Witness Name: David Scullion

Statement No.: WITN4119001

Exhibits: WITN4119002-3

Dated: 18 March 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DAVID SCULLION

I provide this statement on behalf of Harrogate and District NHS Foundation Trust in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5 March 2020.

I, David Scullion, will say as follows: -

Section 1: Introduction

1. My name is Dr David Scullion, MBBS, MRCP, FRCR. My address is Harrogate and District NHS Foundation Trust ('the Trust'), Lancaster Park Road, Harrogate HG2 7SX, North Yorkshire. Prior to gaining Foundation Trust status in 2006, the Trust was known as Harrogate Healthcare NHS Trust, operating from the same site. I am the Medical Director of the Trust, a position I have held since September 2012.

2. As Medical Director, my portfolio of responsibilities covers a number of areas including dealing with complaints, criticism and concerns, including where these involve liaising with external agencies.

3. The Trust has been notified of significant criticism made by a witness to the inquiry (reference number W2792, Mr Andrew Patrick) in relation to his operative treatment at Harrogate District Hospital following an episode of trauma in 1981. The witness believes he was infected with Hepatitis C virus having received infected blood at that time. The purpose of this statement is to demonstrate to Mr Patrick and the Infected Blood Inquiry why the Trust believes that this is not the case.

Section 2: Response to criticism of Mr Andrew Patrick

4. On June 15th 1981 Mr Patrick fractured the bones of his lower leg following an episode of trauma. This required admission to Harrogate District Hospital where he underwent surgery to repair the fractures.

5. In anticipation that Mr Patrick might require a blood transfusion, three units of O positive blood were cross matched for Mr Patrick and made available should they be required [WITN4119002, WITN4119003]. The term 'made available' means that the blood was stored in the fridge in the transfusion laboratory in order that it could be released to the operating theatre quickly and upon request.

6. At the time transfusion records were written by hand. Our records show that two of the units of blood initially cross matched for Mr Patrick were subsequently released for two other patients (serial numbers 815330 and 815341, removed from the blood storage fridge on 18/06/1981 and 19/06/1981 respectively) Given that O positive is the commonest blood group in the UK, it is not surprising that it was suitable for use in other patients. The third unit of blood had a shorter expiry date of 17/06/1981. Our records show that this was not given to Mr Patrick or any other patient and therefore would have been destroyed. Thus our records confirm that the blood initially cross matched for Mr Patrick during his admission was not administered to him. There are no records that suggest Mr Patrick received any other blood products at that time.

7. In addition to scrutinising the transfusion laboratory records, the Trust has sought additional information from the hospital records to support its view that Mr Patrick was not transfused (referred to at exhibit WITN2792004 to the witness's statement WITN2792001).

8. Prior to his surgery, Mr Patrick's haemoglobin level (a measure of the amount of circulating red blood cells) was within the normal range at 14.7gms/dl. It is recorded that Mr Patrick received an infusion of dextrose saline (sugar and electrolyte solution) during the operation. This fluid had a mild diluting effect on his haemoglobin concentration which was recorded post-operatively as 12gms/dl. There is no record of excessive blood loss occurring during surgery.

9. A post-operative haemoglobin level of 12gms/dl is still an acceptable level of haemoglobin in the early post-operative period and would not trigger the need for a blood transfusion.

10. In 2009 Mr Patrick contacted the Trust to enquire whether he had been transfused during his admission in 1981. The Trust looked at its records and wrote to Mr Patrick confirming that he had not been transfused with any blood products (referred to at exhibit WITN2792002 to the witness's statement WITN2792001). This information was provided by a senior transfusion practitioner who worked in the transfusion service within the Trust. A copy of the letter to Mr Patrick was filed within his medical notes.

11. The Trust heard nothing more till 2016 when the same practitioner was contacted by Mr Patrick's GP practice to ask, once again, whether Mr Patrick had received a blood transfusion in 1981. The practitioner did not recall her earlier conversation with Mr Patrick in 2009 as there was no laboratory record of this (the record was filed in the hospital notes) when she

responded to the enquiry from Mr Patrick's GP practice (referred to at exhibit WITN2792003 to the witness's statement WITN2792001).

12. Unfortunately this letter contained two factual inaccuracies:
    a) The letter incorrectly stated that four units of blood were cross matched rather than three.
    b) The letter incorrectly stated that blood was transfused into Mr Patrick when it was not.

13. The following is an explanation of how these errors occurred.

14. The practitioner was able to retrieve the blood transfusion ledger for June 1981 and identify the 3 units of blood cross matched for Mr Patrick, listed in three consecutive rows and identified by the relevant unit numbers. She photocopied a section of the relevant page and cut out by hand the units of blood assigned to Mr Patrick from the photocopy. In doing so she inadvertently included a unit of blood in the line immediately above these three, giving a total of four lines and four units of blood. The ledger confirms that the 4th unit, included by mistake, was cross matched for a different patient. Thus in her letter to Mr Patrick's GP, the practitioner incorrectly identified 4 units of blood as being cross matched for Mr Patrick rather than three.

15. The practitioner then went on to photocopy the far right hand column of the ledger which designates the outcome of the units of blood in relation to the person for whom they are cross matched (U for used, N for not used). In the process of amalgamating the unit number data with the designation data, the wrong designation data was used (from further up the page) and it appeared that 4 units of blood had been cross matched for Mr Patrick, all of which were designated "U" implying they were transfused into Mr Patrick. In reality the information should have stated three units, none of which were transfused into Mr Patrick.

16. To this day the practitioner is unable to explain her error which would have gone unnoticed had Mr Patrick not contacted the Trust to state his intention to take legal action. On hearing this, the Trust reviewed its documentation and communications with Mr Patrick and his GP, identified the error and informed Mr Patrick, apologising at the same time (referred to at exhibit WITN2792004 to the witness's statement WITN2792001).

17. I have reviewed the original ledger with the transfusion practitioner who still works in the Trust. It is clear that three units of blood were cross matched for Mr Patrick, none of which he received. When the photocopied section of the ledger page is compared to the original, the misregistration of printing that occurred when the data was erroneously transposed can be clearly seen.

18. Today the process has an electronic and double checked written function such that a similar error could not occur.

19. Mr Patrick makes reference in his statement to the enquiry of a chance meeting with Dr Igpimi, the surgeon who operated on him in 1981. This meeting was a chance one, taking place some thirty years after the original surgery in a Post Office.

20. I believe Mr Patrick is referring to Mr Joseph Ikpeme who was a member of the Orthopaedic senior team in Harrogate at that time but who retired from practice many years ago. Whilst I understand the general point regarding bleeding in trauma that Mr Ikpeme was making, it is clear that Mr Ikpeme did not recall the specifics of the cases and his implied assertion that Mr Patrick would, almost by default, have received a blood transfusion cannot be relied upon. The evidence presented by the Trust demonstrates that this was not the case. Mr Patrick's belief was bolstered in this regard by a letter from the Trust to his GP dated 2016 that, regrettably, contained inaccurate information. Thus I can appreciate how Mr Patrick would have formed the view that the Trust was not being completely truthful with him. I can confirm that the original confirmation by the Trust that Mr Patrick did not receive any blood products in 1981 remains true.

21. In summary, I can understand how Mr Patrick formed the view that he was given blood products at the time of his surgery in 1981. The Trust acknowledges he was given inaccurate information in 2016 and apologises unreservedly for the distress and anxiety this has caused Mr Patrick. This reinforced the view formed by Mr Patrick following his meeting with Mr Ikpeme, though I do not believe this view can be supported by the evidence provided by the Trust.

22. I can confirm that Mr Patrick was not given any blood transfusion during his admission following trauma in 1981, nor has there ever been any attempt on the part of the Trust to engage in a cover up. The Trust made an administrative error which, when realised, was acknowledged and corrected. We have apologised to Mr Patrick for this error and I am happy to do so again now.

23. The Trust has previously invited Mr Patrick into the hospital in order that we can go through his hospital notes and transfusion records with him with a view to explaining how the error in communication occurred. He has declined this offer in the past, but it still stands. Equally the Trust will provide the inquiry with all relevant documents in order that they themselves can be satisfied that the information contained in this statement is correct.

Section 3: Other Issues

24. There are no other issues to which I would like to draw the attention of the inquiry.

Statement of Truth:

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

GRO-C

Dr David Scullion, MBBS, MRCP, FRCR
Medical Director
Harrogate and District NHS Foundation Trust
18 March 2020