I have outlined below an account of my experience during the Clostridium difficile outbreak in relation to the Public Inquiry's Term of Reference 2, as requested in the letter which I received from the Inquiry, dated 25 March 2010. I have first addressed the four points highlighted in that letter. My responses to the themes identified by the Inquiry in Annex A are detailed under the specific headings outlined by the Inquiry.

Accessing accurate data on deaths related to clostridium difficile

I was not involved in the diagnosis of cases of Clostridium difficile or determining the cause of death of patients who had died. I received regular information about the number of new cases (based on positive toxin tests) and the number of deaths (based on death certification) in daily updates from the Trust which were circulated by email.

Stress and uncertainty

Throughout the outbreak, I was very conscious of the impact of the outbreak in relation to associated morbidity and mortality among patients affected. The scale of the outbreak in terms of the number of patients affected and the

duration also contributed to the sense of gravity of the situation we were dealing with.

Significance of declaration of outbreak

I was first informed that the Trust was considering declaring an outbreak of *Clostridium difficile* on 7th January 2008. I immediately advised the Director of Public Health of the situation and was a member of the Outbreak Control Team from the meeting of the Outbreak Control Team on 14 January 2008. Following the Trust's declaration of an outbreak on 7 January 2008, there were regular Outbreak Control Team meetings where measures to control the outbreak were agreed and implementation monitored. The Outbreak Control Team met on 43 occasions during the course of the outbreak. In addition, the Epidemiology subgroup of the Outbreak Control Team met on 16 occasions.

Views on relationship between Northern Health and Social Services Board and the Trust

By the time of the outbreak, I had worked closely with relevant colleagues in the Trust for eight years and this close working relationship continued throughout the outbreak. I was a member of the Trust's Outbreak Control Team and chaired the Epidemiology subgroup at the request of the Trust's Chief Executive.

PERSONAL EXPERIENCE

My experience of working with the Northern Trust during the very difficult circumstances of the *Clostridium difficile* outbreak has been a unique experience. It was clear from the outset that we were dealing with a very serious situation because of the large number of patients affected with high associated mortality. The prolonged nature of the outbreak requiring a sustained response over several months added to the difficulty of the experience.

While I was not directly involved in caring for patients or implementing the control measures, I had through the Outbreak Control Team a sense of the gravity of the situation and the importance of getting the outbreak under control. My professional relationship with the Trust was very good.

ORGANISATION & MANAGEMENT

Workload and resources

The *Clostridium difficile* outbreak resulted in a significant increase in my work load. I was a member of the Trust's outbreak control team which met weekly initially and subsequently met regularly throughout the outbreak. I also chaired an Epidemiology subgroup which reviewed the epidemiology of the outbreak and produced the Epidemiology subgroup reports. I was involved on a daily basis with issues related to the outbreak until the outbreak was declared over at the end of August 2008 and subsequently producing the Epidemiological Subgroup Report.

Systems

As I was not an employee of the Northern Trust, I was not working through the Trust's management systems. My involvement in the outbreak was through discussions at the Trust's Outbreak Control Team.

Priorities

Supporting the Trust to control the *Clostridium difficile* outbreak was a priority throughout the outbreak.

Responsibility and accountability

I was involved in the outbreak in my position as Consultant in Communicable Disease Control (CCDC) at the Northern Health and Social Services Board (NHSSB). I was accountable to the Director of Public Health (DPH) at the

NHSSB and kept the DPH fully informed of developments after meetings of the Outbreak Control Team. I also chaired an Epidemiological subgroup of the Trust's Outbreak Control Team to provide an epidemiological perspective to the OCT and produce the epidemiological reports.

COMMUNICATION: to include both written and oral

To staff from management

I was not directly involved in the internal communication within the Northern Trust but would have seen some of the documentation incorporating communication from Trust management to staff at the regular outbreak control Team meetings

To management from staff

I was not involved in internal communication from staff to Trust Management.

To patients / relatives

I was not directly involved in providing information to patients or relatives.

Guidance / protocols from Control of Infection team

I had access to the guidance and protocols produced by the Trust's Infection Control Team when these documents were being reviewed at the Outbreak Control Team meetings. I was not directly involved in producing or using the guidance.

From microbiology

I received updates on the number of Clostridium difficile cases which was issued daily by the Laboratory at Antrim Hospital. I also had regular updates on infection control issues through the Outbreak Control Team Meetings.

Access to relevant meetings

I had access to all meetings of the Trust's Outbreak Control Team. I found the Outbreak Control meetings to be open and colleagues in the Trust receptive to proposals to control the outbreak. I chaired the meetings of the Epidemiology subgroup which produced the epidemiology reports.

Media handling by Trust

While most of the media issues were managed by the Trust, I responded to several media enquiries received by the Northern Health and Social Services Board. These interviews principally related to provision of information to the public about Clostridium difficile.

SUPPORT

Management (both top and line management)

I received support from the Director of Public Health and Chief Executive of the Northern Health and Social Services Board throughout the outbreak. While I was not part of the management structure of the Trust, I found the management arrangement through the Outbreak Control Team to be professional, constructive and urgently intent on controlling the outbreak.

Public/visitors

I did not have direct contact with the public or visitors at the Hospitals during the course of the outbreak.

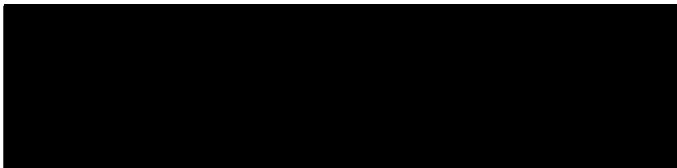
Morale of staff

I did not have contact with front-line Trust staff during the outbreak. I was aware from discussions at the Outbreak Control Team of the pressures being experienced by those providing direct patient care.

Stress

Throughout the outbreak, I was very conscious of the impact of the outbreak in relation to associated morbidity and mortality among patients affected. The scale of the outbreak in terms of the number of patients affected and the duration also contributed to the sense of gravity of the situation we were dealing with.

I confirm that the contents of the above statement are true.

A large black rectangular box redacting the signature of Dr Michael Devine.

16th April 2009

Dr Michael Devine

Consultant Communicable Disease Control

Date