



Witness Statement Reference No.

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

WITNESS NAME: NORMAN MURPHY

STATEMENT OF EVIDENCE

I Norman Murphy say as follows:

1. My father (Mr John Murphy) was admitted to the cardiac unit of the Antrim Area Hospital following a visit to his GP. This was in March 2008. It became clear very quickly that he needed to be fitted with a pacemaker. The consultant caring for my father started making arrangements for him to be scheduled into the Belfast City Hospital. His condition seemed to be worsening and he was moved into the Coronary Care Unit. In light of his worsening condition the consultant very quickly carried out operation and fitted a temporary pacemaker. As I saw the situation, my father would probably not have survived long enough to have a pacemaker fitted in Belfast had this temporary one not been provided. His condition immediately improved and he remained in the Coronary Care Unit waiting to be transferred to Belfast. During this time the consultant and a member of nursing staff spoke to me privately to inform me that my father had contracted cdiff.

2. He remained in a side ward of the Coronary Care Unit while they tried to treat him for the infection. Belfast City Hospital required that he be verified as free from infection before they would admit him and carry out the procedure to fit the pacemaker. I'm not sure what tests were carried out to satisfy the City Hospital that he was free of infection, other than going for a period of time

without evidence of diarrhoea, (I'm not sure but think that may have been a period of 24 or 48 hours). Clearly the infection was weakening him significantly but eventually he was considered to be clear and free to go to the City Hospital. (I assume he was considered free of infection since this was what the City hospital required in order for them to admit him there for the operation). It seemed to me that the staff in the Coronary Care Unit did all they could for him during this time.

3. When my father returned to the Antrim Area Hospital from the Belfast City Hospital he was admitted to Ward 'A', which was being used as an isolation ward at that time. He was not with other patients but was in a small room by himself.

4. His return to Antrim Area coincided with the beginning of the Easter weekend 2008 and the holidays at the beginning of the following week. I was concerned that he had been inactive for some time, was weak and needed to receive some physiotherapy and perhaps some assistance with standing, walking, etc. I asked about his care plan, what they were going to do for him I was told that the staff in that ward were not responsible for his care, they were simply providing food and basic care. They said that my father was still under the care of the cardiac unit. When I spoke to staff in the cardiac unit, they told me that he was in Ward 'A' and the staff in that ward were responsible for his care. I noticed that there was no board or sign at his bed indicating who was the nurse or doctor in charge of his care. When I enquired about this I was told that in that ward they did not operate that system of having a specific person in charge of patient care. As the weekend progressed and on into the holidays I became increasingly concerned for my father who was becoming weaker, he was also becoming very low in spirits and was losing any desire to eat. I felt if he had some positive nursing care at this time, if had been encouraged to get out of bed, perhaps start to walk a little, it would have helped him recover both physically and physiologically. I also became increasingly frustrated that I could find no one to help or do anything positive for my father. I asked about his rehabilitation and was told someone would

Speak to me after the holiday. I could make contact with no one of any authority in any department over the holiday period.

5. Eventually he was moved to the Braid Valley Hospital for rehabilitation. The care he received there from a severely overworked and dedicated staff was 'second to none'. Had he been placed in their care immediately after having the pacemaker fitted, and not wasted that precious week of recovery time in Antrim, I believe there would have been a much greater chance of his recovery. As it happened, he developed diarrhoea once again and died in the Braid Valley Hospital on 1st May 2008. The primary cause of death as recorded on his death certificate was 'Clostridium difficile associated diarrhoea'.

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

Signed *Signature Protected*

Dated: *17th April 2010*