Inquiry Witness Statement of
Dr Javed AKHTER

PERSONAL INFORMATION

1. My name is Dr Javed Akhter. My contact details are known to the Inquiry. I have been a locum consultant on ward 14 and ward F at the Vale of Leven Hospital ("VOLH") since 2007.

2. My qualifications are MRCP (Member of the Royal College of Physicians) and I hold an MBBS.

3. My role involves the clinical care of patients on the wards. I also handle out-patient clinic referrals. I have an out-patient clinic twice a week. I do a ward round once a week on wards 14 and F. I also participate in an on-call rota for Acute Medicine.

VOLH AT THE TIME (1 DEC 07 – 1 JUNE 08)

Facilities

4. The VOLH looked okay. It was typical of a hospital built in the 1950s or 60s. I had no concerns regarding the look of the hospital or its cleanliness.

5. Nurses would be responsible for commode-handling and therefore I have no comments to make on the quality or use of commodes.

6. Since June 2008 there have been changes made throughout the VOLH. Bed-spacing has improved by reduction of areas with 4 beds to 3 beds. There are more hand washing facilities across the VOLH than previously. Some of the wards have almost had a complete refurbishment. For example, paint work and flooring has been renewed.

Beds

7. The layout of VOLH was typical of hospitals built in that period. The bed-spacing was in line with the hospital design in that the hospital had the maximum amount of beds.

8. I am not aware of bed-spacing having caused any issues prior to the outbreak.

9. I am not aware of extra beds being squeezed into bays or rooms which took them over capacity.

Specialist mattresses

10. Specialist mattresses were available and would be dealt with by the nursing staff.

Pressure sores

11. A patient would be assessed on admission for a risk of sores and then a daily assessment would be carried out as part of the general patient care. This would be dealt with by nursing staff.

Transfers to and from VOLH

12. There were guidelines in place to determine whether a patient would be admitted to VOLH or the Royal Alexandra Hospital ("RAH"). The ambulance service also had a scoring tool which allowed them to assess whether they bypassed the VOLH and went direct to the RAH.

13. The real criterion is the need for acute medical services which we do not have at the VOLH such as an Intensive Care Unit. A clinical decision is made as to whether the patient is likely to need this level of care and if so, they would be transferred to the RAH.

14. In terms of coming back from the RAH to the VOLH, a patient may require a few days recuperation following treatment at the RAH or may be awaiting residential or nursing care. They would come to the VOLH for recuperation or until a care place was available.

15. The decisions about transfer are generally made by the consultants at each hospital.

16. If a patient had an infection that would not necessarily preclude the patient's transfer. The requirement for transfer would be a clinical judgement and infection control ("IC") procedures would be observed. If necessary, advice could be sought from the Infection Control Team ("ICT").

Cleaning

17. There were policies and standards in place for cleaning. I have a general idea of standards of cleaning of wards.

Laundry

18. Laundry would be a nursing issue.

Staffing

19. I was managed by Liz Rawle, the Clinical Services Manager for Rehabilitation and Assessment directorate.

20. If I had any concerns, I could raise them with Liz, although on a day-to-day basis, I was effectively self-managed. I did have a job plan or description. It had no specific HAI or IC responsibilities. I had annual appraisals.

Leadership of staff

21. I do not remember the name of the hospital manager at the time of the incidences.

22. The Senior Charge Nurse ("SCN") would be responsible for managing their ward at any given time. The SCN would also be in charge of supervising IC practices within the ward.

Staffing levels

23. I am not aware of any particular ratio of staff to patients, though I would say that staffing levels at the time appeared sufficient. Staffing shortages are fulfilled by contracting other staffs on leave or locum agencies.

Staff morale

24. I did not notice any effect on staff morale.

Health Board

25. Members of the Health Board were visible on site from time to time.

26. Their priority was good patient care within a safe environment. I believe that we were all working towards that.

Estates

27. Prior to the incident, I am not aware of any major estates works being carried out at VOLH. I was aware that the HDU was combined with the Coronary Care Unit ("CCU") but am not aware of any other works.

CLOSTRIDIUM *DIFFICILE*

Education and training

28. I had general education within my degree studies covering infectious diseases including their spread and treatment of them.

29. I had no specific IC or Clostridium *difficile* ("C. *diff*") training at VOLH prior to the incidences.

30. After the incidences, the ICT at VOLH provided training on IC and C.*diff*.

Infection Control

31. The SCN in conjunction with the ICT are responsible for IC practices on the ward. The SCN would generally supervise IC practices on the ward.

32. I am aware of the existence of the Infection Control Manual ("ICM"). This is kept in the nurses' office on each ward. I would consult the ICM if I had to but cannot recall requiring to consult it.

33. I am aware of the existence of the ICT. I do not think they were particularly visible on the wards.

34. There was no Consultant Microbiologist on-site at the VOLH, though there were various Consultant Microbiologists, such as Dr Weinhardt, or Dr De Villiers who were available by phone if need be. It is better if the Consultant Microbiologist is on-site for communication reasons. I do not recall the name Dr Biggs.

35. I had no particular IC responsibility within my job other than observing good practice.

Meetings

36. I do not remember being invited to attend meetings discussing specifically infection control but these discussions were part of clinical governance meetings as well as our monthly mortality and morbidity meetings which I attended.

Outbreak planning

37. I would have expected the ICT to be responsible for handling an outbreak, or identifying greater than usual numbers. They have all the information about cases of C.*diff* across the hospital.

Awareness of incidences of C.*diff*

38. I became aware of the incidences the day before the press published the story. I believe I was informed by someone from the Health Board management. I was not asked to disseminate the information to anyone but I had informal discussions with nursing and medical staff. I believe all the consultants at VOLH were informed.

Samples

39. Samples are taken by nurses and sent to the laboratory (lab). It is standard practice to take a sample if a patient has loose stools.

40. The lab would notify the ward of the sample result. Whoever on the ward spoke to the lab would then tell the other nursing staff on the ward. The nursing staff would tell the junior doctor who would then act upon the result, and if need be consult a more senior doctor, such as a Senior House Officer ("SHO") or a Consultant. The junior doctor could also call a microbiologist if they were unsure of prescribing in a particular case.

41. The result from the lab is noted within the medical notes section of the patient's medical records.

42. The result is not noted anywhere else, for example, by ward on a separate recording system.

43. I believe it is the role of the ICT to identify a higher than usual level of incidences of C.*diff.*

44. If the patient was suspected of C.*diff* I would reassess the patient condition, consider their medications, start treatment if they were not already started on treatment and make sure they were isolated.

Location of patients

45. A patient would normally be allocated to a single room based on their symptoms, before a positive result is obtained from the lab.

46. It is hard to say if there were enough single rooms. Sometimes a patient might be relocated to another ward to find them a single room.

47. I cannot recall wards or rooms being closed, other than for norovirus outbreak.

Hygiene

48. Isolation notices were used and placed on doors of single rooms. They said something like "see nurse" or "take necessary precautions".

49. I usually washed my hands with soap and water after detailed physical examination of a patient and used hand-gel if touching the patient superficially or touching their observation records at bedside.

50. If I was treating an infectious patient I would be extra-cautious with hand washing and would also wear gloves, mask, and gown.

51. I would expect visitors to wash their hands with soap and water after visiting a patient. The nurses reinforced hand hygiene to visitors.

52. There was no practical difficulty in observing hand washing practices. You could always locate a wash hand basin.

Personal Protective Equipment

53. I would wear gloves, mask and gown if treating an infectious patient. These would be located outside an infected patient's room.

Information

54. I believe verbal information was given to relatives regarding the patient's condition. I believe a leaflet was also available detailing the nature of C. *diff.*

55. I cannot recall ever being asked to speak to a relative about C.*diff.* However, I would have done so had I been asked. Generally nurses would speak to relatives and give them basic information.

Treatment

56. The treatment of choice for a patient with C.*diff* is vancomycin or metronidazole.

57. Re-testing is not normally carried out. If the patient is asymptomatic and has passed a formed stool or had been symptom free for 48 hours then they would be considered free of C.*diff.*

Management response

58. I am not aware of how management become aware of the incidences of C.*diff.*

INVESTIGATIONS

Internal investigation

59. The Internal Investigation Team spoke to me. I thought that the interview process was okay.

Outbreak Control Team

60. I played no part in the Outbreak Control Team.

Antimicrobial Management Team

61. I played no part in the Antimicrobial Management Team. I was not spoken to. Changes to prescribing regimes were made.

TREATMENT OF CERTAIN PATIENTS

Sarah McGinty

62. Sarah McGinty was admitted to the VOLH on 3d December 2007 although I did not admit her. I cannot say what ward she was in on admission.

63. I can confirm that Dr Khan consulted me about Mrs McGinty.

64. I first saw Mrs McGinty on 11th December 2007 and was aware that this lady had suffered a stroke. I agreed to continue the management of this patient and prescribed 40mg daily of simvastatin to be administered orally for her cholesterol levels.

65. On the same day I attended a multi-disciplinary team ("MDT") meeting. Usually all the people involved in a patient's rehabilitation will be present at such a meeting. The physiotherapist, occupational therapist, speech therapist, social worker, nurse, junior doctor and consultant would usually attend. I noted that Mrs McGinty would need additional physiotherapy but could transfer from her bed to a chair with assistance. At the same meeting the occupational therapist suggested a home visit with a view to Mrs McGinty getting home in the future.

66. On 18th December 2007 I noted at the observations of the MDT meeting that in relation to Mrs McGinty there was severe left-side neglect which would have been the result of her stroke. The physiotherapist's assessment was that she required to go to a nursing home for ongoing care. I also noted at that time that she was on intravenous fluids and feeding by mouth.

67. Later that day I noted that I had met the patient's daughter Helen and informed her that her mother required to go to a nursing home. Helen McGinty told me that she would rather take her mother home. I would have recommended the decision of the MDT meeting but it would be Mrs McGinty's decision at the end of the day.

68. On the 8th January 2008 I noted that Mrs McGinty still required two persons to help mobilise her and the neglect of her left side was the same.

69. On 15th January 2008 I noted that I thought that we should aim to have Mrs McGinty home within a couple of weeks. She had mentioned pain on the left side but that would not be unusual in a stroke victim. I did mention administering tramadol as a pain killer if and when required, but I did not note the dosage. I also noted that there should be an increase in her dose of baclofen which is a muscle relaxant.

70. Later the same day I attended a MDT meeting and it was noted that Mrs McGinty had pain in the upper and lower side of her left arm. I stopped her dosage of kapak which is a pain killer and changed to paracetamol regularly (that would mean 3 or 4 times a day). I have also noted that 2mg of perindolpril should be taken daily by mouth. This was in order to prevent another stroke.

71. On 22nd January 2008 I noted that Mrs McGinty was recovering from a chest infection, noted right basal crepts and that her blood pressure was 180/100 which is high. I had planned to have her chest x-rayed and I increased her dose of perindolpril to 4mg per day. I also noted that she was able to sit in a chair and physiotherapy had been restarted. It may have been stopped because of the chest infection. There is a note in her records that augmentin had been started in relation to a chest infection which was confirmed on 15th January 2008. The dosage was 625mg 3 times per day and by mouth.

72. On 18th January there is a note that augmentin had been changed to intravenous and clarithramycin added. These are broad-spectrum antibiotics which are most appropriate for chest infections.

73. It was noted at the MDT meeting that Mrs McGinty would require a hospital bed, 2 carers 4 times a day, a hoist and a commode if she was to return home.

74. On 31st January I had a conversation with Dr Khan regarding resuscitation. I stated that I did not think that Mrs McGinty was suitable for cardiopulmonary resuscitation and I knew how ill Mrs McGinty was. The DNAR order was signed by Dr Khan on 31st January 2008.

75. I am aware from the notes that Mrs McGinty was C.*diff* positive, confirmed on 25th January 2008. I was consulted the previous day as it had been noted that she had a raised white blood cell count, temperature and a urine dip stick had tested positive for infection. I had requested that stool and blood samples be sent for culture and that metronidazole should be started with a dosage of 400mgs orally (three times daily). I had no other dealings with Mrs McGinty.

76. Mrs McGinty died on 1st February 2008. I was not involved in issuing her death certificate. This would have been done by one of the junior doctors.

Margaret Gaughan

77. Margaret Gaughan was admitted to the VOLH on 1st January 2008 with shortness of breath. Her main consultant was Dr Al-Shamma.

78. On 7th January 2008 she was sent to the RAH as her condition had deteriorated. She returned to the VOLH on 10th January 2008, and I noted that I attended to her in ward 6. Her diagnosis at the RAH was chronic obstructive pulmonary disease. I do not recollect what treatment she was receiving. I am happy to refresh my memory by looking at notes. The patient was on 10 litres of oxygen and there were crackles in her chest. I noted that she should be seen by Dr Al Shamma.

79. On 10th January 2008 at 1659 hours I recorded in the medical notes that it was Mrs Gaughan's own wish to have a DNAR order put in place. The DNAR order was probably signed on this day but I do not have that information. I had no other dealings with Mrs Gaughan other than those I have described.

80. I can confirm from the notes that Mrs Gaughan was C.*diff* positive on 31st January 2008 and she died on 3rd March 2008.

Agnes Campbell

81. Agnes Campbell was admitted to VOLH on 18th December 2007 with shortness of breath.

82. I saw Mrs Campbell later that day and noted that she had a chest infection and her heart was beating very fast and fluttering. I started her on augmentin and 500mg of clarithramycin. Having checked the drug card at the time of this interview I realise that augmentin was not actually given to Mrs Campbell, and clarithramycin was given once later that evening.

83. I requested blood cultures, a urine dipstick and oral digoxin for an irregular heart beat. I ordered that an echo-cardiogram be carried out. My subsequent diagnosis was non-ST elevation myocardial infarction. On that basis I suggested a few more treatments, low molecular weight heprain, aspirin and clopidogrel. In addition I requested a repeat of the blood and renal functions tests.

84. On 28th December 2007 I saw Mrs Campbell on ward 6. I noted that her chest was clear and that bloods should be taken again the following day. Mrs Campbell went to the RAH on 19th December 2007 and returned to the VOLH on 28th December 2007.

85. On 30th December 2007 I mentioned the report on the echo-cardiogram and suggested that she needed warfarin.

86. On 30th December 2007 I noted that Mrs Campbell was mobile with a zimmer and stated that she was not suitable for warfarin because of risk of fall. I think this may have been because of her poor mobility. If someone falls a lot we do not prescribe warfarin. I suggested that she might be suitable for discharge the following Thursday or Friday.

87. On 3rd January 2008 I noted that Mrs Campbell was complaining of sickness and that the physiotherapist did not think that she was ready to go home until the following week. I noted that her kidney function was getting worse and that a course of frusemide should be stopped. I believe this would have been because that tablet can cause worsening of renal function.

88. On 6th January 2008 I noted that Mrs Campbell had tested positive for C.*diff.*

89. I saw Mrs Campbell in ward 3 on 7th January 2008 as she had been moved there for isolation. I noted that she had had a loose stool and that she was tolerating oral fluid. I noticed a raised C-reactive protein and white blood cell count and that a few crackles could be heard in the chest. Her abdomen was soft to touch. I asked that her fluid balance chart should be maintained.

90. On 8th January 2008 I saw Mrs Campbell in ward 3 and noted that she was unwell. I noted the finding of the abdominal x-ray, that there was no evidence of an obstruction. I noted dilatation of colon which is where the bowels distend and is a sign of severity of illness. C.*diff* organism produces toxins which can cause dilatation of bowels. Her prognosis was poor and she was not suitable for resuscitation. A DNAR order was signed on 8th January 2008 by Dr Khan. On the advice of the microbiologist Mrs Campbell had been started on oral vancomycin and metronidazole through an intravenous drip.

91. On 9th January 2008 in ward 3 I noted that Mrs Campbell remained unwell. She was passing little urine and continued to have evidence of infections from her blood tests. Her kidney function was getting worse and I suggested that the surgeons at the RAH were contacted to see if they could operate for the abdominal condition. From the medical records I see that the surgeons were contacted but declined to operate as they thought it inappropriate.

92. On 10th January I saw Mrs Campbell again and noted that her condition was getting worse and I had a discussion with the microbiologist.

93. Mrs Campbell died on 12th January 2008.

Charles Cook

94. Mr Cook was admitted to VOLH on 1st May 2008 as he was feeling generally unwell. He was originally in the medical assessment unit under Dr Al-Shamma then he was taken to a medical ward. On 2nd May 2008 he was taken to ward 14 on the advice of Dr Al-Shamma.

95. I never saw Mr Cook when he was in ward 14 but I know from the notes that he had passed malaena and his mobility was very limited at this time. It was decided that someone should speak to his daughter and inform her of the increased need for care if he returned home. His kidney function was noted to be impaired.
96. I had no other dealings with Mr Cook.

97. I am unsure what day Mr Cook was confirmed as having C. *diff* as the doctor's notes in his medical records mention 11th May 2008 and the nursing notes note it as 9th May 2008.

98. Mr Cook died at the RAH on 28th May 2008.

Margaret Waddell

99. Mrs Waddell was admitted to the medical assessment unit of the VOLH on 22nd April 2008 **(Production - GGC00560009)**. She was moved to my ward, ward 14, on 22nd May 2008 **(Production - GGC00560053)**.

100. I first saw Mrs Waddell on 27th May 2008 **(Production - GGC00560059)**. I noted that she was not eating. A few attempts had been made at giving her food through a nasal-gastric ("NG") but she was not tolerating that either. I also commented that intravenous fluid had to continue but antibiotic treatment should be discontinued. I noted that she was frequently C.*diff* positive in the past but had been free of any diarrhoea for the last 24 hours. I noted also

that Mrs Waddell was not suitable for resuscitation. The DNAR order was signed by me on 3rd June 2008 **(Production - GGC00560004)**.

101. I saw Mrs Waddell again on 28th May 2008 and noted that she was stable and that the NG tube was out **(Production - GGC00560059)**.

102. I saw Mrs Waddell on 2nd June 2008 **(Production - GGC00560059)**. I noted that she had a problem again with feeding, her oral intake was poor, and she had had no further diarrhoea and was on vancomycin. Mrs Waddell was non-compliant with medication and was refusing her medication sometimes. I suggested repeat blood tests and to send a specimen of urine to the laboratory to diagnose a possible urine infection.

103. On 12th June 2008 we discussed Mrs Waddell at an MDT meeting **(Production - GGC00560061)**. A comment was made by a nurse at this meeting that Mrs Waddell still had loose stools, that a sample had come back as C.*diff* negative and that they planned to send a second sample.

104. I saw Mrs Waddell on 16th June 2008 **(Production - GGC00560061)**. I noted that Mrs Waddell was non-compliant with medication and was taking metronidazole on and off. She was still having loose stools and I suggested continuing metronidazole for 2 more days and if no response to seek advice from the microbiologist.

105. On 17th June 2008 **(Production - GGC00560062)** I noted that Mrs Waddell was still non-compliant with medication and that the nurses should keep persuading her to take the medication.

106. On 18th June 2008 **(Production - GGC00560062)** I have noted that Mrs Waddell continued to have loose motions and commented again on her non-compliance. She was C.*diff* positive for toxin but C.*diff* negative for culture, on the basis of the sample sent to the laboratory on

For distribution to CP's

12th June 2008. I suggested that a further stool sample be sent for testing.

107. On 19th June 2008 **(Production - GGC00560062)** I noted that Mrs Waddell was refusing medications, that there were no loose motions overnight and that I would speak to her daughter to explain the condition to her. Later that same day I have noted that I spoke to Mrs Waddell's daughter **(Production - GGC00560063)**. I explained the poor prognosis of her mother. Mrs Waddell's daughter was insisting upon the withdrawal of all treatment. I explained to her the non-compliance of medication and the fact that Mrs Waddell was not eating or drinking much. We agreed that no active treatment would be given if any further infection arose but I said that I would discuss whether to stop or continue the C.*diff* treatment with the microbiologist. I discussed this with the microbiologist and he suggested the treatment be continued. I noted that as the next of kin wanted treatment to be withdrawn she required to sign a statement to that effect.

108. I think Mrs Waddell's daughter was insisting during this meeting on 19th June that C.*diff* was put on her mother's death certificate but that is a vague memory. I think I would have told her that C.*diff* would be a contributing factor but not a direct cause of death.

109. Mrs Waddell died on 22nd June 2008. On 23rd June 2008 I noted what I thought should be put on the death certificate **(Production - GGC00560063)**: 1(a) general debility, 1(b) self-refusal of oral medication, 1(c) dementia and 2 C.*diff* colitis.

110. I have no objection to my witness statement being published as part of

the evidence to the inquiry. I believe the facts stated in this witness statement to be true.

Signed..

Dated......19 – 1 – 2011......