

## **Inquiry Witness Statement Of**

**Anne CHISHOLM**

### **BACKGROUND**

1. My name is Anne Chisholm. My contact details are known to the Inquiry. I am the third eldest daughter of the late Coleman Conroy. I have six sisters and one brother.
2. My dad died at the Vale of Leven Hospital ("VOLH") on the 30<sup>th</sup> March 2008. He was 84 years of age. Prior to his admission to the VOLH my dad lived on his own at 5 Garshake Terrace, Dumbarton. My dad lived at this address for 52 years. My mother died about 20 years ago.

### **Dates of Stay in Vale of Leven Hospital**

3. My dad was in the VOLH from the 23<sup>rd</sup> of December 2007 until the 12<sup>th</sup> January 2008. He was then transferred to the Royal Alexandra Hospital ("RAH") in Paisley. My dad was in the RAH from the 12<sup>th</sup> January 2008 until the 5<sup>th</sup> March 2008. He was then transferred back to the VOLH on the 5<sup>th</sup> March 2008 where he remained until his death on Sunday 30<sup>th</sup> March 2008.

**Do Not Attempt Resuscitation ("DNAR") Order**

4. The family were told on the 7<sup>th</sup> March 2008 that Dad had pneumonia in both lungs, that his kidneys were not functioning properly and that his heart could give out as he was not so strong. The family were told that the medical staff would not attempt to resuscitate if anything else happened. There was no discussion about this, we were just told.

**Reasons for Admission**

5. On the 3<sup>rd</sup> December 2007 Dad was complaining of pain in his hips and knees and his shingles. Dad had shingles in 2000 and was left with neuralgia whenever he exerted himself. Dad referred to this neuralgia as his shingles. However, Dad did not want to see a doctor. He rarely went to see a doctor anyway.
6. On the 10<sup>th</sup> December 2007 I arranged to have Dad's bed moved into the living room of his house as he was not coping with the stairs. He began to deteriorate and I saw a big change in him between the 10<sup>th</sup> and 17<sup>th</sup> December 2007.

7.

8. On the 19<sup>th</sup> December 2007 Dad fell when he was in the living room. I was round caring from him on the 20<sup>th</sup> December 2007 when he took two seizures. This was the first time Dad had ever taken a seizure. Dad had a panic alarm cord for emergencies. I pressed this for help but just as I did so the District Nurse came to the door.

9. The District Nurse phoned Dumbarton Health Centre

10. My sister, brother and I organised a rota between the three of us to ensure that someone was with my dad 24 hours a day. My dad also had daily visits from the District Nurse, carers and physiotherapists.

11. On the 22<sup>nd</sup> December 2007 Dad was still poorly. He was not getting out of bed and was sleeping most of the time.

On the 23<sup>rd</sup> December 2007 the GP arranged for Dad to be taken into hospital. When Dad was admitted the medical staff did not know what was wrong with him.

**Impressions of general health at admission**

12. In November 2007 my dad was a man who lived on his own, climbed fourteen stairs to his bed, did his own washing, cooked for himself and attended Church once a week. He still walked with a stick and was waiting for a knee operation for arthritis. During the month of December 2007 Dad went from this independent man to being bed bound and unable to do anything for himself. Dad was sleeping most of the time, was not eating, was drinking very little, could not get out of bed by himself and required assistance with his personal care needs. Dad did not know the time of day and was in a lot of pain.

13. When my dad was asked whether he wanted to go into hospital he said "If I need to go, I need to go". I was surprised by this as it was not like my dad to accept that he required medical attention. He must have felt really ill.

14. When Dad was first admitted to the VOLH he was taken to the Medical Assessment Unit. He was then taken up to ward 3. Whilst Dad was in the Medical Assessment Unit the doctor was asking him what was wrong with him. All Dad would talk about was his shingles. I eventually had to say to the doctor that it was not my dad's shingles that had brought him in and that he was very unwell.

## C.DIFFICILE

### *C.diff*

15. I am not aware of when my dad started to suffer the symptoms of *C.diff*. By the time I was told Dad had *C.diff* it was between the 28<sup>th</sup> January 2008 and 31<sup>st</sup> January 2008 and he was in the High Dependency Unit of the RAH. My dad was connected to all sorts of machines and tubes and was being treated for a number of different things. My dad had caught the winter norovirus when he was in the VOLH. I believe that the symptoms of this are very similar to *C.diff*.

16. I was told by a nurse in the High Dependency Unit of the RAH that Dad had *C.diff*. The nurse explained that it was due to the antibiotics Dad had been given. The nurse explained that the bad bacteria had taken over from the good bacteria in my dad's gut because the antibiotics had killed the good bacteria. The nurse also told me that *C.diff* was contagious and that I had not to touch my dad. The nurse told me to use soap and water when I washed my hands as well as the hand gel. My dad was isolated when he was in the High Dependency Unit of the RAH.

### Location

17. When Dad was admitted to the VOLH on the 23<sup>rd</sup> December 2007 he was put in ward 3. I have been shown WARD 3 ORIGINAL (**PRODUCTION NO 5**) and from this I think he was in room 14. I cannot remember exactly but I think there were 4 beds in the room. My dad was in the bed by the window. It was quite a spacious room and there was good space between the beds. The

room was next to the nurses' station. I remember that two other beds were occupied but that the bed across from the nurses' station was empty.

18. On the 25<sup>th</sup> December 2007 my dad had become agitated during the night. He was jerking a lot and was unsettled. He was transferred to the other end of the ward and he settled down there. Again looking at WARD 3 ORIGINAL **(PRODUCTION NO 5)** I can tell you that my dad was transferred to room 12 in the first bed on the left as you go into the room. I cannot remember exactly but I think there were 4 beds in the room.

19. On the 26<sup>th</sup> December 2007 a nurse told me that my dad was dehydrated but that the doctor did not know what was wrong with him. The nurse said that Dad had the classic symptoms of an infection but his urine, chest and blood test results were all clear and his medication had been stopped on Christmas Eve. The nurse told me that they were continuing to take blood samples. My dad had become incontinent, was hallucinating and was agitated. The doctor had sedated him. My dad did not know me at all when I was visiting him that day.

20. On the 27<sup>th</sup> December 2007 there was a big improvement in my dad's condition. He was sitting up by himself in the chair and the nurse told me that whatever it had been that was making him ill the day before had gone.

21. On the 28<sup>th</sup> December 2007 my dad was moved to ward 15. He was getting ready to come home and ward 15 was the rehabilitation ward. I have been shown WARD 15 ORIGINAL **(PRODUCTION NO 15)** and from this I can tell you that he was in room 47. This was a four bed ward and all the beds were occupied.

22. I was informed between the 29<sup>th</sup> December 2007 and the 1<sup>st</sup> January 2008 that the norovirus was infecting patients in the VOLH and that Dad had it. The nurse told me that Dad had been improving but that he had caught the norovirus and that this had set him back. The nurse told me to use the hand gel because of the norovirus. The staff moved all the patients to the dining room and cleaned the ward then moved all the patients back.
23. On the 2<sup>nd</sup> January 2008 my dad took another seizure. However, between the 2<sup>nd</sup> January 2008 and 11<sup>th</sup> January 2008 my dad's health began to gradually improve. He was working with the physiotherapist and the hospital staff had put in a package to prepare my dad for going home. On the 8<sup>th</sup> January 2008 I met with Dr Herd and Sister Madden to discuss what was required for my dad to return home. Dr Herd said if Dad continued improving Dad would probably be home in two weeks time but his needs at home would have to be assessed before Dad could go home.
24. At the meeting with Dr Herd the doctor said he was concerned about the seizures. They had done an intelligence test with my dad and he had scored 7 out of 10. They thought my dad may be diabetic as the blood tests had shown that his haemoglobin had fallen and his glucose levels were high, but as my dad had the norovirus this was to be expected.
25. On the 12<sup>th</sup> January 2008 my dad was transferred to the RAH. He had a burst ulcer and they carried out a seal to stop internal bleeding. However, the bleeding started again and on 13<sup>th</sup> January 2008 he was operated on. On the 14<sup>th</sup> January 2008 Dad was responding well and the bleeding had stopped. On the 15<sup>th</sup> January 2008 Dad was transferred to the High Dependency Unit of the RAH. Between the 26<sup>th</sup> January 2008 and 28<sup>th</sup> January 2008 Dad suffered renal and respiratory failure and was transferred back to intensive care. On 29<sup>th</sup> January 2008 he was transferred back again to the High Dependency Unit. On the 31<sup>st</sup> January 2008 he was transferred

again to ward 26 of the RAH. Initially he was in a two bed room of ward 26 then went to his own room. I was not told why Dad was transferred to his own room but this would have been between the 31<sup>st</sup> January 2008 and 2<sup>nd</sup> February 2008. On the 29<sup>th</sup> February 2008 he went back again to a shared room of ward 26. I think there were four beds in this room.

26. On the 5<sup>th</sup> March 2008 Dad was transferred back to the VOLH and taken to ward 3. I have been shown WARD 3 ORIGINAL (**PRODUCTION NO 5**) and can tell you that it was room 16 of ward 3 he was taken to which was a two bed room. The nurse told me this was a holding room because Dad was actually back in the VOLH for rehabilitation but there was not a bed for him in the rehabilitation ward. I remember at this time they had to put fans next to Dad's bed because of his high temperature.

27. On 12<sup>th</sup> March 2008 my dad was moved again, this time to ward 14. I have been shown WARD 14 ORIGINAL (**PRODUCTION NO 12**) and I think that it was room 22 of ward 14 my dad was in which was a four bed room. My dad was then transferred again on the 13<sup>th</sup> March 2008 to room 33 of ward 14 which was a single room. My dad remained in this room until he died on the 30<sup>th</sup> March 2008.

#### **Effect of *C.diff* infection**

28. When my dad was taken to the VOLH on the 23<sup>rd</sup> December 2007 he was not my dad. He was hallucinating saying he was seeing wee boys, or that his dad was washing his feet. The stories he told were unbelievable. My dad improved and was able to get up and get dressed. Dad was talking about going home. Then he caught the norovirus which put him back a bit again, but he was fine.

29. Then on 12<sup>th</sup> January 2008 I got a call from the VOLH to say that Dad's ulcer had burst. I did not even know that he had an ulcer. My dad then went through a terrible time in the RAH during his admission there from 12<sup>th</sup> January 2008 to 5<sup>th</sup> March 2008. The care he received in ward 26 was questionable. For example, they were keeping a record of his food intake and would record what he was served at meal times but they did not record what he had actually eaten. The food was left on his table for him to feed himself but he did not have enough energy to lift the cutlery. My sisters and I attended every day to feed Dad lunch and dinner to ensure that he was being fed. He was also not being given his medication.
30. It was between 28<sup>th</sup> and 30<sup>th</sup> January 2008 when Dad was at the RAH that I was told for the first time that he had *C.diff*. I was told that Dad was being given antibiotics but I don't know if they were to treat the *C.diff*. Dad was in such a bad state anyway it was difficult to tell what the symptoms of *C.diff* were. Dad was sleeping all the time and was exhausted. He had suffered a heart attack on the operating theatre and also had pneumonia in one lung. His condition was so serious I made an appointment to speak to a doctor.
31. My sisters, brother and I met with the surgeon at the RAH, Mr Porteous, on 5<sup>th</sup> February 2008. Mr Porteous told us that Dad had pneumonia in one lung. Mr Porteous told us that he did not expect Dad to survive but that he would continue to treat Dad with antibiotics. This was the second time we had been told that my dad was not expected to survive.
32. On the 6<sup>th</sup> February 2008 my sister was told by a nurse at the RAH that Dad had got MRSA. My sister passed this information on to me. My sister had been told when she had taken her grandchildren up for a visit. The nurse had said to her "You had better not take the children in as your dad has MRSA." I

went to speak to a nurse to ask why we had not been told that Dad had MRSA. The nurse got very defensive and became rude. The nurse said to me I would have to take it up with the Sister, Sister Horsefield. This incident happened because the nurse thought she knew what she was talking about but was mistaken. The nurse told me that Dad had been moved to a single room because he had MRSA. She actually had to be corrected by a colleague who said that Dad had been moved because his condition had deteriorated.

33. On 7<sup>th</sup> February 2008 I met with Sister Horsefield and asked her about my dad having MRSA and why I was not told. I told her I was not there to complain but just wanted to know why I had not been told. All she said was that the nurses were very busy and could not inform relatives of everything. When I visited the RAH later that night there was a leaflet about MRSA lying on my dad's bedside table.

#### **Information about *C.diff***

34. On the 10<sup>th</sup> March 2008 the family were told for the second time that Dad had *C.diff*. This was when he was in ward 3 of the VOLH. Before he had been transferred back from the RAH Dad had started vomiting. They had put him on antibiotics on the 4<sup>th</sup> March 2008.

35. I was never told that there had been an outbreak of *C.diff* in the VOLH. *C.diff* is on my dad's death certificate. I did not even realise the significance of this until I saw reports in the paper that a lot of people had died and that is when it clicked with me. I thought then "I wonder if my dad's case is relevant."

36. I don't know if Dad was ever clear of *C.diff* the whole time he was in the VOLH and the RAH. On the 13<sup>th</sup> or 14<sup>th</sup> March 2008, just after Dad had been transferred down to ward 14 of the VOLH, my sister was told by a nurse "C.diff was a nasty little bug which was not pleasant, that it makes the patient feel nauseous." That was it, that was all the information we were given.

## **VOL HOSPITAL**

### **Impressions**

37. There are a number of things I noted about the VOLH when I was visiting Dad that I would like the Inquiry to note. In relation to cleaning the cleaning staff would often enter the rooms during visiting hours and begin just cleaning around the visitors. I do not know how they expected the wards to get cleaned properly this way. The cleaning staff did not appear to be using any special cleaning agents for the *C.diff*. I did not see the cleaning staff use the hand gel nor did they change their gloves when entering or leaving a room which had a *C.diff* patient in it.
38. I would notice that some of the nursing staff did not wear plastic gloves or aprons when entering or leaving a room which had a patient in it who was infected with *C.diff*.
39. On one particular afternoon I saw a patient urinating in the corridor as she was being escorted by a nurse. Whilst I am aware that such things are bound

happen in a hospital with elderly people, what shocked me was that the urine was still there when I came back to visit my dad in the evening. It was sticky and had been trailed about the ward.

40. At times the stench on entering ward 14 was unbearable. On a number of occasions I took lavender in and wafted it around my dad's room to try to mask the smell.

41. There were patients with mental illness on ward 15 and I noticed two of them wandering about during the norovirus outbreak. I was told that Dad was infected with the norovirus sometime between the 29<sup>th</sup> December 2007 and 1<sup>st</sup> January 2008. The norovirus outbreak would have been around this time.

42. I also noticed a mentally ill patient wandering around ward 14 when Dad was there after 12<sup>th</sup> March 2008 when he had been diagnosed with *C.diff*. The patients must have been at risk of being infected, or if they themselves were infected they must have been spreading the infection.

43. On one occasion there were another patient's pyjamas in my dad's laundry bag. I have no idea if this patient had *C.diff* or what was wrong with the patient. On the subject of laundry I was given no instructions about how to wash my dad's laundry. The laundry was left in my dad's locker in an untied white plastic bag. There was usually a bag there waiting on every occasion I visited. Dad's laundry was soiled at times. On one occasion the clothes were so badly soiled the laundry bag was put straight into a litter bin as we left the VOLH. I would not have let my dad wear them again even if I had washed them myself.

44. My dad was able to feed himself when he was in the VOLH the first time round. The nurses used to comment on how well he had done.
45. When he was in the RAH I could visit Dad all day but when he was in the VOLH the visiting times were restricted so I did not have as much contact with him in the VOLH as I did in the RAH. I phoned the VOLH every morning and asked the nurse how Dad had been during the night and had he eaten his breakfast. They would often tell me he was not eating very much.
46. I asked the nurses if it was okay to bring in food for my dad any they said it was. I brought in food for my dad. He liked custard.
47. When my dad was on ward 15 of the VOLH during the first two weeks of January he had little privacy. The beds were close to one another. I would have to move the chair if I wanted to pull the curtain around my dad. The privacy appeared to have been adequate when Dad was in his own room during the last two weeks of March 2008. However, there was one patient who wandered around the ward when we were there during visiting times so I do not know if she ever entered Dad's room or not. I can tell you that Dad's glasses went missing. Dad had his glasses when he was in the VOLH in December 2007 but I do not know what happened to them after that. The glasses were never found.
48. Dad was taken back to the VOLH in March 2008 for intensive rehabilitation. This was a surprise to me as he was in such a state. Dad had lost so much weight. The doctors were amazed that he had survived the operation and everything else, but before he went into the VOLH he had been strong. I do not know why he was taken to rehabilitation. I think it may have been better if he had been given palliative care.

49. When I visited Dad I never noticed him having diarrhoea. Dad never complained of having pains in his stomach. Dad only complained of being tired and sore when he coughed after his operation in the RAH. The day before Dad was transferred back to the VOLH on the 5<sup>th</sup> March 2008 he vomited during visiting hours in the afternoon and again in the evening. Dad was still vomiting when we visited him on the 5<sup>th</sup> March 2008 at afternoon visiting time. This is when we were told that Dad was to be transferred back to VOLH. I spoke to Sister Horsefield as I was concerned that Dad had been vomiting for two days. All Sister Horsefield said was it was good to see Dad getting better. When I told my sister this she asked the doctor, Mr McDonald, why Dad was being transferred when he was still vomiting. Mr. McDonald said he was not aware that Dad had been vomiting. My Dad was transferred to the VOLH at 1700hrs on the 5<sup>th</sup> March 2008. When we arrived at the VOLH at visiting time Dad was still vomiting and had a very high temperature. The nurse had to put a fan next to Dad's bed to try and bring his temperature down.

50. I was never told what treatment my dad was receiving unless I asked a nurse or made an appointment to see a doctor. I had to phone a secretary to make an appointment to meet with a doctor. The appointment had to be kept between 0900hrs and 1700hrs and I was informed that there was no guarantee that the appointment would be kept by the doctor if the doctor was needed elsewhere.

51. Dad was on a drip and oxygen in the RAH and he was being fed intravenously, although they stopped this in order to get him to start eating again. I assumed that my dad got *C.diff* through the antibiotics. My dad did start vomiting before he left the RAH so he might have had *C.diff* in the RAH before being transferred back to the VOLH.

52. I have been shown C DIFF ADVICE LEAFLET – NHS GG&C (**PRODUCTION NO 1**) and C DIFF ADVICE LEAFLET- HEALTH PROTECTION SCOTLAND (**PRODUCTION NO 2**). I have not seen either of these before. Whilst my dad was in hospital I was never given or shown any leaflets about *C.diff*.
53. In wards 14 and 15 of the VOLH there was a wash hand basin in each of the shared rooms that my dad was in. There was also a wash hand basin in the single room of ward 15 which my dad was in. There was no information about hand washing near the wash hand basins.
54. When it was visiting time in the RAH the staff would have their handover. There was never anyone to talk to about my dad when I was visiting because they were in this meeting. It was no good. The staff who knew how my dad had been would all go off shift and the staff coming on would not know how my dad had been. All you could get was second hand information.
55. The nurses were all very, very busy but there should be someone for relatives to talk to about their dad or whoever it might be. People need to know what is going on with their relatives' care. I keep saying to myself now "Why didn't I ask this or ask that", but my dad was in hospital in the care of professionals and I was not medically qualified so how was I know what to ask.
56. I was very emotionally involved at the time. I am glad that this Inquiry is looking at what happened. I would like the Inquiry to get some answers and improve the situation. I know *C.diff* is not going to disappear, but it should be managed.

57. I realise that the focus of the Inquiry is on the VOLH and not the RAH, but I would like to tell the Inquiry about a few observations I made about the RAH. The first time I was informed that Dad had *C.diff* was when he was in the High Dependency Unit of the RAH on the 28<sup>th</sup> January 2008. There were restrictions in place to ensure that visitors used the hand gel but I often noticed staff entering the wards without using it. I remember the folder which my dad's medical notes were kept in was filthy. I actually cleaned it myself with anti-bacterial hand wash. I also had to give my dad a manicure when he was in the RAH as he had dirt underneath his fingernails.

58. My dad's medication was often left lying on the table for him to take himself, but he was not capable of taking them himself. When I highlighted this to the staff in the RAH they said that they could not force him to take the medication. Also Dad was expected to feed himself at lunch and dinner when he was hardly able to lift a spoon.

59. In the RAH I also noticed a blood stained blanket on my dad's bed which remained there unwashed for two days and was only changed when I asked it to be. Also I was not informed when my dad was diagnosed with MRSA and my sister had to find this out in a very difficult way. It was always difficult to see anyone in the RAH who I could speak to about my dad except for the nurses coming on duty who didn't know anything. On more than one occasion we found my dad with his oxygen mask or nebuliser either on the floor or lying on top of his bed. I would then go searching for a nurse to attend to him. Dad's room was close to the nurses' station but there was very rarely anyone there. On another occasion Dad's catheter was leaking all over the floor of his room. Again I had to go and find a nurse to fix it.

## DEATH CERTIFICATION

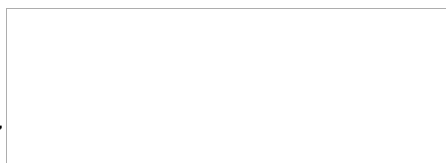
60. I would phone every morning to see how Dad was. The day before my dad died the nurses had got him up. They had given him a shower and sat him in his wheelchair. The nurses had said jokingly it was party time and told us we could take him to the dining room during visiting time. I gave him a haircut as his hair was now long and curly and I knew that Dad would not be happy with it that way. Dad was in high spirits, the best he had been since before he went into hospital. He slept all through visiting hour that night. We reckoned all the excitement of getting out of his room had exhausted him.
61. On Sunday 30<sup>th</sup> March 2008 I did not phone until 1000hrs. The nurse said that he was fine and I said I would be up to visit at lunchtime. However at 1215hrs my sister got a phone call saying that Dad had died. I felt cheated that I was not there when Dad died. I am also surprised that a couple of hours earlier the nurses could not tell that my dad was going down hill.
62. My dad died on the 30<sup>th</sup> March 2008. This was a Sunday and the death certificate was issue on Monday 31<sup>st</sup> March 2008. *C.diff* was listed on the certificate. I am not sure if it was listed as the underlying cause of death or as a contributing factor.
63. One thing that I am confused about is that a couple of months after my dad's death my sister from Canada had to submit an insurance form. She had missed a flight home because of my dad's death. My sister sent the form to me to get the doctor to confirm my dad's death for the insurance company. The same doctor who filled in the death certificate wrote on the insurance form that the cause of my dad's death had been septicaemia. Septicaemia had never been mentioned during my dad's illness. I do not know why it was mentioned on the insurance form.

64. I went up to the hospital a couple of days after my dad had died and took flowers and chocolates for the nurses. I also took home some of my dad's belongings.

65. There are a few specific questions I would like answered about my dad. Firstly, why was he moved to a shared ward in the VOLH between 5<sup>th</sup> March 2008 and 12<sup>th</sup> March 2008 when it was known that he had *C.diff*? Secondly, if my dad had been given his flu jab when he was supposed to would this have prevented him from getting pneumonia? Lastly, why was he transferred back to the VOLH on 5<sup>th</sup> March 2008 for rehabilitation when it was clear that it was palliative care that he required?

66. 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..... 20/4/10 .....