Witness Name: Stephen Greener
Statement No.: WITN3330001
Dated: 06/09/2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF Stephen Greener

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 8th May 2019.

I, Stephen Greener, will say as follows: -

Section 1. Introduction

1. My name is Stephen Greener. My date of birth is GRO-C 1939 and my address is known to the Inquiry. I am the son-in-law of John William Horsnell who was diagnosed with HCV in 1993/94 as a result of a blood transfusion and died as a result of cirrhosis of the liver in GRO-C 2005. I intend to speak about how John was infected, how the illness affected him and our family, and in particular, the treatment and care he received at The Diana, Princess of Wales Hospital in Grimsby.

2. I confirm that I do not have legal representation and do not require anonymity.

Section 2. How Affected

3. The following statement is based on notes, records, and research made by me during the period 1992 and 2005. I kept these notes to expose the incompetence shown by the staff at the Diana, Princess of Wales

Hospital in Grimsby, which I believe caused the death of my father-in-law. No action has been taken by the family since 2005 out of respect to Joan, John's widow, who declined to provide her support. Joan died in 2016. The remaining members of John's family welcome the opportunity to make the facts available to the Inquiry in anticipation of contributing.

4. John was admitted to Diana, Princess of Wales, Hospital in Grimsby, Lincolnshire in 1992, having been diagnosed with benign colon cancer, where he was under the care of Dr Donaldson.

5. An operation was performed to remove diseased tissue, and the surgery appeared to be successful. However, a few hours after waking from anaesthetic, hospital food including ham sandwiches, were given to John despite the day-old internal sutures. Within twenty-four hours, the sutures ruptured and John was re-admitted for emergency surgery where he received a blood transfusion.

6. This time the hospital staff felt it prudent to avoid the damaged area, which was sealed off to allow it to heal, and so John was given a colostomy bag. The colostomy bag was a constant source of irritation for John, and so after further appointments with Mr Donaldson, he persuaded the doctor to perform a reversal. The procedure was successfully completed in 1994.

7. During this period, John regularly attended hospital and GP appointments where blood samples were routinely taken for undisclosed reasons.

8. In 1994 John, was asked to attend a hospital appointment with Dr Moss at the Gastroenterology Clinic, where he told John that he had been infected with Hepatitis C. Dr Moss told John that it was likely that he had been infected by a blood transfusion during one of the previous surgeries.

9. Dr Moss offered no treatment and provided no advice on how to manage the virus. Nevertheless, he did issue a blunt warning to John for all other

members of his family not to use his toothbrush or share hand towels. This was the only verbal advice offered to John by Dr Moss.

10. John then continued his regular appointments and medical monitoring for the next five years.

Section 3. Other Infections

11. I do not believe that John received any infection or infections other than HCV as a result of being given infected blood products.

Section 4. Consent

12. John was treated without any information being provided to him to solicit his approval. He merely trusted completely the clinicians from the onset, and like the vast majority of patients, would have been intimidated by their own ignorance of the medicines and procedures used.

Section 5. Impact

13. In 1999, John was diagnosed by his GP as being diabetic, suffering from type 2. He was provided with insulin tablets. Within months the diagnosis was changed to type 1 and John then had to self-inject insulin.

14. For the first time, a dietary regime was introduced into his medical programme. According to a NHS leaflet issued to the public at the time, blood sugar levels should ideally be around 4.5. To achieve this figure, only sugar and starch food intake should be controlled, whilst fat consumption was of no importance. A more detailed leaflet to the same effect was given to him by his GP medical team.

15. At that time, John was not referred by his GP, nor by Drs Moss or Donaldson, to the diabetic clinic at the Hospital run by Dr Adiotomre.

16. John had difficulty managing his injection routine. Therefore, to make his quality of life better and more comfortable, I suggested that John might benefit from the use of a personal insulin pump. In an attempt, to achieve this he requested to be referred to the hospital's diabetic clinic.

17. Dr Adiotomre saw John on a first and only appointment. Without clinical analysis or further investigation Dr Adiotomre casually dismissed the insulin pump as inappropriate, and merely made a further appointment for John in six month's time. John attended the appointment alone, but his surprise at the lack of detailed consultation by Dr Adiotomre regarding the employment of the insulin pump was conveyed to me by John and so I have included it in my statement.

18. In the late summer of 2003, John suddenly collapsed at home, vomiting blood. He was admitted to C5 ward (emergency admissions) under the care of Dr Woosnam. He was diagnosed as having suffered a burst vein in his oesophagus. Dr Woosnam prescribed a beta blocker, told him to drink no alcohol, and discharged him a few days later.

19. In early 2004, John was told that he had an infection in his urinary system and was given repeated doses of antibiotics but the problem persisted. His medical team appeared baffled by John's ever-present gross haematuria. Apart from the suspected urinary infection, no other investigation or diagnosis of any kind was made and the problem persisted uncontrolled.

20. In early 2005 lethargy began to appear into John's life. He lost the will to go out as before. Added to the tiredness, he suffered from painful callosity of both feet partly due to diabetes. This condition compounded his unwillingness to venture out of doors. The lethargy worsened to an extent he was sometimes barely able to feed himself; he was twice referred to his GP but despite a lengthy examination no diagnosis was made.

21. In September 2005, he was unable to get himself to bed and was again hospitalised in C5 for observation. Again, he was discharged within a day or so and no new medication was prescribed.

22. This cycle of collapse, of C5 re-admission, and of rapid discharge was repeated on two further occasions.

23. In November 2005, he was hospitalised for the fourth time. This time, his medical team, still under Dr Woosnam, tried to determine the cause of his problem. John's haematuria persisted. Nursing staff observed that John had a swollen abdomen and sent him for a scan believing that John may be suffering from an obstructed bowel, but the scan proved to be negative. Other diagnostic theories were introduced. These included a series of mini-strokes (to explain his lethargy), for which he was scanned on his head, throat and chest; and then epilepsy, for which he was prescribed medication. He was also prescribed diuretics for his swollen abdomen.

24. During this time I witnessed Dr Woosnam attempting to comfort her patient by sitting at his bedside, stroking his hand and declaring to him: "You are a mystery to me"!

25. After two weeks in C5, John's condition worsened. He lost weight and kept lapsing into prolonged comas. Dr Woosnam's team called these comas "vacant episodes" and were baffled by them. Many further blood samples were taken from him; he was also sent for an MRI scan. All these investigations came to nothing and two weeks later John deteriorated to an extent I likened his appearance to that of a Belsen survivor. When we visited him he was emaciated, often comatose, white in complexion, and appeared to be on the verge of death. During these periods of unconsciousness, when he was evidently unable to eat anything, no other nutritional intervention was made available for him. Only a saline drip was administered. His appearance began to suggest he was in the process of terminal starvation. It alarmed all members of his family.

26. On behalf of John's family, I began to question the Hospital's care of their patient. The obvious first concern was that of his nutritional requirements and whether John should not urgently be prescribed a food supplement in liquid form at least by nasogastric tube.

27. Enquiries were made from my local pharmacist. He produced a liquid called Fortisip, claiming the hospital caring for the patient should already have prescribed the product as a matter of routine. Fortisip is specifically designed for patients with disease related malnutrition.

28. I referred Dr Woosnam to it. She casually indicated she did not object to prescribing it to John. Despite my offer to pay for the product, Dr Woosnam insisted the hospital would fund it. I stressed the matter was now extremely urgent and she undertook to make supplies available the very next morning.

29. On that day I checked with nursing staff whether John had indeed been given the Fortisip, but was told he had instead been given a high energy drink by the dietician. Upon questioning the dietician later that day, she revealed the Hospital had only two sample bottles of Fortisip in stock and was waiting for a delivery. I now regret I failed to obtain the name of the dietician.

30. I found this difficult to believe. Accordingly, I checked this information directly with the Hospital pharmacy which informed me, to my surprise, the Hospital had ample supplies in stock, and in various flavours. This information was immediately relayed back to Dr Woosnam's secretary. The next morning John had been given his first prescription of Fortisip.

31. Within twenty-four hours, John was sitting up in bed and chatting to nurses, wide awake and seemingly full of energy. Still nourished by the product his pleasing progress continued for the next three days. His "vacant episodes" disappeared altogether and he continued to gain strength, and began to put back on some weight and facial colour. During this period he also started to eat diabetic hospital food again.

32. But, instead of waiting at least a week for John to begin recuperation from his starvation, Dr GRO-D, under Dr Woosnam, ordered physiotherapy. The next day, after the therapy, John was rushed in an emergency to a High Dependency ward suffering from a burst stomach ulcer. Predictably he was back on the regimen of a saline drip with no food taken by mouth of any kind. To my deep concern and frustration his health began to deteriorate again.

33. I now began seriously to doubt the competence of each and every member of the medical staff, including Dr Woosnam herself. I could not understand the reason why these individuals, jointly and severally, had not reached the same obvious and basic conclusion as myself, that John was dangerously undernourished. Nobody other than myself saw fit to do anything about it. To my surprise, his positive response to the Fortisip seemed to amaze his medical team.

34. Although the Hospital pharmacy had existing and ample stocks of Fortisip, no prescription had been previously made for him by any one clinician. I believe, had I not intervened, John would certainly have lapsed into a deep coma and died.

35. I also failed to understand the reason why I had been given incorrect information by the dietician about the stock of Fortisip in the Hospital pharmacy. I asked myself whether the dietician had actually checked stock levels as I had done. Had she done so, she would have received the same answer as I had been given. But the very specific response she had given to me could not have been an error. It was an obvious fabrication.

36. An attempt at explaining the reason for her having lied about Fortisip stocks is now highly relevant. Firstly, at best, the fabrication resulted from reckless indifference. As a caring professional, however, she should have been aware of the existence of the product; if she was not she did not bother to require clarification from me before making enquiries. Furthermore, her training must have included the effects of

malnutrition and its ensuing symptoms; she therefore should have recognised them instantly in John's appearance and have responded urgently.

37. If Dr Woosnam had, herself, overlooked John's appearance, the dietician should have directly reported them to her without delay and my intervention would have been unnecessary. If no such report at all was made, then coupled with her fabricated response to me, the combination of the two indicates reckless indifference in discharging her professional duties. Secondly, at worst, if the dietician had indeed reported her observations, she must have then been instructed to take no action; her response to me was made in support of senior staff.

38. I now believe without any doubt at all that this fabrication was intentional. I suspected the dietician had collaborated with other medical staff all of whom were under instruction not to provide the Fortisip or any of its equivalents to prosecute a conspiratorial strategy to let him "slip away" by controlled passive neglect. I felt relieved at having temporarily thwarted this conspiracy. But, as if on cue, and to overcome their temporary setback, the team's strategy changed within hours to one of active participation in John's demise.

39. In spite of his slowly improving condition, John was still barely strong enough to lift his arms level and feed himself. But, having visited him regularly on their rounds, and thus being fully acquainted with his weak condition, Dr GRO-D, Dr Woosnam's junior, instructed John to have the physiotherapy.

40. Dr GRO-D must have been aware of the danger of increasing John's blood pressure by exercise and exposing him to the risk of internal injury (knowing he already had had a burst vein in his oesophagus and for which he was still prescribed beta blockers). This change to an active strategy worked with predicted effect and, as previously indicated, John was admitted in emergency to the High Dependency ward, with a burst ulcer, immediately after just one physiotherapy session.

41. The conspiracy was completely exposed and was confirmed in what followed. During his stay in HD, my wife Ruth, (John's daughter), and I had an opportunity to speak briefly with Dr Woosnam who, without warning, bluntly announced John was very seriously ill and that nothing further could be done for him. His problem, according to her, was not a nutritional one and he could die at any moment. She did not elaborate further. Joan, John's wife, was fortunately not party to that conversation. But about the same time, together with her sister Sally, Joan had a separate meeting with a Dr Adams in HD which I will refer to in paragraph 51.

42. The revelation made by Dr Woosnam about John's parlous state of health came as a shock to all of us. For the first and only time we were made aware of John's condition but not the reason for it. We began to question what indeed was causing his decline as we knew his only known disease, the diabetes, on its own was not so chronically deleterious.

43. I, together with John and his family were all aware of his HCV infection since the declaration by Dr Moss in 1994. Whilst the presence of the disease was acknowledged, the information relating to the insidious and chronic progression of this fatal agent was deliberately withheld from John both by Dr Moss, but seemingly, also by John's GP during the ensuing five years when John attended his many GP clinics. I am confident that Moss having discharged John from hospital care in 1994, his GP must have been given the hospital notes which contained the HCV information. I have, therefore, no knowledge as to why the GP failed to pursue this alarming information and act on it immediately. One evident explanation in the GP's defence is that he was deliberately not made aware of it. Woosnam's C5 ward evidently were unaware of John's infection at the time he was readmitted in 2005.

44. During his recuperation in the High Dependency ward, John had his ulcer treated with steroids, which were administered by nasal tube

directly into his stomach. A few days later, John was released back into C5, but this time in an isolation room.

45. To add to John's mysterious life-threatening illness, and to reduce his chances of survival still further, hospital nursing staff then announced that John had contracted MRSA. Back in C5, in isolation, visitors had to wear plastic aprons and rubber gloves, but hospital staff did not, except on rare occasions.

46. Whilst John was sometimes alert, it was obvious that he had suffered a significant relapse in overall strength. Further to his general discomfort, he was now suffering from severe bedsores. So painful were the sores, nursing staff administered painkillers and even, on some occasions, on their own admission, injected him with morphine. Immediately after the last such injection, John lapsed into a deep coma.

47. When John awoke from his coma, two days later, he requested an immediate referral to another gastroenterologist, Dr Naqvi. I made the request on his behalf only to be told Dr Naqvi was on leave for three weeks until after the Christmas holidays. In order not to waste time we had no choice but to fall back on Dr Moss, and I requested John's transfer to him.

48. Although Dr Woosnam verbally agreed to the transfer, Dr GRO-D continued to be prominent in John's care for the next few days. Now, under my scrutiny, John was apparently recovering from MRSA. He was actually being fed by tube with a Fortisip equivalent. The MRSA was of nasal location and according to nursing staff, was being treated with antiseptic cream.

49. A few days later, to our astonishment, we were informed John's MRSA had cleared completely, but he was nevertheless retained in isolation. I had come to understand MRSA infection was extremely difficult to overcome and the family had braced itself for the inevitable consequences. But, the news that John was clear of MRSA within such

a short period, instead of causing relief, further fuelled my suspicion that his isolation was organised because of HCV, and not for MRSA.

50. Without warning, and as if to prepare for the next part of the secret agenda, Dr GRO-D casually announced to me in the presence of Joan, that John's family had agreed that John should not be resuscitated in the event of his falling into a coma from which recovery was deemed unlikely. Shocked, and in disbelief, we both vehemently denied such a consent had been approved.

51. In his defence Dr GRO-D produced a document from John's medical file, hand-written by Dr Woosnam, indicating her authority for the non-resuscitation. I demanded to see her immediately, but was told she was absent on that day.

52. Later the same day, Dr GRO-D as if to defend Dr Woosnam, voluntarily produced a further A4 sheet of notes, this time hand-written and signed by a Dr Adams. The notes indicated she had fully explained the situation, had consulted with members of John's family, and had confirmed that all agreed with unconditional non-resuscitation.

53. Joan well remembered the meeting that she had had with her sister and Dr Adams. Not only did Joan emphatically deny having agreed with John's non-resuscitation, but also denied that subject was indeed raised at all. The meeting according to her was an informal verbal report by Dr Adams on John's progress whilst in the HD ward.

54. When I read the document, I commented that it did not bear Joan's signature and the matter was now Dr Adam's word against Joan and Sally's. I asked Dr GRO-D for a photocopy of Dr Adams' document. Predictably, I have never received it.

55. It is my view that this documented intention to commit euthanasia (manslaughter) on a named person, with or without their family consent, which is in itself unlawful. It makes Dr Adams liable to criminal prosecution. I found out later that Dr Adams was a junior member of Dr Moss' team. I now believe her document was written and produced after

a secret consultation with Drs Adams and Woosnam whilst John was in HD ward.

56. The meeting would have confirmed John's hopeless condition and perhaps revealed to Dr Woosnam, for the first time, his HCV infection. There is only one logical way of looking at this. I believe, because of the appalling state of the Hospital administration, patient's records were in disarray. It followed that Woosnam would not have known of John's infection simply because of his admission eleven years previously. This time element alone would have contributed significantly to the record system's disarray. It is my belief it took examination by the HD ward to discover John had HCV and Dr Adams then passed this information on to Woosnam who immediately organised her team to place John in isolation. This knee-jerk reaction was made under the guise of an MRSA infection whilst plans were then put into operation as to what to do next. It follows from that reaction that Woosnam did not know of the HCV, for had she been aware of it from John's first admissions to her Ward C5, she would not have contemplated the risk of infecting other patients nor indeed her own staff. Thus, she had permitted his re-admission on three previous occasions, but the last one of which John was put and kept in isolation until his death. The document was then inserted into John's file to pave the way for his planned demise when the moment was deemed appropriate. When John was transferred from High Dependency he was immediately put in isolation in C5.

57. Two days later, I attended a meeting with Drs GRO-D and Seeva, a locum consultant standing in for Dr Naqvi. Dr Seeva attempted to soften the blow of the planned manslaughter subject by struggling to explain that some undisclosed invasive clinical interventions and procedures would not be suitable for John in his fragile condition. Otherwise hospital staff would, according to him, of course continue to fight for his survival. I pointed out that Dr Adams' written document had remained silent on all these procedural options, and in spite of Dr Seeva's reassurances the family's conviction of an hospital manslaughter agenda remained.

58. The solution to John's mystery illness began when a hospital nurse informed me that John's swollen abdomen was ascites. This information was made available to me whilst John was in isolation in C5 Ward. It confirmed what HD had discovered that the cause of the ascites was cirrhosis. The cirrhosis itself was to be passed off ultimately as the result of chronic liver failure. This explanation, but omitting of course the underlying reason for it, was included in John's original Death Certificate. Ascites is caused by cirrhosis of the liver, which in turn is caused by the HCV, which we were told he had contracted. The "vacant episodes" were in fact hepatic encephalopathy, a condition symptomatic of cirrhosis.

59. On the 20th December 2005 John suffered further internal bleeding from an undisclosed source. Whether it was a new rupture or the compromise of one or other of two existing wounds, nursing staff did not provide further details. John did not possess the strength to resist any further mistreatment. He died that afternoon.

60. John was an ex-D Day Royal Navy war veteran and not given to complaining nor seeking sympathy. It was therefore difficult to ascertain whether he was in pain or discomfort. He was always positive and cheerful. I can only guess that his ever-increasing ascites severely restricted his breathing, his gross untreated haematuria was a constant source of deep concern, and his occasional vomiting of blood causing some panic, he never demanded an explanation from either his GP nor from the Hospital as to what his problem really was. Regrettably he never sought help from me nor from any one of his family members. He believed completely in his perceived sacrosanct benevolence of the NHS. Decisions made on his behalf by his clinicians were accepted without question. I became involved only when he was weakened to a point of no return and I did so without his knowledge or consent, but also in response to deep concern and alarm from his daughter, Ruth, at his uncontrolled deteriorating condition. His family had no choice but eventually to accept his premature death.

61. My statement is designed to make a contribution to the Inquiry. The emotional effect of John's death on his family is irrelevant. More relevant to us was, and still is, the concern over the insidious nature of HCV itself. John was discharged from Hospital diagnosed with HCV in 1994. Upon his discharge, Moss played down any possible chronic contamination effects by issuing his trivial instructions for the patient's family. But the Hospital, 12 years later in 2006, panicked at the risk of possible general ward contamination by placing John in isolation. This extreme measure immediately also renewed fears in us all of possible contamination within John's family. We were then left to evaluate the increasing risk of HCV transmission by air and dermal contact during the 12 years John had so casually been discharged. The family considered the possibility for each member to be blood screened by the Hospital itself. This would have entailed a GP involvement but only Joan, John's wife, lived in GRO-C. At that time I suspected the GP of collaborating in the Hospital conspiracy of silence and any application to him would have in consequence most probably been declined. Ruth and I both lived in Kent so did Paul, John's son. It was considered by us that to be screened in Kent, and possibly receive a positive result, would have opened another can of worms. The proven source of the contamination would have been impossible to establish had we wanted to pursue the matter. We therefore took a risk and decided not to proceed. But even today, 14 years later after John's death, we all understand and remain constantly aware of the chronic nature of HCV. No advice whatsoever nor assistance of any kind was proffered by the Hospital to John nor his family.

62. No stigma is or was involved. Family members had no choice but to accept John's death and stomach their grief. Apart from contributing to the current badly overdue but very welcome Inquiry, outraged relatives were left imbued at that time with a sense of helplessness. To have pursued it would have entailed a lengthy legal and very expensive process, to say nothing of Joan's reluctance to proceed. We did what we could given the circumstances. John's family members carried on with their lives as before. Educational considerations were not involved.

Section 6. Treatment/Care/Support

63. The suspected source of John's HCV infection was not denied by the Hospital. Dr Moss admitted that it was from an infected batch of blood used in a transfusion. However, despite knowing that John had HCV, he didn't prescribe Interferon or Ribavirin treatment.

64. HCV is a viral infection for which no antibiotic is effective. Control of HCV depends upon a patient's own auto-immune system which is insufficiently effective and must be boosted by Alpha interferon and Ribavirin therapy. Without this therapy, HCV is progressive and lethal.

65. Dr Moss remained silent on the whole subject of this lethal infection. He chose instead merely to issue the hygiene warning for other members of John's family.

66. Had Dr Moss revealed the full extent and nature of John's disease to him and those other family members, there would have been an immediate demand for therapy. The only explanation for Dr Moss' silence must lie in either his own ignorance as to what to do next, or much more probably, the cost to the Trust of the two drugs needed for John and all the other patients.

67. It was public knowledge Interferon was an expensive remedy costing each patient at that time a reputed £13000 per annum. Therefore, with many potential patients all needing the drug at the same time, I believe it would have been financially expedient for the Hospital and for Dr Moss to do nothing at all.

68. A further dimension could have been added to strengthen Dr Moss' decision. I was informed that hospitals usually give patients, having suffered colon cancer (even presumably benign cancer), a survival period of no more than five years. I believe that, in light of this, Dr Moss saw little point in the Hospital paying for the treatment for John.

69. In 2003, when John suffered from the burst vein in his oesophagus and was admitted to C5, medical staff should have referred him immediately to Dr Moss' clinic for specialist gastroenterology care. Instead, John was admitted to emergency admissions in ward C5 under Dr Woosnam and stayed there.

70. Dr Woosnam then either cared for him in complete ignorance of his infected condition, or did so recklessly in full knowledge of it. If the first premise is true, the fault lies in the inadequacy of Hospital patient records. But the second premise if true, is puzzling.

71. Why would Dr Woosnam care for Dr Moss' cirrhotic patient without Dr Moss' involvement, if she knew that he had HCV? If Dr Moss had been informed by her, but had refused (for perhaps understandable reasons) to accept the return of his former patient, it was left to Dr Woosnam to muddle along.

72. Dr Woosnam was half right and made a correct diagnosis of cirrhosis, the cause of the haemorrhage. I now believe the absence of John's records denied her vital information to comprehend the cause of John's cirrhosis. She probably guessed that his problem was alcohol related, which, in any event is the most common cirrhotic cause. Accordingly, she correctly prescribed beta blockers and advised him to consume no alcohol, which is normal for patients with cirrhosis.

73. Later evidence does confirm that Dr Woosnam was not in possession of all John's history. She was mystified by John's encephalopathy and evidently did not know how to manage it. This is clearly supported by evidence of her treating his "vacant episodes" as suspected epilepsy, or earlier, as an unconfirmed series of mini-strokes.

74. Consequently, she failed to give directions to her team to guard themselves, as well as other patients and visitors, against John's highly infectious condition.

75. A hepatic scan, ordered by Dr Woosnam, revealed, perhaps for the first time, the extent of the advancing cirrhosis. The records however were unable to indicate the percentage extent of the damage to John's liver. With this continuing mismanagement, the encephalopathic "episodes" predictably became more frequent.

76. Whilst suffering these episodes, John continued to miss opportunities of ingesting at least some, although inappropriate, nourishment. He was prescribed nothing other than a saline intravenous drip, which understandably made him weaker.

77. Whilst nursing staff monitored his state and made him as comfortable as possible, no other remedial intervention was applied to him. He was thus merely left to deteriorate.

78. The internet also provided a valuable insight into management of patients with these conditions. Some of the information provided is highly relevant in John's case. Hepatic encephalopathy can be caused by undigested animal proteins improperly entering the blood supply and causing a toxic build-up of ammonia in the brain. Obviously, to minimize an onset of hepatic encephalopathy, cirrhotic patients should be fed with no animal protein, and routinely be kept on a strict vegetable low-protein diet. This decline in adequate digestive function is attributable to the advancing cirrhosis.

79. However, no instructions were given to catering staff to provide a diabetic, but strictly vegetarian, diet suitable for his decreasing digestive capability. Records of food given to him, when he was not semi-comatose and able to eat, included the usual daily meat products and milky puddings. It was clear that Dr Woosnam was well out of her depth with John's condition, yet being aware of it, she still did not refer John to Dr Moss.

80. Cirrhosis is irreversible if left untreated, and the degree of damaged tissue directly relates to the patients' digestive performance. Blood is unable to pass and be filtered through the cirrhotic tissue and trapped

veins swollen by normal blood pressure routinely burst in the oesophagus. Ruptures of this kind are classic symptoms of the advancing condition. Furthermore, in this damaged state, the liver can no longer prevent other toxins from entering the bloodstream, toxins which include alcohol and narcotics; they directly intensify encephalopathy.

81. Had she known of these effects, Dr Woosnam should have given clear instructions to nursing staff to only apply analgesic spray to the external area and avoid ingested or intravenous narcotics. If she knew, she failed to review their actions. During his lucid moments John gave instructions to nurses not to give him further painkillers because he instinctively feared their side effects!

82. Ascites is fluid which can be drained periodically to relieve a patient's discomfort and make breathing easier. John was neither offered nor received any such intervention.

83. No counselling nor psychological support whatsoever was offered to members of John's family, let alone myself. I was undoubtedly regarded as a potentially dangerous and troublesome ignoramus. I therefore encountered obstruction, falsehood and obfuscation, and what I later believe to have uncovered, a conspiracy of action designed to protect the reputation of the Hospital and its Trust members. Therefore the very last thing on the Hospital's mind was passively and truthfully to acknowledge any trauma created from its initial negligence.

Section 7. Financial Assistance

84. No approach of any kind was offered by the Hospital Trust, nor any offer of financial assistance ever made to John nor to his wife and family.

Section 8. Other Issues

85. I understand blood transfusions were not routinely screened for HCV after receiving supplies. But Dr Moss' revelation in 1994 that John had contracted the disease would have resulted from screening a number of other surgical patients at that time. The suspected source of John's infection was not denied by the hospital – it was a rogue batch of blood used in a transfusion.

86. John's highly contagious HCV was known about by the hospital since 1994; it should, as a matter of top priority, have been meticulously documented should he have ever needed to be re-admitted. Hospital administration was thus put to the test nine years later.

87. However, the appalling catalogue of error in diagnosis and subsequent mistreatment can partly be explained away by missing hospital patient records and appalling hospital administration.

88. On visits to see John in the hospital, I observed, both in the C5 area and in other wards, open brown folders bearing the names of patients, some as thick as nine inches or more containing loose documents, closed with a single elastic band. These bundles lay on their sides on shelves, chairs, trolleys, and desk tops. Some were piled six high balancing on shelves above stenographers, their bulging open ends on display, others placed under chairs in waiting rooms.

89. Immediate medical access to these critical patient records was evidently compromised simply because of their disarray. No attempt had been made to index them properly, to colour code them, or to centralise them in secure filing rooms for immediate and controlled access. Their confidential contents were available for all (including waiting visitors) to examine.

90. During our attempt to obtain an amended Death Certificate Ruth found a document in a waiting room adjacent to C5 bearing John's name. It had evidently fallen from his file.

91. This documentary shambles is directly responsible for, misdiagnoses; failure to delegate immediately to appropriate departments upon admission; compromises patients' recovery; and wastes hospital resources. It also shows a complete lack of respect to patients and clearly demonstrates the hospital has abandoned its role in delivering effective and urgent patient treatment.

92. Furthermore, the catastrophic disorder also provides uncontrolled opportunities for sinister destruction of certain files, deletion of sensitive documents to disguise error or to divert blame. Any proper investigation or audit of hospital performance is therefore instantly emasculated by the chaos.

93. The inexcusable absence of John's records whilst in Dr Woosnam's care is sadly confirmed by his hospital misdiagnoses and ensuing mistreatment.

94. The Death Certificate signed by a Dr Ahmed, when produced by the Registrar, failed to specify HCV as the cause of the cited "chronic liver disease". The family objected to its omission and requested insertion of HCV by the Hospital.

95. Dr Seeva was still locum consultant at the time; he agreed to add a hand-written note to that effect on the Certificate and signed it. The registrar was unable to accept the Certificate with two signatures and Ruth and I had to return to the Hospital to require a new document.

96. Dr Krishnan, another member of Dr Woosnam's team, was reluctant to produce a new document in spite of him having personally treated John. His reasons were not specified. We indicated we would wait as long as necessary, and if we were faced with continued refusal, we would refer the matter immediately to the Hospital administration for explanation. An hour and a half later he produced the Document properly completed and indicating the HCV.

Statement of Truth

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

Signed _____

Dated _____

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Statement of Truth

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

Signed GRO-C

Dated 6/9/2019