Witness Name: Tracey Gillies
Statement No.: WITN6932043
Exhibits: WITN6932044-055
Dated: 8th March 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF TRACEY GILLIES

I provide this statement on behalf of NHS Lothian in response to the request under Rule 9 of the Inquiry Rules 2006 dated 13 September 2022.

I, Tracey Gillies, will say as follows: -

Section 1: Introduction

1. **Please set out your name, address, date of birth and professional qualifications**

   My name is Tracey Gillies, my date of birth is GRO-C 1966, and my professional qualifications are MBChB FRCS. My address is NHS Lothian, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

2. **Please set out your current role at the Lothian Health Board and your responsibilities in that role.**

   My current role is as Executive Medical Director with consequent responsibilities and as Responsible Officer for NHS Lothian.

3. **Please set out the position of your organisation in relation to the hospital/other institution criticised by the witnesses (for example "NHS Foundation Trust ('the Trust') operates from Hospital X and Hospital Y (formerly Hospital Z)").**

NHS Lothian is responsible for healthcare provision for the population of the Lothian area.

Section 2: Response to Criticisms by W2317

4. **The criticisms the Board has been asked to respond to are set out at page 2, paragraph 7 and page 6, paragraph 19 of the first witness statement of W2317 which state:**

Paragraph 7

"In April 1986 when I was seventeen, I was involved in a car accident where I suffered an injury to my spleen. I went to the Edinburgh Royal Infirmary and was admitted onto the Haemophilia ward and treated by Dr Ludlam. During this time I remember a nurse came to my bed with a big bag of blood. I had never been given blood in my life, it had always been Factor VIII. I asked the nurse what it was for and I remember she said it was just a precaution. I remember this well because I was on the phone to a friend at the time and I told him I had to go because I was being hooked up to be given blood. I later made an insurance claim regarding the accident GRO-B GRO-B GRO-B ***The solicitors wrote to the Haemophilia Department to confirm my treatment following the accident. The solicitor then advised me that the hospital letter that they had received which I refer to as WITN2317002 stated that I had not received a blood transfusion. I could not understand at the time why they would lie about this. I clearly did receive a blood transfusion, I remember it so well. Reviewing the medical records now, the situation is complicated further as immediately after the letter which I have exhibited, there are a number of pages that have been blacked out."***

Paragraph 19

"I have cirrhosis of the liver as a result of having hepatitis C. I recall that my liver results were as such in the early 1990s that I was advised that I had cirrhosis in 1993. I exhibit a reference to this as WITN2317007. I cannot locate the record that this list refers to though and there are no other entries in my medical records that refer to cirrhosis until 2012. I was officially told by a Registrar at Edinburgh Royal Infirmary in 2012. I exhibit a letter dated the 6th September 2012 as WITN2317008. My health has deteriorated recently very rapidly so every day is a

constant worry. My gallbladder has been removed now and I believe this is as a result of the cirrhosis caused by the hepatitis C."

In my role as UK IBI lead for the Board I received the aforementioned Rule 9 Request of 13 September 2022. I identified Professor Peter Hayes and Professor Christopher Ludlam, treating consultants of the witness, as the most appropriate people to consider and respond to the criticisms made. They have now done so and their responses are set out below, in their own words.

Response of Professor Christopher Ludlam

I have been provided with a copy of W2317's Lothian Health Board case notes. The following is a description of those parts of the records that pertain to the above statement.

W2317 was seen by Dr Craig (Registrar in Haematology) in the afternoon of 21 April 1986 having been a front seat passenger in a car which was hit from the side at a road junction at 9.30 pm the previous day. He reported sustaining a whiplash injury but no injury to his head. He had pain in his right neck and had taken 5 bottles of factor VIII concentrate at 2 pm on 21 April.

On examination the case notes record there was possibly a little swelling of his right trapezoid muscle of his neck with some pain on neck movements. Some tenderness was noted over his 3 and 7th ribs.

X-rays did not reveal any bony injury.

He was treated on my advice with factor VIII concentrate 1000 units at 5.30 pm and recommended to have further similar treatments at 10 pm and 6 am. It was recommended that he stay in hospital for observation. W2317 (who was accompanied by his mother) refused to stay as he had a job interview the following day. Before he left he was given 1000 units factor VIII and he agreed to treat himself at home. He agreed to return the following day for review.

On 22 April 1986 I personally reviewed W2317 and noted that his main symptoms were pain over his left lower ribs and stiffness in his neck. Examination of his neck revealed

it to be a little stiff. On abdominal examination there was some tenderness and fullness in the left upper quadrant.

Because of the possibility of a splenic haematoma I recommended an abdominal ultrasound, along with a factor VIII level and haemoglobin estimation, and continuation of his factor VIII therapy. I suggested that he should be crossmatched for blood (in case of a splenic haematoma or rupture).

His ultrasound revealed a slightly bulky spleen with patchy echoic areas, which had been noted in a previous ultrasound in October 1984 but they were possibly a little more obvious. There was no evidence of a haematoma.

He was admitted to the Royal Infirmary for observation. His medical notes record that on systematic enquiry he reported some left sided pleuritic pain, but no other respiratory symptoms.

On examination he looked well but clearly had some neck discomfort. Pulse was 65/min and blood pressure 115/62. There was some tenderness over his left ribs in the mid axillary line. Some tenderness was noted on the left side of his abdomen, but his spleen was not palpable.

The plan was to observe him in hospital for a few days in case he had a splenic injury and continue his regular infusions of factor VIII concentrate.

His haemoglobin was 16.1/dl (normal) and he was cross matched for '3+3 units' by the ward doctor (this requests 3 units of blood be sent to the ward, and 3 units should remain in the blood bank. This would allow him to be given a blood transfusion quickly if his spleen should rupture, which can give rise to torrential haemorrhage).

In W2317's volume 1 of his case notes there is evidence that he received a unit of blood on the evening of 22 April. The Blood Transfusion Service Mount Sheet (with what looks like the initials of two individuals (possibly nurses) records an O+ until of blood (pack 2268124) (WITN6932049). The Fluid Balance Chart for 22 April (WITN6932050) records 'RCC 1 unit, 350 ml' being administered at 20.00 hr over three hours (RCC – red cell concentrate). There are initials in the column headed Dr's Initials against the entry at 20.00 hrs. There is also a Chart of pulse, blood pressure and temperature starting at 20.00 hrs for several hours (this is standard practice during a

blood transfusion so as to detect any reaction to the blood early) and the daily pulse, blood pressure and temperature chart (WITN6932054). The nursing notes record a 'Blood transfusion commenced at 8 pm' (WITN6932051). The narrative hand-written medical records (WITN6932055) make no mention of the blood transfusion.

His left upper quadrant abdominal symptoms and signs continued and a further ultrasound on 25 April did not demonstrate any haematoma. At this time his haemoglobin was 15.9 g/dl (normal). The symptoms settled and he was discharged on 1 May 1986.

He was readmitted on 4 May 1986 with a history of several small haematemesis. He still had some left upper quadrant tenderness. Investigation revealed duodenitis from which he may have bled. His symptoms settled with therapy.

In summary

W2317 was involved in a car accident on 20 April, attended the Royal Infirmary on 21 April when he was assessed. He had a possible small injury to his trapezoid muscle in his neck. He was treated with factor VIII concentrate but declined to stay for observation. He returned the following day when it was noted that he had some abdominal discomfort and there was concern that he might have had an abdominal bleed. His haemoglobin, pulse and blood pressure were all normal. He appears to have received a unit of red cell concentrate on the evening of 22 April. His car injury symptoms eventually settled and he was discharged on 1 May. There is no record in his narrative medical record of him being prescribed blood nor any apparent reason as to why he had received it. The discharge summary does not mention the transfusion of red cells (WITN6932052)

Comment on his management

From the records I consider that he was assessed and investigated appropriately following the road traffic accident. The regular treatment with factor VIII concentrate is recorded. It is not clear why he was given a unit of red cell concentrate on the evening of 22 April as there was no apparent clinical or laboratory evidence of acute bleeding.

Response to paragraph 7 in the Statement

Prior to writing the letter to GRO-B (WITN2317002) on 17 October 1986, I would have reviewed the Discharge Summary from the April admission (WITN6932052) and the narrative handwritten medical notes (WITN6932055). Neither of these record that W2317 received a blood transfusion. The charts recording his transfusion would have been filed with the nursing notes and I would not routinely have reviewed these. It is unlikely that I knew of, or would have suspected, that he received a blood transfusion because there was no objective evidence that he had an intraabdominal bleed. I did not state in the letter that he did not receive a transfusion. It appears that the solicitor told W2317 that he had not had a transfusion, although this is not stated in the letter.

Response of Professor Peter Hayes

This is a statement, written by Peter Clive Hayes (DOB GRO-C 57) Professor of Hepatology and Honorary Consultant Physician at the Royal Infirmary of Edinburgh. I am replying regarding the Rule 9 request, W2317- namely the paragraph 19 on page 6.

The criticism is that he claims to have been told he had cirrhosis in 1993 but there wasn't any record of cirrhosis until 2012. I first met W2317, in June 1994 regarding his hepatitis C. My letter of 14th June 1994 (WITN6932044) refers to his symptoms and his recent interferon therapy. No mention of cirrhosis is included in this letter or my subsequent letter of 7th October (WITN6932053). I did discuss him having a liver biopsy which he wasn't keen on. I can see no indication that we considered him to have cirrhosis at that time. Certainly, it was not mentioned in the referral by Dr Anderson to me in letter of 17th March 1994 (WITN6932045). He was seen on a number of occasions by my team and again cirrhosis was never mentioned (see letters from Margot Miller 2nd Feb 1998 (WITN6932046), 17th July 2007 (WITN6932047) and 28th Sept 2007 (WITN6932048). The diagnosis of cirrhosis was made in 2012 when he was an in-patient at the RIE and had a fibroscan (measures liver stiffness) which was in the cirrhosis range. I saw and explained the diagnosis of cirrhosis to him and his wife on the 6th of September only a week or so after the diagnosis of cirrhosis was made. In my letter of 6th September (WITN2317008) when I explained about 'probable cirrhosis' I note that he was understandably upset at this probable diagnosis.

In summary my view is that the diagnosis of cirrhosis due to hepatitis C was made in 2012 and not in 1993.

Regarding the comment that he had his gall bladder removed due to his hepatitis C cirrhosis, I don't think that this is at all likely. This generally would have nothing to do with having cirrhosis. Gall bladder disease is probably seldom related to cirrhosis and in fact, the fact they have cirrhosis is likely to mean less likely to have the gall bladder removed because of potential operative risks. I have subsequently been informed that he has not had this operation.

Section 3: Other Issues

5. If you hold evidence you consider may be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference, please insert here.

Statement of Truth

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

Signed GRO-C

Dated 8th March 2023

Table of exhibits:

Date	Notes/ Description	Exhibit number
14/06/1994	Letter to Dr Anderson from Prof Hayes	WITN6932044
17/03/1994	Letter to Prof Hayes from Dr Anderson	WITN6932045
02/02/1998	Letter to GP from Margot Miller	WITN6932046

17/07/2007	Letter to GP from Margot Miller	WITN6932047
28/09/2007	Letter to GP from Margot Miller	WITN6932048
	Excerpt from Records - Mount Sheet	WITN6932049
22/04/1986	Excerpt from Records – Fluid Balance Chart	WITN6932050
22/04/1986	Excerpt from Records – Nursing Record	WITN6932051
11/06/1986	Discharge Summary dated 11th June 1986	WITN6932052
07/10/1994	Letter to Dr Parker from P Hayes	WITN6832053
April 1986	pulse, blood pressure and temperature charts	WITN6932054
	Narrative Handwritten Medical Records	WITN6932055