

**Inquiry Witness Statement of
Gareth Tennent BOURHILL**

1. My full name is Gareth Tennant Bourhill. My contact details are known to the Inquiry.

BACKGROUND

2. I am the surviving son of Janet McCairns Fitzsimmons who was born on the 1st July 1939. My mother died on the 9th August 2008 in the Vale of Leven Hospital, Alexandria.
3. My mother was in the Vale of Leven Hospital and the Royal Alexandria Hospital, Paisley. She was admitted to the Vale of Leven Hospital on the 17th December 2007 and was admitted initially to Ward 3. She was an insulin dependant diabetic who also cared for my 83 year old step-father, which took a toll on her health. She had suffered a number of hypoglycaemic attacks and this resulted in her being admitted to the Vale of Leven Hospital. The low blood sugar level, combined with the fact that she was a smoker, identified the fact that she had a chest infection.
4. Because of the chest infection she was transferred to the Royal Alexandria Hospital and was placed in a high dependency unit on oxygen therapy and strong antibiotics. I do not know what antibiotics she was prescribed. She made a significant recovery, in my opinion because of the level of care, and she was then moved back to the Vale of Leven Hospital on the 28th December 2007 and placed in Ward 6. I have been shown a plan of Ward 6, **Ward 6 Original (Production No 10)**. I believe that she was placed in Room 15, which contained 4 beds. She would have been in one of the two beds closest to the corridor.

5. My mother was discharged back to home sometime between mid February 2008 and early March 2008. She was receiving care in the community with district nurses coming in to ensure she was eating and generally looking after her. My step-father, who was suffering from Alzheimer's disease, was, at this time, in permanent care in Erskine.
6. My mother had been suffering from diarrhoea when she was discharged from the Vale of Leven Hospital. I have never got to the bottom of why she was suffering from this. I have been told that it could have been caused by either the antibiotics or the liquid diet. I believe that arrangements had been made for her to have an endoscopy, but due to her weakened condition this had not taken place.
7. The diarrhoea had started whilst my mother had been in Ward 6 at the Vale of Leven Hospital. She had never been placed in isolation and we were never given any instructions regarding general hygiene or hand cleaning procedures.
8. On the 27th March 2008 my mother was re-admitted to the Vale of Leven Hospital. She had not been eating and was also vomiting, incontinent and suffering from diarrhoea. Her next door neighbour had called an ambulance and a female Asian doctor from my mothers GP practice had attended and insisted that she be re-admitted to hospital.
9. Whenever I visited my mother in hospital the doors to the ward were shut until visiting time started. When the doors were opened, the visitors would rush in. If one in three visitors washed their hands it was a good day. Also at visiting times, I was never able to speak to a member of the medical staff. This seemed to be because staff change over or shift change seemed to take place during the visiting hours.

10. When my mother went back into the Vale of Leven Hospital in March 2008 she was placed back in Ward 6. I believed that she went back into the same room, Room 15 and was then moved to Room 13. This room had two beds, but it appeared that the only time that the other bed was occupied by another patient was at the weekend. This spare bed seemed to be used for overspill and the second patient would be gone by the Monday. Room 13 also seemed to be used for storage of surplus equipment and was full of boxes that looked like they were waiting for a removal van.
11. I believe that whilst my mother was in Room 13 the hospital carried out an endoscopy. The staff told me that she had a severe case of thrush which was the reason why she was not eating. She was then moved to Ward 14. I have been shown a plan of Ward 14, **Ward 14 Original (Production No 12)**. My recollection is that she would have been in either Room 22 or Room 24, in the bed on the right hand side near the window. It was only after a few days that she was moved to Room 37 and placed in isolation.

C DIFFICILE

12. It was at this time that one of the staff nurses told me that my mother had C Diff. I was given a leaflet on C Diff, **C Diff Advice Leaflet – NHSGG&C (Production No 1)**. I read this leaflet and noticed the comments regarding antibiotics and hygiene. I showed this leaflet to my wife who stated that neither she nor my very young son would be visiting.

Hand Washing

13. I can recall that there was a wash station outside the room. This consisted of a gel dispenser which I think contained pink gel. Within Room 37 there was a plumbed in wash hand basin. There were two

dispensers at the basin, but I am unable to say if they both contained gel or if one contained soap. At no time did staff tell me to wash my hands using soap and water.

14. I was present when staff cleaned my mother. They usually pulled the curtain across the window and the door was shut. I would wait outside the room while they cleaned my mother, so I am unable to say exactly what they did. I could not say if her hands were cleaned.

15. When staff were dealing with my mother they sometimes wore aprons, but sometimes they did not. I would say that generally the staff wore gloves.

16. I was then told that my mother was being prescribed antibiotics and that she was unlikely to leave hospital. I told my brother, Grant Bourhill, about this and he in turn spoke to a consultant, Dr Akhtar. Dr Akhtar told my brother that my mother had underlying problems and that she was unlikely to recover. My mother was somewhat delirious at this point. I do not know if this was due to the infection or the medication.

17. I made an appointment to see Dr Akhtar and eventually managed to speak to him. He explained to me that he felt that she would never get home. She was still incontinent at this time. He then agreed that, with the right amount of care she might be able to be discharged. I was told that there was a time scale that dictated how long she could stay in hospital before going to a nursing home.

18. My mother had been on Fortisip and was moved to either Room 42 or Room 41 in the bed in the corner against the window. She remained there for about a month before she was discharged back home.

19. My mother had only been home a couple of days and fell whilst I was visiting her. I suspected that she had broken her hip when she fell. She was taken to the Royal Alexandria Hospital for an operation to her hip. I

went to visit her in the Royal Alexandria Hospital and she was looking much better. After a few days she was discharged from the Royal Alexandria Hospital and admitted to the Vale of Leven Hospital. She was again placed in Ward 14 in Room 28. She was in the bed against the window.

20. Unfortunately I am not able to be more specific with regards to dates of admission or discharge from the Royal Alexandria Hospital.

21. I went to visit her and she was in a considerable amount of pain. I think that this was because being moved and also still in pain from the operation. I felt quite happy that there were none of the previous issues and that this time she just in hospital for rehabilitation.

22. On the 6th August 2008 I went to visit her again and noticed that she did not look well. She was still incontinent. I then left the hospital as I had to go abroad to the Philippines on a business trip.

23. On the 9th August 2008 I received a telephone call from my wife telling me that my mother had literally minutes to go. As I was still in the Philippines I told her to contact my brother in England. About two hours later I received another telephone call telling me that my mother had died.

DEATH CERTIFICATION

24. I was able to get back home and my brother and I went to the hospital on the 12th August 2008 to get the death certificate. After some confusion we managed to obtain the certificate which we took to register the death. The cause of death was listed on the death

certificate as 1a) Sepsis, ii) Fracture of neck of femur, Right heart failure. Her death was certified by Amy Blair.

25. My brother asked a female doctor what Sepsis was and was told that it was general poisoning but they did not know what of.

26. At no point was a post-mortem mentioned, although I do recall that I was told that the death may have to be reported to the Procurator Fiscal.

VOL HOSPITAL

27. When my mother was in Room 42 of Ward 14, she told me about the outbreak of C Diff at the Vale of Leven Hospital and told me that they were going to clean the hospital. She commented to me how could they do a deep clean of the hospital without even taking the curtains down.

28. My mother also mentioned to me that she had heard Dr Akhtar being reprimanded for not wearing his white coat. This would have been either late May 2008 or early June 2008.

Laundry Facilities

29. Whilst my mother was in the Vale of Leven for the first time I was given her soiled laundry. I took this to my mother's house to wash. This was rather because of convenience and circumstance and common sense not to mix my mothers' laundry with our own.

30. The staff never told me that there was laundry to take home. The only way that I knew that there was laundry would be if my mother told me or if I smelled it when I went into the room.

31. At some point I became aware of the red laundry bags. All I was told regarding them was not to open the bags but to put the bag and contents into the washing machine. I was never given an explanation for this and was never told the difference between the red and white bags.

Impressions

32. I have been asked my general impression of the standards of cleanliness at the Vale of Leven Hospital. I would say that it was shocking. The floors were being cleaned by one person using a dirty pail and mop. The wards were generally grubby. I would say that Ward 6 was definitely better than Ward 14, but not significantly so.

33. There was not a tremendous amount of space between the beds. Two nurses would have struggled to get between the beds. I would say that Ward 14 was definitely understaffed. This may possibly have been because of the nature and age of the patients.

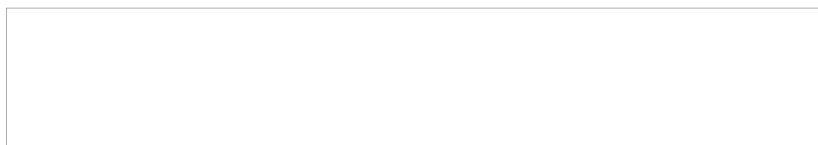
34. I have been asked about ward management. I would say that there was clearly a large number of agency staff working there and there was a distinct lack of consistency within the wards.

35. I have been asked about the general condition of the Vale of Leven Hospital. My impression was that it was totally run down and tired looking. I would say that there was lethargy amongst the staff and that morale was pretty low.

36. I would not say that there was any significant difference in the treatment of either the patient or their family following the diagnosis of C Diff. The only significant change that I noticed was following the announcement of the outbreak of C Diff in the press, but, in my opinion, they were only paying lip service to it.

37. I am not directly involved with the C Diff Justice Group. I have received information with them. I was contacted by Thompsons Solicitors and have completed the application form to be a core participant and have returned this to Thompsons whom I assume will be acting for me.

38. 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 are true.



Dated...*30th January 2010.*