

Inquiry Witness Statement

Of Sheila Mary CHANDLER

BACKGROUND

1. My full name is Sheila Mary Chandler. My contact details are known to the inquiry. [redacted] and I am [redacted] years of age. I am the daughter of the late Alister Anderson Johnston.
2. My Dad died on the 9th March 2008. He was 66 years of age. Prior to his death he resided at 3b Roseneath Drive, Helensburgh with my Mum and my brother. My Dad worked right up until he was 64. He worked at Faslane naval base in the food servery of the officers' mess. He hated this work as he did not see it as man's work. He had been a HGV driver and a builder when he was younger and fitter.

Dates of Stay in Vale of Leven Hospital

3. My Dad first went into hospital on the 21st December 2007. He took a bit of persuading before he was admitted. He had asbestosis and was very prone to chest infections. He had been suffering from chest infections since about July or August 2007. His GP, Dr Brown, had been prescribing antibiotics for a chest infection for five months or so prior to his admittance. There was a recurring pattern of him being put on a 2 week course of antibiotics then going back to his GP and given another antibiotic to try. [redacted]
[redacted] He did not think that going into hospital would help him. He also didn't want to go in to hospital at Christmas time.

Do Not Attempt Resuscitation ("DNAR") Order

4. My Dad did have a DNAR order in place. This was discussed with the whole family and we all agreed that it be put in place. This was agreed on the evening of the 9th march 2008.

Reasons for Admission

5. My Dad had been in his bed on and off for 10 days leading up to his admittance to hospital. His breathing was really bad. He had not managed to eat very much and was basically not very well. He just wanted to lie in bed. My mother called me on the 21st December 2007 in a state. [REDACTED]

[REDACTED] I said to my Dad that he needed to go into hospital. I was trying to persuade him that he needed oxygen for a few days and that the doctors in hospital could re-examine him and perhaps prescribe different antibiotics.

6. Ironically he was terrified that they would send him to Paisley. Two of my uncles died in the Royal Alexandra Hospital ("RAH"). It has a really bad reputation around here. My Dad had heard of people catching infections in there. He had heard horror stories about the RAH. I asked him if I could guarantee that he got into the Vale of Leven Hospital ("VOLH") would he go. He kept on saying no, no, no, but eventually I said to Mum to just call an ambulance. His breathing had got really bad. An ambulance was called and he was admitted on the 21st December 2007.
7. If it had not been Christmas time I think he would have been treated quicker and therefore been less likely to have caught an infection. His consultant Dr Al-Shamma was away on holiday for 2 weeks. I got the impression that because he was my Dad's consultant the other doctors did not want to go change the treatment without his say so. If it had not been for the Christmas holidays he would have been in and out much quicker.

Impressions of general health at admission

8. When my Dad was admitted to the VOLH he was originally put in the assessment unit. They said there that his oxygen level was very low and his

infection level in his blood was very high. They started him on oxygen and on antibiotics. I think it was Augmentin he was on. However, after a few days there was no change so they put him onto a different antibiotic.

9. During the first 2 weeks in hospital my Dad did pick up a little. He was on oxygen all the time so his was breathing better. He started eating well again and his general state of mind was better. However, he had to wait on Dr Al-Shamma coming back. They wanted to do a bronchoscopy to see how his asbestosis was progressing and to check for cancer. A previous X-ray had shown some sort of shadow on his right lung.
10. When Dr Al-Shamma came back around the end of the first week in January 2008 a bronchoscopy was carried out. We got the results from that a few days later and it had gone well. My Dad had been worried that he had cancer but Dr Al-Shamma told him that there was no sign of it. My Dad burst into tears. He said to me "Thank goodness I don't have cancer". He was getting a bit depressed at this time. He did not know when he was getting home. I actually asked the consultant if they would give him something for his mood. He was tearful all the time. They gave him Citalopram.

C.DIFFICILE

C.diff

11. My Dad had been in hospital for about 3 ½ weeks when he started to get diarrhoea. This would have been around 15th to 17th January 2008. He was not tested immediately. Dad did not say anything to them at first. I think he thought if they knew he was having diarrhoea that they would not let him home. The nurses noticed that he was constantly going to the toilet and asked him if he had diarrhoea. They then gave him something to stop it. I don't know what the medication was. It was not until three or four days after the diarrhoea had started that my Dad was tested for *Clostridium difficile* ("*C.diff*"). The test came back as positive around the 17th or 18th January 2008.

12. I found out quite accidentally that my Dad had *C.diff*. I knew that he had been suffering from diarrhoea. I went into visit him and he was not in his usual bed. My Mum shouted to me from room 16 of ward 3. My Dad had been moved to this two bed room. My Mum had been told by someone to put on a plastic apron. I had not been told to do this by anyone. We were actually laughing and I said to my Mum "what have you come dressed as". My Dad was laughing as well. He said to me "They say I've a wee bug".

Location

13. My Dad was put in a bed in ward 3, room 15. Room 15 of ward 3 has five beds in it. I have been shown a diagram of WARD 3 ORIGINAL (Production No. 5). He was in the bed nearest to the corridor, looking down the corridor. When it was confirmed that he had *C.diff* he was moved to room 16 which had two beds in it.
14. When I went into visit my Dad on the day *C.diff* was confirmed the doctors and nurses were coming in and out of his room all the time. The nurses had on plastic aprons, but the doctor did not. The doctor did have a white coat on. I went in and sat on my Dad's bed. No one said to me not to do this. Also no one said anything to me about washing my hands or wearing an apron.
15. Whilst my Dad was in room 16 another patient was brought in and put in the other bed. This patient had been admitted with chest pains so they put him in with my Dad who had *C.diff*!
16. My Dad was moved again after that. This would have been around the 18th of January 2008. He was moved to room 19 of ward 3 which was a single room this time. That was him in proper isolation now. I asked why my Dad why he was in there and he told me that it was because of this "wee bug".
17. My Dad had asked me if there was any prospect of him getting home. I asked a nurse. I was told that they would have liked Alister to get home but with him having *C.diff* it was making things a bit awkward. This was the first time I heard anyone mention *C.diff*. I was told that they would need to wait until the medication for the bug had kicked in and calmed the diarrhoea down before they would think about letting him home. This would have been around the 18th or 19th of January.
18. My Dad was in the single room for a week receiving treatment for *C.diff*. He had started to pick up really quite well. The diarrhoea was lessening. Whilst

he was in the single room we were told by a nurse to wash our hands before we came out. There were no isolation signs or notices up. I think there were signs saying "please wash your hands" at wash hand basin and things like that.

Effect of *C.diff* infection

19. They discharged my Dad from hospital on the 25th January 2008. He was still suffering from diarrhoea two or three times a day. They let him home on the understanding that he would continue to take his medication at home.

20. The symptoms of *C.diff* were still present when my Dad was discharged. He had been visibly weakened by the time he was let home. He was still receiving treatment for his chest. When he went home it was agreed that he carry on receiving oxygen at home. My Dad was delighted to be allowed back home. He continued to take the tablets for the diarrhoea. It was metronidazole that he had been receiving. The diarrhoea was down to two or three times a day and he was feeling better. He started to eat a bit better when he was home as well. For four or five days he was doing really well at home. When he was at home I would probably see him ever second day or so, although I phoned my Mum two or three times a day to see how he was.

21. The *C.diff* medication finished around the 29th or 30th January 2008. A couple of days after this the diarrhoea started to come back up to seven or eight times a day. It was obvious to me that he required more of the same treatment.

22.

23. The diarrhoea progressed and became worse and worse. My Dad was making a mess of the bed and not making the toilet. He was having diarrhoea twenty times a day and more during the night. His worse time was between 0300hrs and 1200hrs. My Mum had to nurse him and change his pyjamas and the bedding three or four times a day. She also had to bleach and disinfect the whole bathroom several times a day. This went on all through February 2008.

24. [redacted]

[redacted] My Mum knew that my Dad was still getting worse. He was losing weight dramatically and was dehydrated all the time. He was getting no medication other than the antibiotics which Dr Brown had prescribed for his chest infection.

25. This went on right up to the 7th March 2008. My Mum would be calling a doctor two to three times a week. She was heartbroken, phoning me in tears saying that Dad was wasting away in front of her eyes. I could see that he was badly dehydrated and couldn't eat or drink. [redacted]

[redacted]

26. On the morning of the 7th March 2008 my Mum had got my Dad up and dressed. She had been told by the GPs' surgery that a patient transport ambulance would be coming to pick him up and take him to the VOLH for a colonoscopy. The colonoscopy was to see why the diarrhoea was continuing. The ambulance did not show up and my Mum phoned to see why. She was told that there had been no appointment made for my Dad. This made my Dad agitated and he became upset. My Mum put him back to bed around midday. At about 1300hrs he got up to go to the toilet. He got to the bathroom door and collapsed. My brother picked him up and helped him into the toilet. My Dad collapsed again in the toilet. He was too weak to hold himself up. My mother phoned me in tears saying that my Dad had collapsed and was dying. I told her to phone an ambulance and that I would be there in 5 minutes.

27. By the time I arrived two ambulances were there with their blue lights flashing.

[redacted]

[redacted] My Mum grabbed me and said he is dying. The paramedics were in the bedroom seeing to my Dad. My brother had to tell me to let them deal with him. [redacted]

[redacted]

[redacted]

[redacted]

[redacted] The paramedics stabilised my Dad and took him to the VOLH. He was re-admitted and taken to the assessment unit. An Iranian doctor assured my Dad that he would now get the help he needed.

28. My Dad was re-admitted upstairs to ward 3 into exactly the same bed he had been in before. On Saturday 8th March 2008 they took a stool sample and tested my Dad for *C.diff*. The test came back negative. I am not sure that the lab tests were always correct. One test which came back after my Dad had a bronchoscopy said that he did not have cancer, but he autopsy showed that he did. I am glad in a way that my dad never knew that. At this time they were saying that his infection levels were high and his oxygen levels low. They immediately started him on antibiotics. The high infection levels were coming from the septicaemia. I have subsequently learnt from the internet that antibiotics feed a *C.diff* infection. What I realise now is that my Dad's infection levels were high, not because of a chest infection for which he was on antibiotics, but because he had septicaemia and the hospital staff had got the diagnosis wrong.
29. When he was admitted on the 7th March 2008 he did perk up a little. He was given oxygen and augmentum. He felt more secure and that he was getting the care he needed. We went to visit him on Saturday 8th March 2008 and he was not too bad. He was not eating or drinking much, but he was on a drip. He had been extremely dehydrated. By the evening of Saturday 8th March 2008 he was very drowsy and tired. When I visited my Dad on Sunday 9th March 2008 he told me that during the night of Saturday 8th March 2008 the hospital staff had called the crash team. The staff never contacted me on Saturday 8th March 2008 to tell me this, nor did the hospital staff tell me when I visited on Sunday 9th March 2008. It was my Dad that told me about the crash team. My Dad had a respirator on during this visit.
30. I knew that my Dad was dying. I came back from visiting him in the afternoon of Sunday 9th March 2008. I was going to go back in and see him that evening. However, when the evening came I didn't want to see him in the condition he was in. I was frightened to go. However, the phone rang and it was my Mum saying that the hospital had called her to say that my Dad was failing. He died on Sunday 9th March 2008 at 2323hrs.

Information about *C.diff*

31. I was never told what the cause of *C.diff* was. When I was told I didn't know what it was. I went back and looked it up on the internet. I learnt that it was persistent and that it could go away and come back again. I learnt that spores could live for up to two years. I printed off the information and gave it to my Mum. We had to do all this research ourselves. At no time was I provided with any information about *C.diff* from staff at the hospital.

32. I was once told to wash my hands but this was never insisted upon. I was told once and then it was left up to me to pass it on. My mother was never given directions on laundry. She was simply being handed my Dad's pyjamas, dressing gown and slippers to take away.
33. At no time was I ever given any leaflets about *C.diff*. If you wanted information in regards to how Dad was getting on you had to go and seek it out, it was never offered. I don't think the *C.diff* was recognised as an outbreak. It was seen as a series of individual cases. I know that there was not a proper system in place to record the incidences of *C.diff*.

VOL HOSPITAL

Impressions

34. My general impression of the VOLH was that it was a bit run down, under funded and crumbling. My husband described it as a "Romanian slum". Internally and externally the building was shoddy. There was chipped paintwork on the walls and doors. The hand gel dispensers were often not re-filled. My Dad told me that he would get up at 0600hrs to make sure that he got into the shower first. It was clean then, but as the day went on it got dirtier and dirtier. There was no sink in the five bed unit on ward 3 for my Dad to use. The toilet cubicle had no sink in it.
35. About three weeks into my Dad's stay a man was brought in and put in the bed opposite. Apparently he was an alcoholic and had very little control of his bowels and bladder. My Dad woke up in the middle of the night to find this man urinating at the bottom of his bed. The nurses came and took the man to the toilet. The next night the man got up and trailed diarrhoea right past my Dad's bed. My Dad was shouting to nurses that it was disgusting.
36. There were often no nurses at the nursing station. The ward seemed understaffed at times. They had a great deal of work to do, particularly seeing to this alcoholic man. I believe that my Dad got infected by the *C.diff* from this man.

37. The spacing of beds was shocking. Where my Dad's bed was there were two beds side by side. If I was visiting the back of my chair would be touching the other bed, whilst my knees would be pressed up against my Dad's bed. I had to spend the visiting time with the curtain draped over my shoulders. Basically two people could hold hands across the gap of the beds.
38. I would say that the ward always seemed to be short staffed. The nurses always seemed to be stretched. I never saw any more than two nurses on at one time and often just one nurse and an auxiliary.
39. There was a novovirus infection going around the hospital at the time my Dad was in. As a result you would see nurses rushing around with commodes. It must have been horrendous, making it very difficult for them to keep on top of cleanliness.
40. The bed next to my Dad's was occupied by several different patients during his admission. However, not once did I see the entire bed being washed down. I did see the bed being stripped and the mattress wiped down, but that was all.
41. I never saw the floors of the ward being mopped. I did see the corridors being mopped. There was a stale atmosphere about the hospital. I noticed in the day room cupboard they kept plastic cups, tissues, tea making facilities, laundry bags all in that one area. There were spare mattresses stacked up behind piles of chairs in the day room. It looked untidy.
42. Whilst my Dad was in he had an oxygen tube in his nose. This was never changed. My Dad had a chest infection, a cold and diarrhoea. He often had to take the tube out, blow his nose and put the tube back in. I kept asking if it had been changed, but it never was.
43. If you ever wanted to ask a question, especially at night, you had to knock on the door of the nurses' staff room. They were often having a change over meeting. I was usually told that someone would be out in a minute to speak to me. There was never any information volunteered about my Dad, I always had to ask.
44. We supplied our own fluids for my Dad. If Dad ran out he would have to wait until we visited him with more. There was a water cooler in the staff room, other than that there was no water available. There were no jugs of water left at the bedside, apparently this is now considered to be unhygienic.
45. A lot of the time my Dad could not eat. He thought the food was quite bland, tasteless and uninteresting. I am not surprised that he lost his appetite going by the smell of the food.

46. As far as my Dad's last hours were concerned it was a case of me sitting by his bed with the curtain draped over my shoulders holding my Dad's hand. In the last hour before he died they moved the bed into the two bed ward. My Dad was put in there for his final hours and we had more room.
47. My Dad had the occasional accident trying to get to the toilet. He would often clean himself up. He was very proud that way, very clean. He did not wish to cause the nurses any extra work.
48. When he was diagnosed with *C.diff* my Dad was move to the two bed room. Then the next day he was moved again to a single room and given a commode. There was no toilet in there and no shower. There was a bed, a T.V, commode and a sink that was all. I remember that the TV remote control was really dirty looking around the buttons. He only had a basin to wash himself in. This was the same basin that we were using to wash out hands as we were leaving.

DEATH CERTIFICATION

49. My Dad was eventually issued with two death certificates. On the first death certificate we expected to see asbestosis as the cause of death and chest infection caused by asbestosis. We received this first death certificate three or four weeks after my Dad died. It said that he had died of pseudo-membranous colitis and septicaemia. We could not understand this. It took so long to get the death certificate because my Dad was an asbestos case and a post-mortem had to be carried out. The post-mortem did not take place for a week or more. We did not have Dad's funeral until eleven days after he died. They had to remove organs and things to test at a later date.
50. In late May 2008 a new death certificate was issued. This stated that the main cause of death had been *C.diff*. We were given no information as to why this had not been included in the first death certificate. There was no contact with the hospital management following my Dad's death. If it had not been for the post-mortem we would never have known that it was *C.diff* which caused my Dad's death.

51. 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 18/2/10

