Witness Name: Dr William Cash
Statement No.: WITN3178002
Exhibits: WITN3178003-12
Dated: 6th November 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR WILLIAM CASH

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 May 2019.

I, Dr William Cash, will say as follows: -

Section 1: Introduction

1. My name is Dr William Jonathan Cash. My date of birth is GRO-C 1974 and my professional address is The Liver unit, 1st Floor east wing, Royal Victoria Hospital, Grosvenor Road, Belfast. My qualifications include a bachelor of medicine & surgery degree (MB Bch BAO) awarded by Queen's university, Belfast in 1998, membership of the Royal college of physicians (MRCP), granted in 2003 and a Doctorate of Medicine degree (MD) awarded by Queen's university, Belfast in 2009. I was elected to fellowship of the Royal College of Physicians (FRCP) in 2011.

2. I took up my current post as a consultant Gastroenterologist and Hepatologist in August 2010 following award of a certificate of completion of specialty training in Gastroenterology and general (internal) medicine with sub-specialty accreditation in Hepatology. Prior to this post, I was a specialist registrar in the Northern Ireland Medical and Dental Training agency gastroenterology training program and completed a 1 year fellowship in St Vincent's University hospital (Dublin) Liver transplant unit in July 2009.

3. I received the IHM medical leader of the year award for Northern Ireland in 2013.

4. I was an elected board member of the Irish Society of Gastroenterology (ISG) 2011-2017. I remain a member of the ISG along with membership of the British Association for Study of Liver Disease and British Society of Gastroenterology.

5. I have always been an active advocate for patients with all forms of liver disease and continue to work with patient groups and charities on a voluntary basis, both as part of my job and in my personal time, to promote population liver health. Examples include participation in national 'Love your Liver' campaigns, regular attendance to support the Royal Victoria Hospital Liver support group (a NI-wide charity) and attending UK haemochromatosis society meetings.

6. As a Liver specialist, I work with patients from diverse social, economic and ethnic backgrounds and see many patients with rare diseases and unfortunate circumstances not of their own making.

7. GRO-C

8. I have not been a member, past or present, of any committees or groups relevant to the Inquiry's terms of Reference.

Section 2: Responses to criticism of Christina McLaughlin, Patricia Kelly and Rosemary Devine

9. The team of consultants working in the Northern Ireland Regional Liver Unit have always been proactive in trying to identify individuals with chronic hepatitis C throughout Northern Ireland and offer these individuals appointments to assess suitability for treatment.

10. Mr Edward Conway had attended the Regional Liver Unit in 2004, six years before I took up my consultant post. Mr Conway was offered treatment with pegylated interferon and ribavirin but opted to postpone treatment for a period or time.

11. The records show Mr Conway did not attend appointments offered at the regional liver clinic on 2nd February 2005, 29th June 2005 and 23rd November 2005.

12. Dr Gary Benson referred Mr Conway back to the regional liver service in February 2016, however Mr Conway failed to attend an appointment offered at Dr Neil McDougall's clinic on 1st April 2016.I refer to **Exhibit WITN3178003** being a copy of Dr McDougall's letter dated 15th July 2016.

13. In an effort to track down patients with chronic hepatitis C, I contacted Dr Gary Benson by telephone in May 2017 and asked Dr Benson to furnish me with a list of all remaining individuals attending his regional haemophilia service who were hepatitis C positive. Dr Benson forwarded the list by email on 5th May 2017. I refer to **Exhibit WITN3178004** being the email I received. The email included an attachment with a list of patients. All of these patients were subsequently offered assessment at the regional liver unit.

14. Mr Conway's name was on that list and an appointment was arranged at the liver clinic for 1st September 2017. That appointment was, however cancelled by the hospital and rescheduled for 6th October 2017. Mr Conway cancelled the appointment planned for 6th October 2017 and a further rescheduled appointment was arranged for 3rd November 2017. Mr Conway failed to attend that appointment.

15. Dr Benson wrote to my consultant colleague Dr Ian Cadden on 13th April 2018 requesting a further appointment for Mr Conway. Dr Cadden arranged an appointment for 22nd May 2018.

16. On the day of 22nd May 2018, Dr Cadden cancelled Mr Conway's appointment by telephone as the Fibroscan device was out of commission for servicing. There was a subsequent administrative error and a further appointment was not scheduled. Dr Cadden incorrectly wrote a letter to Mr Conway's GP suggesting Mr Conway had failed to attend that appointment.

17. On 7th November 2018 the Regional Liver unit consultant team received an email from Annelies McCurley. The Public Health Association (PHA) employs Ms McCurley and she works in the NI Hepatitis B & C managed clinical network ("the hepatitis network"). I refer to **Exhibit WITN3178005** being the email the hepatitis network received from Mrs Christine McLaughlin. Ms McCurley forwarded the email to the liver unit team.

18. In response to this email, I requested that an urgent appointment should be offered to Mr Conway at the liver clinic. In addition, I requested that an ultrasound scan of abdomen should be arranged for Mr Conway on the same day of attendance but prior to the outpatient clinic appointment with me. In addition, following the outpatient consultation a Fibroscan and consultation with the liver unit hepatitis nurse specialists was pre-booked for the patient's convenience.

19. I met Mr Edward Conway for the first and only time on Wednesday 28th November when he attended my outpatient clinic as a new patient. Mr Conway attended with his sister Christina McLaughlin and Mrs McLaughlin's son. I have a clear recollection of the consultation and have used both my recollection and the medical records to provide this witness statement.

20. My Specialist Registrar was also present in the consultation room and witnessed the consultation.

21. I found Mr Conway to be a relaxed and pleasant man who seemed happy to be at my clinic to discuss his care and treatment.

22. Despite this, I found the consultation challenging and stressful due to the presence of Ms McLaughlin who appeared upset from the outset of the consultation.

23. During the consultation, Mrs McLaughlin raised a number of issues. These included:

    a. Mrs McLaughlin raised concerns about the care afforded to her late brother Seamus Conway.
    b. Mrs McLaughlin raised vociferous concerns that her brother had been labelled as a non-attender at our service.
    c. Mrs McLaughlin also raised concerns about the presence of and reason for Mr Conway's cognitive dysfunction demanded I arrange a CT scan of Mr Conway's brain.
    d. Mrs McLaughlin requested that I print out all of Mr Conway's blood results during the consultation and furnish them to her.
    e. We discussed Mr Conway's current liver related health, including blood tests and ultrasound result with subsequent discussion about oral therapy for Mr Conway's hepatitis C.

24. I offered my condolences regarding the passing of their brother Seamus. I explained the consultation on that day was to discuss treatment for Mr Edward Conway and offered Mrs McLaughlin and Mr Conway the Belfast Trust formal complaints process, which they declined.

25. Mrs McLaughlin appeared angry about a letter my consultant colleague had written following an appointment cancelled by the hospital in May 2018. The letter indicated Mr Conway had failed to attend and had been discharged. I explained that I did not have all the information required to explain the sequence of events during an outpatient consultation.

26. It has subsequently become clear that Mrs McLaughlin was correct in respect of the May 2018 appointment and Mr Conway was not at fault in any way for non-attendance on that occasion. Moreover, the liver unit accepts it should have rescheduled a further appointment following the cancellation without the need for Mrs McLaughlin sending a further email.

27. Mrs McLaughlin also wanted to discuss Mr Conway's cognitive function in detail. I explained I was not an expert in cognitive function. Mrs McLaughlin wanted me to agree that Mr Conway's cognitive impairment was definitely due to hepatitis C. I was unable to do so for a number of reasons.

28. Mr Conway was diagnosed with Korsakoff's syndrome in Altnagelvin Area Hospital in July 2009 by Consultant Psychiatrist Dr Hussein. In addition, consultant Neurologist Dr Mark McCarron also assessed Mr Conway in September 2009. Dr McCarron did not give a clear diagnosis but indicated there was a possibility of ischaemia or pontine myelitis. I refer to **Exhibits WITN3178006 and WITN3178007** being letters of correspondence from Altnagelvin Area hospital.

29. I have been unable to find a previous mention of vascular dementia as a possible diagnosis in Mr Conway's medical records and Mrs McLaughlin did not raise that as a possibility during the consultation of November 28th or in subsequent email correspondence. Mrs McLaughlin repeatedly told me that Mr Conway had encephalopathy due to hepatitis C.

30. Further, Mrs McLaughlin sent another email to the hepatitis network on 5th December 2018. I refer to **Exhibit WITN3178008** being the email, which was forwarded to the liver unit consultants. It can be seen in this email that Mrs McLaughlin was very

focused on the possibility of hepatic encephalopathy being the cause of cognitive dysfunction and there is no mention of vascular dementia.

31. Hepatic encephalopathy is a clinical syndrome whereby ammonia accumulates in the blood stream due to a failing liver. The ammonia subsequently affects the speed at which brain cells function. It is diagnosed with a clinical examination and there is no role for CT imaging in confirming the diagnosis. Mr Conway did not have a failing liver and displayed no features of hepatic encephalopathy.

32. I do not believe I have disagreed with Mrs McLaughlin's assertion that Mr Conway has vascular dementia. The first time I have seen vascular dementia raised as a possible diagnosis is in her witness statement to the Inquiry.

33. I was clear during the consultation of November 28th 2018 that I was not an expert in memory loss or cognition.

34. Mrs McLaughlin left the consultation room while I examined Mr Conway in the presence of my specialist registrar. Mr Conway scored ten out of ten on an abbreviated mini-mental state examination, had no abnormal eye movements and demonstrated no evidence of a liver flap (a flapping tremor of the hands which is a physical sign of hepatic encephalopathy) . He was not jaundiced and had no other features of liver decompensation.

35. Mr Conway was clear he did not want further tests such as a CT scan of his brain and contrary to Mrs McLaughlin's assertion in her witness statement; I did not agree to arrange a CT scan and have not done so.

36. Mrs McLaughlin also asserts that I did not want to furnish her with copies of Mr Conway's blood results.

37. I can confirm Mrs McLaughlin asked for copies of Mr Conway's blood results and indicated she wanted to use these as evidence for the Contaminated Blood Inquiry.

38. I explained to Mrs McLaughlin and Mr Conway that there was a process for obtaining access to medical records including blood results. In addition, due to time constraints, it would be impossible for me to print out all of Mr Conway's blood results during the outpatient clinic.

39. Nonetheless, I brought a series of Liver function tests and alpha fetoprotein result up on the computer screen in the consultation room. I printed these results on the printer in the consultation room.

40. Mrs McLaughlin refers to **Exhibit WITN2778003** being a copy of Mr Conway's liver function test blood results extending over the period February 2016 to September 2018 inclusive. Mrs McLaughlin incorrectly states I did not want her to see these and that she obtained them from a nurse on the way out of the consultation unbeknown to me.

41. The blood results in **Exhibit WITN2778003** include the name of the health care professional, user log-in name, date and time at which the blood results were printed from Mr Conway's Northern Ireland Electronic care record (NIECR). This clearly shows Johnny Cash, jcash001 printed the blood results on 28 November 2018 at 15:03:56.

42. Jcash001 is a unique user identification code for NIECR for which only I know the password.

43. I can confirm that I personally printed the blood results in the consultation room and handed them to Mrs McLaughlin myself. My specialist registrar witnessed this. There will undoubtedly be a digital record to confirm the blood results in **Exhibit WITN2778003** were not only printed by me, but printed by the printer in room 1 of level 6B outpatients, Royal Victoria Hospital; The room in which the consultation took place.

44. I therefore refute the allegation that I refused either Mr Conway or Mrs McLaughlin access to blood results. I refer to **Exhibit WITN3178009** being the blood results printed by me for Mrs McLaughlin and initially submitted as an exhibit by Mrs McLaughlin. On this occasion, the exhibit contains highlighting drawing attention to the text confirming who prepared and printed the results.

45. Mrs McLaughlin and Mrs Patricia Kelly also assert that I had explained "all was looking good with Eddie's liver" based on the ultrasound scan report.

46. Mrs Kelly was not present at the consultation and I have never met her.

47. I can confirm I explained to Mrs McLaughlin and Mr Conway that the ultrasound scan had been reported as showing a smooth liver with normal spleen and no definite evidence of cirrhosis. The liver texture was slightly coarsened but that is a non-specific finding and a Fibroscan later in the day would clarify if there was underlying fibrosis or cirrhosis so I did not mention this. I used the description "there is no definite evidence of cirrhosis on the ultrasound scan". I refer to **Exhibit WITN31780010** being the typed written Ultrasound scan report.

48. I went on to clarify that Mr Conway still needed to undergo a Fibroscan following the consultation as it was a more sensitive test to detect scar tissue in the liver. Indeed, I clarified that Mr Conway would remain under follow-up with our team if the Fibroscan revealed cirrhosis.

49. The Fibroscan subsequently confirmed Mr Conway had cirrhosis of the liver (liver stiffness 15KPa). The term "advanced cirrhosis" is not a term I would expect a colleague to use to describe a liver stiffness score of 15KPa.

50. In paragraph 22 of Rosemary Devine's statement she asserts Mr Conway's care has been neglected with a lack of monitoring and scans.

51. I met Mr Conway for the first and only time in November 2018 and the appointment in May 2018 was not for my clinic. I have described the events surrounding the appointment of November 2018 above.

52. I took up a consultant post at the liver unit in August 2010. Mr Conway had previously attended the regional liver unit in 2004. At that time consultant hepatologist, Dr Neil McDougall had recommended treatment with pegylated interferon and ribavirin. The treatment was to be administered via the haemophilia clinic. Mr Conway did not attend three subsequent appointments at the liver clinic in 2005 and no further appointments were arranged.

53. In addition, I have described the interaction between the liver unit's team and Mr Conway since 2016 in detail above.

54. Regular monitoring and scans are important aspects of clinical follow-up for patients with chronic hepatitis C. Nonetheless, for a patient such as Mr Conway the only definite way to prevent progressive disease in the liver and ultimately cirrhosis is eradication of the hepatitis C virus and maintaining a healthy lifestyle.

55. Because of the concerns raised in Mrs McLaughlin's email of December 5th, the Belfast trust have undertaken an internal review of the care provided by me and the hepatology service. Deputy medical director Dr Chris Hagan and clinical director Dr Neil Patterson (consultant gastroenterologist) undertook these reviews. I refer to **Exhibits WITN31780011 and WITN3178012** being their written reports.

Section 3: Other Issues

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 6/11/19

Table of exhibits:

Date	Notes/ Description	Exhibit number
21/5/19	Dr McDougall's letter dated 15th July 2016	**WITN3178003**
21/5/19	Email received from Dr Gary Benson dated 5th may 2017	**WITN3178004**
21/5/19	Email received by liver unit from Mrs McLaughlin dated 7th November 2018	**WITN3178005**
21/5/19	Dr Mark McCarron's letter of Neurology assessment dated 30th September 2009	**WITN3178006**
21/5/19	Altnagelvin Area hospital discharge letter including summary of Dr Hussein's diagnosis dated 11th July 2009	**WITN3178007**
21/5/19	Email received by liver unit from Mrs McLaughlin via NI hepatitis network dated December 5th 2018	**WITN3178008**

21/5/19	Blood results printed for Mrs McLaughlin	**WITN3178009**
21/5/19	Typed ultrasound report of November 28th 2018	**WITN3178010**
21/5/19	Dr Chris Hagan, Deputy medical director BHSCT. Review of care of Mr Edward Conway by liver unit	**WITN3178011**
21/5/19	Dr Neil Patterson, clinical director BHSCT. Review of care of Mr Edward Conway by liver unit	**WITN3178012**