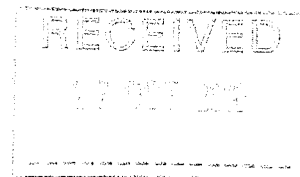
Witness Statement Reference No.________

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

WITNESS NAMES: SAMANTHA McKAY AND NICHOLA McKAY

STATEMENT OF EVIDENCE



We, Samantha McKay and Nichola McKay, say as follows:

1. Our names are Samantha McKay and Nichola McKay and we live at the addresses which are known to the Inquiry Team.

2. We are both granddaughters of Mrs Mary Jane McKay who died at Antrim Area Hospital on 2nd September 2007.

3. Samantha McKay is a full time student and Nichola McKay works for Queen's University in the Legal Department. We have requested that we be allowed to make a joint statement.

Pre-existing medical history

4. Our grandmother had an eye condition and was partially sighted but otherwise in general terms she was quite fit and healthy. She was able to look after herself, do her own banking and look after her own affairs. She also did her own housework, cleaning, shopping and cooking. Mentally and physically she was in good condition.

5. When she died on 2nd September 2007 she was 79 years of age.

6. She was admitted to Antrim Area Hospital on three occasions. As well as that there may have been a couple of visits to the Accident and Emergency

Department but we would need to see the medical records to be completely certain of the exact dates and times.

Family

7. Our grandmother had one son Samuel Taylor McKay who is our father and he lived alone two doors away from our grandmother's home. Our mother and father had three daughters namely Samantha, Nichola and Pauline. We all called with our grandmother and were in and out of each other's houses on a regular basis.

First admission to Antrim Area Hospital

8. On her first admission to Antrim Area Hospital they thought that she may have had a UTI and possibly a stomach ulcer. It was only after they had done a heart trace that they discovered that she had suffered a heart attack at some point in her recent past and that she also had a leaking valve. She was suffering from chest and abdominal pain.

9. We believe that the first admission would have been in or around March 2007. She was taken by the family to the Accident and Emergency Department where she was examined and then admitted to one of the B Wards, then the Coronary Care Unit and finally into the Cardiac Ward. She would have been in hospital for approximately five weeks on that occasion and for four of those weeks she would have been in the Cardiac Ward.

Ward

10. The ward was broken down into three or four bays with six beds in each bay. There were also side rooms but she was in a six bedded bay. The toilets were in the corridor outside the bay area near to the Nurses' station, not in a general corridor. She was able to use the toilet with the assistance of the nurses.

Symptoms

11. We are not sure whether she had any diarrhoea at this time or not but after she returned home she did exhibit symptoms of diarrhoea. She was home for about four weeks during which she complained of loss of power in her legs. She had difficulty mobilising and seemed quite depressed and lethargic.

Second admission to Antrim Area Hospital

12. Her second admission to Antrim Area Hospital would have been in or about May 2007. We believe she was admitted because she was run down, showing signs of heart failure, weakness in her legs and diarrhoea. On this occasion she was admitted to Wards B1 and B2. She was in hospital for approximately two weeks in total. Our father died on 5th May 2007 and he was buried on 11th May 2007 and our grandmother was at the funeral. She could not have been admitted to Antrim Area Hospital for the second time until after that date.

Wards B1 and B2

13. Wards B1 and B2 are broken into three or four bays each with six beds and once again the toilet was in the corridor.

Symptoms

14. She was dehydrated and on a drip. She was getting weaker and had difficulty walking prior to her release a Social Worker disregarded our grandmother's opinion and harassed her into trying to walk and mobilise herself. She could not walk any distance but tried. After about two weeks she was sent home again.

Third Admission to Antrim Area Hospital

15. The third admission would have been in or about June 2007. She was admitted full owing a review appointment with Doctor Troughton. She was also suffering from diarrhoea and was not eating well. She was again taken by car to hospital and admitted to the Cardiac Ward where she stayed for about ten weeks until she died on 2nd September 2007.

Ward

16. She was initially in a six bedded bay but was later on moved to an isolation room.

Symptoms

17. She was very low spirited, demoralised and lacking enthusiasm. She would/could not eat or drink very much and was getting weaker. She had lack of mobility and had to be helped on and off the commode. She had difficulty getting out of bed and needed help with her own personal hygiene and care. She also had a further heart attack during this period.

Visits

18. The family visited every day when she was in hospital.

Next of kin

19. During her first admission our father was her next of kin but when it became practically impossible for him to continue, Nichola took over but after the second or third admission because of work commitments the role was then passed to Samantha.

C difficile

20. We were never given any information by the hospital about C difficile. Anything we know about it has been picked up from outside sources. We do not have extensive knowledge of the infection.

21. We were never given any pamphlets or leaflets by the hospital. Nor did we see any notices or other information on the notice board or anywhere else.

22. There was no communication from any of the staff in the hospital about C difficile.

23. Samantha suspected that something was wrong with our grandmother at the time but Nicola was completely unaware that our grandmother had C difficile until the family received the letter from the Inquiry Team in 2009, which was some two years after our grandmother had died.

24. We did not know until we received this letter from the Inquiry Team that our grandmother had proved positive for C difficile when she was in hospital. We then requested the date that she proved positive and have been informed that it was 31st July 2007.

25. We did not receive any information or advice from the hospital regarding cleanliness, hygiene, laundry, washing of hands or anything else.

Care

26. The level of care in the Coronary Care Unit was very good but when our grandmother was moved from there into the B Ward we believe that there was a lack of interest from the staff. We felt that they were disinterested and dismissive of our grandmother in that she would tell them that she felt unwell or unable to walk and they would tell her that in their opinion she was fine. We do not believe that she was being listened to. We felt that the staff were less attentive and that they wanted her removed from the ward.

27. The staff were telling us that there was nothing wrong with her but she was complaining to us of symptoms of diarrhoea and weakness in her limbs. The Social Worker who released her behaved in a patronising and condescending way towards her. She was telling my grandmother to get up and walk when my grandmother was saying that it was impossible for her to do so.

28. We thought that the care in the Cardiac and Coronary Care Unit was very good. Dr Troughton was in charge and we thought that he was a fabulous doctor. He was compassionate, communicative and professional but also very personable. He kept us fully informed of our grandmother's condition. However, in hindsight we were not advised of the C difficile outbreak and the required hygiene standards.

29. Dr Troughton was unaware that she had been admitted on the second occasion to Ward B and following a conversation with Doctor Troughton we believe he would have liked to have been made aware that she had been readmitted.

<u>Cleanliness</u>

30. We do not recall seeing cleaning being done except on a Saturday in Dr Troughton's ward but we have no complaint regarding the cleanliness of the wards or toilets. This is not saying that it did not take place as we are not aware of what happened outside visiting hours.

<u>Laundry</u>

31. Our grandmother's dirty or soiled clothes were sometimes put back into her bedside locker along with her clean clothes. We were also not given any advice regarding the washing of her clothes. We feel that there was a lack of communication in relation to cross-contamination.

32. We first noticed the soiling of her clothes on her second admission to hospital. Nichola at this time was responsible for the laundry and is very concerned about the lack of information given by the hospital regarding our grandmother's condition and the washing of the clothes as she developed shingles round about this time and if she had known that the clothes were contaminated or infected then she would certainly not have washed them along with her own clothes.

33. Sometimes the laundry was left in a plastic bag or in one of the laundry bags and sometimes it was put it into our grandmother's overnight bag and taken home for washing.

34. But the point is that if the hospital knew that she had proved positive for C difficile on 31st July 2007 then why was the family not informed of the situation and advised regarding our own personal hygiene and what precautions we should take in relation to the laundry.

Precautions

35. Once our grandmother was in the isolation room we saw some of the staff wearing gloves and aprons but not on every occasion but we do remember them wearing them in the side room on her third admission. We were not advised that there were gloves or aprons for visitors' use.

36. There were gel dispensers at the foot of the beds, beside the sinks and at the doorways. We used the gel dispensers but we could not say that everyone did so. We were also not told to use them or given any advice regarding their use.

37. There were not enough chairs to sit on and we noticed some visitors sitting on the beds. Chairs were frequently moved by visitors within the bays and into the isolation room and we are concerned regarding the cross-contamination implications of this both within and outside the hospital setting.

38. There were enough wash hand basins and towels in the wards.

39. After a period of time as our grandmother was unable to toilet herself and used a commode we witnessed her being taken straight from the commode and put back to bed so we do not believe that she had the opportunity to wash her hands. There was also one occasion when she complained to us that the commode had not been clean.

40. At the start she was able to get to the bathroom but later on she required bed baths. We do feel however that her personal hygiene was good and that her face and hair were reasonably clean and tidy. She was well cared for in that respect and we never noticed any soiled bedclothes or linen, apart from on one occasion. However our other sister witnessed soiled linen on numerous occasions.

Communication

41. We never received any notices, leaflets or pamphlets from the hospital regarding C difficile or anything else. Nor did we see any notices or other information on the notice board or anywhere else in the hospital.

42. There was no information about C difficile or what precautions to take.

43. Dr Troughton was very communicative but not in relation to C Difficile and no-one else gave us any useful information. The staff were generally too busy to spend a lot of time with us.

44. They only made general remarks rather than giving any specific information. The Coronary Care Unit was the only one that gave us any proper information. They would give us a report on what was happening but on Ward B there was a lack of interest. We got the feeling from the staff that they felt that our grandmother was wasting their resources and that she should not be there.

45. When she had a further heart attack we arrived at the hospital before they had an opportunity to contact us following a phone call from another patient who was a family friend.

46. We would have liked the staff to keep us informed of her condition on a regular basis rather than us always having to seek them out for information. The hospital should have in place procedures and resources for weekly progress updates. Furthermore, the names of the primary carers were not always above the bed.

47. The family should be consulted once or twice a week and given a progress report. There needs to be more feedback and we did not even know on occasions who the key members of staff were who were supposed to be looking after our grandmother.

48. We were getting conflicting reports from the hospital staff who were telling us that we should encourage her to mobilise and that her heart condition was not too severe. The care team were supposed to do physiotherapy with our grandmother even though she was saying that she was not physically fit enough to do so.

49. Between the first and second admission our grandmother had a home care package in place. We are also concerned that the care team at home may have cross-infected other clients on their round as our grandmother had been undiagnosed with C Difficile at this time.

50. Our grandmother was tested positive for C difficile on 31st July 2007 but we feel that she must have had C difficile for some time prior to that date. She had been complaining of symptoms of diarrhoea before the second admission to hospital and may well have had it before then.

51. Our grandmother did not discuss any intimate details with us but we noticed a very strong odour on occasions when we were visiting her. It was a smell of very bad diarrhoea.

52. If she had C difficile then she could not have been expected to make better progress with her exercises and mobilisation and indeed she should not have been asked to do these exercises.

53. There should have been better communication, more information and it should be given openly, automatically and transparently. Someone should meet with the family on a regular basis on a face to face meeting and explain what is happening.

54. The hospital phoned Nichola to work when she was being discharged on the first occasion but only gave us 24 hours in which to organise a care package, meals on wheels, medication and other necessary care. Our father was unwell and could not provide the level of care required and one day's notice of her discharge was not enough time to get everything arranged.

Death Certificate

55. We are concerned that C difficile is not mentioned on the Death Certificate as one of the causes of death even though she was tested positive for C difficile on 31st July 2007. We believe we should have been and still wish to be advised as to whether C Difficile was the main cause of death or a contributory factor. We find it significant that Dr Troughton believed that our grandmother should have recovered from her heart attacks and up until the end we were working with the social work team on residential care packages.

Food

56. Our grandmother was reluctant to eat and we had to encourage her to do so. Our grandmother's meals were removed from her tray uneaten and if we did not arrive in time to encourage her to eat she would not have done so.

Conclusion

57. The issue of the laundry is quite a concern because we were handling her clothes that were obviously contaminated with the C difficile infection and were not given any advice as to how to wash them. We were taking the clothes home in different bags and were not told about the biodegradable bags. The dirty clothing was being left in very close proximity to the clean clothing and if the hospital knew that she had C difficile then we should have been told immediately and given appropriate advice. There was no communication at all from the hospital about this.

58. We also feel that the treatment of our grandmother in Ward B was atrocious. There was a general lack of attention. Her complaints were treated dismissively by the staff. We feel that their attitude to her was condescending and patronising. We felt that there was pressure on them to clear bed space. They did not take her complaints seriously. We found them to be unhelpful and unpleasant. Some of the treatment was undignified and demeaning to our grandmother.

59. In hindsight we have some feelings of guilt in that we feel that our grandmother was not given appropriate care or attention and that we were ill informed of her condition. The medical experts were saying that there was nothing wrong with her and as a result of their comments we felt she was just reacting to our father's death. Everyone was trying to encourage her to walk and mobilise but if she was weak and ill with the C difficile then she would have had difficulty with walking. In retrospect we are very upset about the lack of information provided regarding her condition.

60. We were not advised that she had C difficile until we were contacted by the Inquiry Team some two years later. We did not even know that tests were being carried out and if the hospital knew that she had tested positive for C difficile then the family should have been told immediately. The fact that Doctor Troughton believed our grandmother would recover from her heart

attacks and be released leads us to believe that C difficile was at least a contributory factor in her death.

61. We have been unable to obtain a copy of our grandmother's medical notes and records in time for preparing this statement. We feel that these would have helped to shed light on the events leading up to her death. We are still hoping to receive these records and would reserve the right to make a further statement should these records or any other information become available.

62. We would like to know exactly when her symptoms first started and when the hospital became aware of the situation. Given that our grandmother displayed symptoms of D difficile for some time before testing positive we would like confirmation as to how many occasions she was tested. If she was not tested we would like to be informed of the reasons for not doing so.

We declare that this statement is true and correct to the best of our knowledge and belief.

Dated 12 \ October | 2010

Signed ....

Samantha McKay

Date

Nichola McKay