Witness Name: Dr Roger Chinn
Statement No.: WITN7266001
Exhibits: WITN7266002 - 008
Dated:

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR ROGER CHINN**

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I provide this statement on behalf of Chelsea and Westminster Hospital NHS Foundation Trust in response to a request under Rule 9 of the Inquiry Rules 2006 dated 25 May 2022.

I, Dr Roger Chinn, will say as follows: -

## Section 1: Introduction

My name is Dr Roger Chinn. My date of birth GRO-C 1964. I hold the following professional qualifications: MB, BS, MRCP, FRCR.

I am the Chief Medical Officer of the Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust"). I am a full voting member of the Board of Directors. Amongst other duties, I am responsible for ensuring the high standards of patient safety and clinical effectiveness at the Trust and for providing professional leadership for all medical staff. I am the Chief Clinical Information Officer (CCIO) at the Trust. I was not holding this position at all material times, and I am therefore providing this statement using information from various sources at the Trust.

## Section 2: Background to the Chelsea and Westminster Hospital

1. In the Rule 9 Request the Inquiry asks if there was a fire, flood or any other event at Chelsea and Westminster Hospital which caused the destruction of records between the early 1980s and 2012. The Chelsea and Westminster Hospital ("the Hospital") opened in 1993. As such, the Hospital was not in existence in the early 1980s.

2. The Chelsea and Westminster Healthcare NHS Trust was created in 1994 by virtue of the Chelsea and Westminster Healthcare NHS Trust (Establishment) Order 1994. In 2006 the Trust became a Foundation Trust. It is currently called Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust"). The Chelsea and Westminster Hospital has been operated by the Trust from 1994.

3. I understand that some of the records from the Westminster Hospital, the St Stephen's Hospital and Westminster Children's Hospital, which closed in 1992, 1989 and 1995 respectively, were transferred to the Hospital.

4. Two significant events resulted in destruction of the Hospital's medical records.

## Section 3: The Fire in 2006

5. Since July 2003, when a records management company Iron Mountain Ltd (Iron Mountain) acquired Hays IMS, the Trust used Iron Mountain for off-site storage of archived patient records. Records of patients seen in the last 2 years were kept on site and not in storage. Medical records dating prior to 1999 were held on microfilm at the Trust.

6. In the late hours of 12 July 2006, a fire started at the Iron Mountain storage facility in Bow, East London. The fire burned for two days and involved the paper storage unit known as Cody 5 that held the bulk of the Trust's medical records. The London Fire Brigade subsequently commissioned a report into the cause of the fire. Amongst its findings were that the main pump for the sprinkler system had been disabled prior to the fire by a management engineer; and that the back-up pump had failed to operate due to it being disabled in the early stages of the fire's development by a security guard who had turned off the back-up pump in the mistaken belief that the alarm was sounding as a "nuisance trip", there having been a history of such spontaneous trips.

7. The following were destroyed in the fire:

    - 242,000 Trust medical records for the period of 1999 to 2004 and those relating to deceased patients;

- Approximately 200,000 Trust X-ray films from pre-2002;
- 36,000 patient therapy files, some of which were duplicated in the main records;
- Some boxes containing clinical risk paperwork (old incident and complaints papers).

8. On 14 July 2006 the Trust Medical Records Department was informed of the incident. In accordance with the Trust incident reporting procedure, an internal incident report form was completed. I exhibit this report as WITN7266002. The incident was classified as a Serious Untoward Incident and reported via NHS Strategic Executive Information System (StEIS) under the reference 2006/4521. I exhibit the StEIS report as WITN7266003.

9. At the material time, the Trust had a Policy and Procedure for Responding to, Reporting and Investigating Incidents. Due to lapse of time, we were unable to retrieve the version in force at the time. However, I exhibit the Procedure for the Management and Investigation of Incidents in force in 2011 as WITN7266004; it refers to the preceding document. I also exhibit as WITN7266005 the Risk Management Strategy and Policy in force in July 2006.

10. The matter was taken with utmost seriousness. On 18 July 2006, the Trust Executive Board was briefed. An action plan at the Trust was set up and implemented, which made provisions for patient contact, dissemination of information to key personnel at the Trust, a recovery plan, and ultimately a consideration of deploying a digital solution for future records.

11. On 2 August 2006, the Trust also undertook to visit another Iron Mountain storage unit, known as Cody 3, where some of the Trust's other X-rays were stored, in order to assure itself of its fire safety, working practices and general arrangements. On the basis of the visit, the physical inspection, the protocols in place and the examination of records it was felt that the risk of fire was acceptably low.

12. Sending records for storage off-site (culling) was discontinued on 17 July 2006. It was re-introduced when additional controls to mitigate any future risk of damage to clinical records were put into place by Iron Mountain. I understand that an independent report confirmed that adequate fire and security precautions were put in place by Iron Mountain.

13. The incident was discussed at the Clinical Governance Committee on 5 September 2006. An assessment of risk to patient safety caused by the fire was conducted by the Trust, with consideration of impact on different

specialities. One of the mitigations was the electronic patient records systems in use at the Trust at the time, predominantly Lastword, still contained some of information, such as X-ray reports, electrocardiograms (ECG) and discharge summaries, and copies of other records, such as outpatient letters, were also held electronically. Where tests were performed by other Trusts, copies of the results were retained by them.

14. External stakeholders including Medicines and Healthcare products Regulatory Agency (MHRA), NHS Litigation Authority (as it was then called) and the National Blood Transfusion Service were informed of the incident, all of which did not raise any additional concerns.

15. Specifically in respect of the records relating to blood and blood products transfusions, the Trust was unable to undertake any look-back exercises for notes that were destroyed. Blood transfusions records were normally documented within the patient records, so unless an individual patient record is reviewed, it would not necessarily be possible to know whether this individual patient had a blood or blood products transfusion. The National Blood Service advised that it was sufficient to respond to any enquiry that records were destroyed.

16. Within the year after the incident, only 3 incidents relating to unavailability of patient records were completed and none of them were significant.

17. The Executive Board remained actively seized of the incident and in July 2007 reviewed the position.

## Section 4: The flood in 2018

18. As is noted in paragraph [5] above, medical records from the Hospital, as well as several other closed hospitals in West London, dating prior to 1999 were held on microfilm at the Trust. The microfilms were stored in a room in the hospital basement. The microfilms were historic, thus the room was not frequently accessed.

19. According to the Datix incident report, on or around 30 November 2018, the room with microfilms was flooded. It is believed that the flooding was caused by a leaking pipe in the ceiling, or alternatively, the water had leaked from the ceiling when a sprinkler system was being installed.

20. On or around 4 March 2019, a member of staff at the Health Records Department had a cause to visit the microfilm room. On entering, it became apparent that the room was wet and strongly smelt of damp. Two members of Health Records staff cleaned the area to the best of their ability, and reviewed the consequences. In accordance with the Trust incident reporting policy, an incident report was completed using Datix electronic system. I exhibit is as WITN7266006.

21. It is believed that the following was damaged in the flood:

- 12 crates of records;
- 6 cardboard boxes;
- 10 to 20 boxes containing a particular type of Emergency Department record (CAS cards);
- The cabinets with microfilms and index;
- The projector for reading the microfilms.

22. The Health Records Department were able to save some records, apart from those that were in the crates full of water.

23. The Information Governance team were informed of the incident and it was reviewed at the Information Governance Steering Group.

24. For completeness, I exhibit the current Incident Management Policy and the Risk Management Strategy and Policy as WITN7266007 and WITN7266008 respectfully.

**Statement of Truth**

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

Signed GRO-C

Dated 3rd October 2022

**Table of exhibits:**

| Date | Notes/ Description | Exhibit number |
|---|---|---|
| 14 July 2006 | Internal incident report | WITN7266002 |
| 19 July 2006 | Serious Untoward Incident report 2006/4521 | WITN7266003 |
| November 2011 | Procedure for the Management and Investigation of Incidents | WITN7266004 |
| May 2006 | Risk Management Strategy and Policy | WITN7266005 |
| 4 March 2019 | Datix incident report | WITN7266006 |
| May 2022 | Incident Management Policy | WITN7266007 |
| July 2022 | Risk Management Strategy and Policy | WITN7266008 |