Witness Name: Sandra Elizabeth Carman
Statement No.: WITN3425004
Exhibits: WITN3425005-006
Dated: 3rd December 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF SANDRA ELIZABETH CARMAN

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 3 October 2019.

I, Sandra Elizabeth Carman, will say as follows: -

Section 1: Introduction

1. My name is Sandra Elizabeth Carman and my address is Sheffield Teaching Hospitals NHS Foundation Trust, 8 Beech Hill Road, Sheffield, S10 2SB. My date of birth is GRO-C GRO-C 1969 and my professional qualifications are: BSc in Occupational Therapy, MSc Healthcare Practice, IoD Diploma in Company Direction, Diploma in Human Resource Management.

2. My current role at Sheffield Teaching Hospitals NHS Foundation Trust is that of Assistant Chief Executive. My responsibilities include: Corporate Governance and incorporate the role of Trust Secretary for the organisation.

Section 2: Response to Criticism of GRO-B

3. In responding to these questions I have sought advice from Dr David Smith, Consultant Urologist, Sheffield Teaching Hospitals NHS Foundation Trust.

4. We believe this question relates to a referral to Mr David Smith, Consultant Urological Surgeon at the Royal Hallamshire Hospital. The care and treatment of Mr GRO-B: H was discussed at two multi-disciplinary team meetings around that time. Mr Smith wrote to Mr and Mrs GRO-B in November 2006. That letter is included at WITN3425005. As explained in paragraph one and two of the letter the multi-disciplinary team meeting was unable to establish with any certainty if a nephrectomy would have been curative but the decision was to go ahead should Mr H s chest complications and general health allow.

5. Nephrectomies at Sheffield Teaching Hospitals are routinely performed at the Hallamshire Hospital. However if progressed, surgery for Mr H would have needed to take place at a different hospital location, the Northern General Hospital. On this site provision could be made for access to dialysis. The combination of the limited access to theatre lists, the required provision of a HDU bed due to anaesthetic concerns and the need to ensure dialysis treatment could be provided on site meant that logistically this took some time to organise. The diagnosis of Hepatitis C did not impact on theatre availability for Mr H.

6. We have no reason to dispute this statement and it is regrettable that Mrs GRO-B needed to make numerous telephone calls in order to try to obtain a date for surgery. Mr Smith, Consultant Urologist has provided the following summary with context to the circumstances at that time.

   H *was referred to our service in the summer of 2006, and I saw them in August 2006. CT scans had found a renal mass and chest signs including a pleural effusion. At that time he had chronic renal failure, on haemodialysis, hypertension, dialysis related amyloid, Hepatitis C, polycythaemia, and a previous CVA. His imaging was reviewed in an MDT meeting and I related the findings to* H *and Mrs* GRO-B *. Essentially he had a renal cancer and there was concern about possible spread of metastatic disease to his chest. Subsequent Respiratory advice was inconclusive; and on that basis I discussed a nephrectomy (kidney removal) but being very clear he was a high anaesthetic risk and there was a real likelihood of no cure.*

   His diagnosis of Hepatitis had not increased his risk of renal malignancy, and didn't materially increase his anaesthetic risk, although contributed to his frailty and anaesthetic complexity.

His period of time on haemo-dialysis is recognised as a risk for renal malignant cyst development. I do not recall any other risk factors.

Prior to his planned surgery which took 2-3 months to plan given anaesthetic concerns and logistics of operating at NGH, we performed an up to date repeat CT.
This unfortunately showed further local progression of his renal cancer with local invasion and lymph node metastatic disease. Again reviewed in our local/regional MDT.

I met the GRO-B *'s in clinic 30/10/2006 to explain this scan to them and advise that , with progressing disease that we could not hope to cure, high anaesthetic risk, my changed advice was not to proceed to a high risk operation that wouldn't improve* H *s chance of defeating the now metastatic cancer. I referred them to an Oncologist for further advice in the hope of systemic treatment or palliation. Although at that time* H *had no specific symptoms related to his renal cancer.*

The decision to withdraw the offer of planned nephrectomy was based on this progression of disease in a high anaesthetic risk patient and not related to his Hepatitis diagnosis."

7. The discussions regarding the potential for surgery are covered within the letter written to Mr and Mrs GRO-B on the 13 November 2006 and included at witness evidence WITN3425005. Additional context is provided in a GP letter at WITN3425006 written on 31 October 2006.

8. It was the opinion of the multi-disciplinary team that surgery in the case of Mr GRO-B was unlikely to be curative and with the passage of time this likelihood was further reduced to the point of making surgery futile.

Statement of Truth

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

Signed GRO-C

Dated 3/12/19

Table of exhibits:

Date	Notes/ Description	Exhibit number
13 November 2006	Letter from Mr David Smith, Consultant Urological Surgeon to Mr and Mrs GRO-B	WITN3425005
31 October 2006	Letter from Mr David Smith, Consultant Urological Surgeon to Dr GRO-B (GP)	WITN3425006