

STATEMENT OF DR P KEARNEY

1. I am a Consultant Medical Microbiologist employed by the Northern Health and Social Care Trust, based at Antrim Area Hospital.
2. I graduated from Queen's University Belfast with a BSc in Microbiology in 1969 and an MSc in Microbiology University College Dublin, National University of Ireland (UCD, NUI) in 1971. On completion of my MSc, I worked in a research post in the Department of Medicine, UCD, NUI funded by a World Health Organisation grant for one year. Following which I studied medicine in UCD, NUI and was conferred with the degree MB BCh BAO in 1977. After completing one year as a Junior House Officer and one year as a Senior House Officer, I started specialty training in Medical Microbiology. I obtained MRCPATH in 1984 and became a Consultant Microbiologist in the Northern Health and Social Services Board in 1985. I have not changed post since then, although the organisation of Hospitals within the Northern Board Area has changed over the years, so that my current employer is the Northern Health and Social Care Trust. I am also the Infection Prevention and Control Lead within the Northern Health and Social Care Trust.
3. I am making this statement in response to a request by the Public Inquiry into the Outbreak of *Clostridium difficile* in Northern Trust Hospitals. The statement has been requested in response to the second term of reference of the Inquiry namely:

To examine and report on the experiences of patients and others who were affected directly by the outbreak, and to make recommendations accordingly.

4. The Inquiry's request for a statement referred to themes which were set out in an annex to the request for a statement, along with certain themes which were highlighted within the body of the request for a statement. This statement has been prepared, as much as possible to address those specific themes, taking into account the Inquiry's terms of reference and the fact that some of the issues have already been extensively addressed in the RQIA report.

ORGANISATION AND MANAGEMENT

Workload and Resources

5. Prior to the Outbreak there were two Consultant Microbiologists (myself and Dr Davies), and one Staff Grade Microbiologist (Dr El-Shibly) employed by the Northern Health and Social Care Trust. Given the size of the local population relative to the clinical and laboratory service provided, it was recognised that a third Consultant was required to meet the demands of the service. The absence of a third Consultant led to a very heavy workload on the Consultant Microbiologists within the Trust. Aside from duties during

normal working hours (and the volume of work that had to be done at home after work), the Consultants also had to provide an on-call service which was organised between us on a 1:2 basis (although if either of us was on leave, it would be 1:1).

6. The workload shared between Dr Davies and I increased dramatically during the outbreak, as clinicians required much more frequent support and advice as they dealt with patients infected with *Clostridium difficile*. In addition to the input required in dealing with individual cases, the workload also increased due to the need to initiate/review/update policies and guidance to respond to the outbreak.
7. Dr Davies went off work on sick leave in April 2008, and was replaced by two locum Consultant Microbiologists who started in May and June 2008 respectively. The Department of Health also provided assistance by assigning a Specialist Registrar in Microbiology for a four week period to the Trust in March 2008 by way of secondment. The availability of extra clinical staff significantly boosted the resources of the Microbiology department and resulted in the workload becoming more manageable.

Systems

8. Initially, infection surveillance tables were prepared which listed the numbers of new cases of *Clostridium Difficile*. Unfortunately we did not have the necessary computer skills to present the data in graphical form, which did make it quite difficult to identify trends developing across the hospitals within the Trust. In January 2008 a Medical A&E consultant colleague suggested that the data could be presented in graphical format in pivot tables, and we sought advice on how to use the data to prepare the pivot tables. These permitted us to present the data in a way that was much easier to follow trends within the Trust.

Priorities/Priority given to Infection Control pre and post Outbreak

9. Infection control was a priority within the Trust, but as with all NHS organisations, there were other priorities too and hence there were competing demands on a finite budget. For example, in 2005, we submitted a business plan for Ward A1 to be made available for isolation of patients, but other departments within the hospital also had need for the Ward, and ultimately it ended up being a ward for Stroke Therapy and Chemotherapy patients (until it was designated an isolation ward during the outbreak).
10. The Trust had in place Infection Control governance arrangements which were in keeping with regional guidance.
11. The United Hospital Trust's Annual Infection Control Plan in January 2007 identified the objective of developing an organisational culture where responsibility for infection control was everyone's business. It would be fair to say that this was a 'work in progress' at the time of the outbreak, and, at

times, ownership of infection prevention and control was seen as an IPC Team problem, rather than a Clinical Leadership issue being managed by the clinical teams with expert advice from the IPC team.

COMMUNICATION

12. The Infection Control and Environmental Hygiene Committee (of the United Hospital Trust) discussed the Stoke Mandeville report, to consider the implications for the Trust, on a number of occasions. There was a plan to set up a working group to formulate recommendations for the United Hospital Trust but it never came into being due to the Trust re-organisation in April 2007.
13. Before it was known that Ribotype 027 was present in the Northern Trust, I raised concerns about the rising numbers of new *Clostridium difficile* infections in a meeting of the Infection Prevention and Control Committee on 31st July 2007. In July 2007 I prepared specific guidance to assist with diagnosis and management of *Clostridium difficile* infection in individual patients, which were issued on 9th August 2007.
14. The Northern Trust's Annual infection Reduction Plan 2007- 2008 contained a target for the reduction of *Clostridium difficile* infection rate and the essential elements of a *Clostridium difficile* reduction plan. This I understand was relayed to the Senior Management Team by the Medical Director in the August Governance Board meeting.
15. In September/October 2007 I was working on a more focused *Clostridium difficile* infection reduction plan. The first draft was submitted to the Medical Director in late October 2007, however by this time we were aware of the PCR Ribotype 027 and the title was amended to reflect this, to "Trust Action Plan in response to identification of *Clostridium difficile* PCR Ribotype 027". This plan was subsequently amended in November and December 2007 with the title reverting to "Trust action plan to reduce *Clostridium difficile* associated diarrhoea (CDAD)" and this was co-ordinated by the Medical Director.
16. On 11th October 2007 I advised the Medicine and Governance Directorate Management Team Meeting that 3 cases involving Ribotype 027 had been identified and that it was a more serious form of *Clostridium difficile* infection.
17. On 4th December 2007 the Senior Management Team were requested to implement the "Trust action plan to reduce *Clostridium difficile* associated diarrhoea (CDAD)" which retained the essential elements for the reduction of *Clostridium Difficile* infection previously outlined in the Infection Reduction Plan 2007- 2008 and the October 2007 "Trust Action Plan in response to identification of *Clostridium difficile* PCR Ribotype 027". These plans formed the basis of the Outbreak Control plan as they reflected optimal infection control practice.

18. On 13th December 2007, at a Clostridium Difficile Associated Diarrhoea (CDAD) Review group meeting, I advocated the use of Ward A1 as an isolation ward to bring the rising numbers of *Clostridium Difficile* infected cases under control.
19. During the Outbreak, the Outbreak Control Team was set up which met on a weekly basis which provided a forum for communication of issues which needed to be addressed in relation to the outbreak.

SUPPORT

20. During the Outbreak, despite the pressure and stress that everyone was under, I felt the Microbiologists had full cooperation from the Pharmacy Department, the Microbiology and Infection Control department and associated administrative staff.
21. The workload for the Microbiology department became more manageable when the two locums were hired.

VALUING/RECOGNITION OF ICT

22. On the 17th December 2008 the chief executive sent a letter to all members of the Outbreak Control Team acknowledging the commitment of staff in managing the outbreak. I received the letter and copied it to laboratory staff, who were under my professional management. At this time the Infection Control Nurses were managed by the Director of Nursing.

SIGNED



DATED

23.6.2010.