

Witness Statement Ref No

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

WITNESS NAME: MR GWYN HUGHES

STATEMENT

I Gwyn Hughes, say as follows:

1. My name is Gwyn Hughes and I live at an address which is known to the Inquiry Team. I am a retired Bank Manager. I am also the son of Mrs Evelyn Henry who died on 14th January 2008 at Antrim Area Hospital.

Admission to Hospital

2. My mother was healthy until she was about 90 years of age.
3. Then in 2007 she started to have health problems. She was originally receiving home care but then in or about July 2007 she was admitted to Antrim Area Hospital for one day with a urinary infection.
4. She was put on antibiotics and shortly after she returned home she developed diarrhoea. She began to get weaker and she had to be put on a Zimmer and eventually we contacted Social Services and Social Workers came in to assist her during the day.
5. She was readmitted to Antrim Area Hospital in or about August and given more antibiotics.

6. She was then sent to "The Gables" nursing home in Antrim for a while but had to be readmitted to Antrim Area Hospital in or about October because her condition was deteriorating.
7. Her condition improved and she was again sent back to "The Gables". However in or about November 2007 she was readmitted to Antrim Area Hospital for approximately one month.
8. At Christmas time her condition improved and she was then sent to Lakeside nursing home in Crumlin where she was put into an isolation room. However the diarrhoea continued and her condition worsened and she was returned to Antrim Area Hospital where she died on 14th January 2008.
9. I cannot be sure of the exact dates but I think that she was transferred from the nursing homes to Antrim Area Hospital on about five occasions over a six month period from July 2007 up until January 2008.

Ward

10. I think that she was in at least three different wards at Antrim Area Hospital. I cannot remember their names or give any specific details but this information could be obtained from her hospital records.

C difficile

11. I am not precisely sure when I was told she had C difficile. It was probably only two or three weeks before she died. I was told by a nurse at Antrim Area Hospital but she did not elaborate or give me any further details or information about it.

Visits

12. I personally visited three or four times per week. She also had regular visits from my brother and other members of the family. Personal friends also visited her.

Care

13. The medical and nursing care at Antrim Area Hospital was "first class". Everything was done properly and promptly and I could not fault her care in any way (except that in hindsight I wonder if she should not have been given the antibiotics).
14. In particular the bed sheets and linen might have been changed three or four times a day as my mother was soiling the bed.
15. Her pyjamas were changed and washed by the hospital as the family did not have to take them home for cleaning.
16. My mother could not get out to the bathroom and so she had to have a bed bath. She was always clean and tidy with her hair properly brushed. The staff took good care of her.

Isolation ward

17. She was not put into a separate isolation ward until about October 2007. She was only in the isolation room on her last two visits to Antrim Area Hospital.

18. She was extremely upset and embarrassed by her condition but she was always happy with the way she was treated and cared for by the staff.

Cleanliness

19. The wards were always clean and tidy and although I did not see them being cleaned, I do not have any complaint regarding the cleanliness of the wards.
20. Any spillages were mopped up and my mother's bed was changed two or three times a day because she was soiling the bed. The linens were taken off and washed.
21. She had to use a bedpan and this was always emptied and not left lying around.
22. I never noticed any smell or odour at any time in the hospital.
23. There were plenty of gel dispensers and myself and other members of the family always used them.
24. I do not know if there was any protective clothing. There might have been some gloves but we were never given any advice or instruction in relation to their use.
25. No advice was ever given to me or my family in relation to personal hygiene or what precautions we should take.
26. When my mother was in Crumlin nursing home I think that they supplied aprons and gloves but we did not receive any instructions to wear them.

Communication

27. I did not receive any leaflets, brochures or any other written documents advising of the effects of C difficile or anything else. Nor did I see any notices on the notice board or in any of the wards that I entered.
28. In fact I had never heard of the word C difficile until about two or three weeks before my mother died when a nurse informed us that she had this infection.
29. No further explanation was given. I never received any information about what precautions we should take or what the prognosis was for my mother.
30. We were not told to wash our hands when entering or leaving the hospital nor were we given or told to wear any protective clothes.
31. The family were never given any explanation regarding the infection by any doctor or nurse or other member of the hospital.
32. My knowledge of medical infections is very limited.
33. I now realise that it is a virulent disease which should not be treated so lightly. Patients, visitors and staff should be told to wash their hands thoroughly and watch their personal hygiene. This instruction should have been given to everyone entering or working in the hospital.
34. On reflection on what I have heard after my mother died it was very odd that such a virulent disease which was a killer really to old people especially when they had other illnesses, should have been maybe treated so lightly in that there should have been a firmer discipline on cleanliness

of hands and clothes and visitation to the ward if the bug was so transferrable.

Death Certificate

35. The Death Certificate was written shortly after my mother died and the first reason given for her death was "diarrhoea". I was surprised by this as I did not consider this to be a cause of death and I thought that some other more specific cause should have been recorded. C difficile was not mentioned as a cause of death.

Food

36. My mother could not eat or drink very much during her time in hospital. I have no comment to make regarding the food.

Quality of care

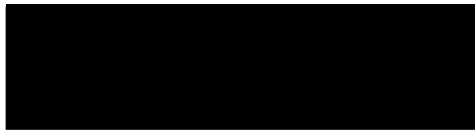
37. Her quality of care was excellent and on reflection my only complaint would be that patients and visitors should be given more information regarding a patient's condition and if they have C difficile then visitors must be informed of what precautions to take as the infection is so easily spread and transferrable from one person to another.
38. It was only on reflection, after I found out or it was made general knowledge that this was a very virulent illness, that I considered there should have been more discipline in telling people to be very careful with their cleanliness owing to the easy transmission of the bug.

Belfast Telegraph article

39. I am attaching a copy of an article marked GH1 that appeared in the Belfast Telegraph on 20th January 2008 which was only about two weeks after my mother died. The article discusses the ways of cutting out the superbug risk when washing clothes. I just wish I had been informed of the risks at a much earlier date.

I declare that this statement is true to the best of my knowledge and belief.

Signed: ..



Dated: 7th August 2010

Superbug risk 'cut out in wash'

BY CLAIRE ROGAN
HEALTH CORRESPONDENT

A SOUTH Belfast elderly care home claims to have significantly stopped the risk of superbug spread between residents after taking part in trials involving a revolutionary new laundry system.

Management at the Haypark Residential Home, close to the Ormeau Road, say they are confident that the new laundry system which recreates a 'thunderstorm effect' has played a major role in stopping the spread of bugs and infections.

The 30-bed home is one of 14 across the Belfast area which have been using the new system which "injects ozone into wash cycles to disinfect contaminated laundry".

Public concern over the spread of superbugs such as Clostridium Difficile and MRSA was heightened this week after an outbreak of C.difficile in the Northern Trust area that contributed to the deaths of 16 patients.

A more virulent form the strain, known as ribotype 027,

Belfast care home claims new laundry system a success

was identified in those patients. It is particularly dangerous for older people.

Most of those affected generally by C.difficile are elderly patients with serious underlying illnesses. Therefore, most infections tend to occur in hospital and nursing homes.

Haypark house manager, Jennifer McClean, said one of the ways in which bacteria can spread is through soiled sheets and clothing.

The home has targeted the laundry as a major carrier of bacteria and invested in the wash system that injects 'ozone' into wash cycles to disinfect contaminated laundry.

She said ozone is a powerful natural disinfectant, 5,200 times faster acting than chlorine

bleach, and occurs naturally during thunderstorms when lightning charges the air with oxygen.

"We are well aware that infection can be spread on soiled sheets and clothing and, in common with other health and social care facilities, have to deal with the so-called superbugs, MRSA and C.Difficile," she said.

"Older people are particularly vulnerable and the new laundry system gives us considerable peace of mind. We are confident that the system is playing a major role in the prevention of cross contamination at the home."

The system, known as Otex, differs from the conventional high temperature thermal disinfection wash processes used in hospitals in Northern Ireland in

that it uses mostly cold water.

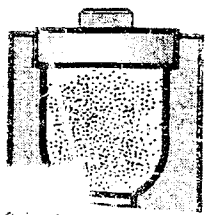
The system's manufacturer JLA said tests were carried out in laboratory-controlled conditions by microbiologists from the widely-known Microsearch Laboratories.

"Comparative tests were carried out on laundry contaminated with a strain of MRSA. One test was with a commonly used 40 degree wash programme and the other was with an Otex cycle. MRSA was still very much in evidence after the 40 degree cycle - but after the Otex cycle, there was no viable trace of the bug," it said.

"When water containing Clostridium Difficile and processed by the Otex system underwent an EU Suspension test, it was found to have no viable trace of spores after only two-and-a-half minutes."

The senior microbiologist who oversaw the testing, RD O'Connor, of Microsearch Laboratories, said: "The tests we carried out proved conclusively that thermal disinfection is ineffective against Clostridium Difficile, while washing with ozone is effective."

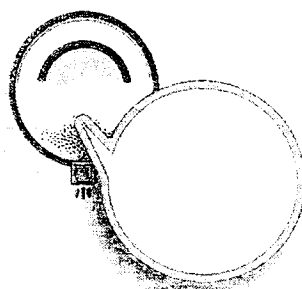
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PATENTED INTERNAL CONTINUOUS OZONATION



KILLS BACTERIA, VIRUSES, SUPERBUGS



FIBRES ARE OPENED - BETTER CLEANING, FASTER DRYING



RESULT - CLEAN, FRESH COMPLETELY DISINFECTED LAUNDRY