

Inquiry Witness Statement

Of David CHANDLER

BACKGROUND

1. My full name is David Chandler. My contact details are known to the inquiry. I am the husband of Sheila Chandler and the son-in-law of the late Alister Anderson Johnston.

C.DIFFICILE

Information

2. I was never given any information about *Clostridium difficile* ("C.diff"). I felt like there was an attitude in the hospital that if it was ignored it was not happening. They were like the three wise monkeys. There was a wall of silence up and the policy seemed to be to keep quiet about it and it would go away.
3. I was never told by staff to wash my hands, although my wife would tell me to do so often enough. You never had a ward sister in your face telling you to do things like wash your hands. There was a senior nurse but if she was away home there was no one really in charge.

VOL HOSPITAL

Impressions

4. My wife has given a substantial statement in my presence and I would concur with what she has said in regards to the state of the Vale of Leven Hospital ("VOLH"). I would just like to add some of my own observations which I made during the times I visited my father-in-law in hospital.
5. I visited Alister about four times a week, usually with my wife in the evenings, although sometimes I would go over on my own in the afternoons if I was off work.
6. Right from the first visit what strikes you about the VOLH is how old-fashioned and run down it is. Paint was falling off the walls in places and doors were scuffed and bashed. The place needs money spent on it.
7. When you went in it did not smell clean. You will remember when you used to go into hospitals they smelt like hospitals, the disinfectant. The VOLH smelt stale, like a food smell or a stale kitchen. It was not a nice smell.
8. In relation to staffing levels I would say there was never very many of them around. I have always said that I am not launching an attack on staff. I am concerned about the system. It was the system that failed my father-in-law, not the staff. The place was under staffed and poorly managed. This led to a set of circumstances which resulted in people dying. It was totally out of control.
9. I saw members of staff wearing uniforms outside the hospital grounds. Staff would come into work wearing their uniforms. Surely if they were working with patients their uniforms should have been washed and kept within the hospital?
10. There was no control over the number of visitors allowed in the hospital. I would see young children run up and down the corridors, climbing all over the bed of the patient they were visiting. If there was *C.diff* on the ward then young children should have been excluded. I

would see the young children crawl about on there hands and knees. This would have been before and after the *C.diff* infection became known.

11. I also noticed the woman who came round with the tea would come into the isolation ward. She would ask if I wanted tea then go around the rest of the ward serving tea. I though this must have been in breach of the isolation policy.
12. I got the impression that when the outbreak of *C.diff* occurred the nurses themselves were not aware of just how serious a situation it was.
13. 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..... 10 / 2 / 10

For distribution to CP's

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