

## SERIOUS HAZARDS FOLLOWING TRANSFUSION WORKING GROUP

### 2nd MEETING - WEST END DONOR CENTRE - 8th FEBRUARY 1995

Present :           Dr Lorna Williamson - Chairman  
                  Prof. A Waters  
                  Dr Audrey Todd  
                  Dr Angela Robinson  
                  Dr Patricia Skacel  
                  Dr A Napier (Acting Secretary)  
                  Dr P Mortimer

#### 1.    **Apologies**

Apologies received from Prof. J. Cash, Dr.D. Norfolk and Dr Elizabeth Love.  
The Chairman welcomed Dr. Philip Mortimer as a new member of the Working Group.

#### 2.    **Minutes of previous meeting**

The minutes of the previous meeting (21st December 1994) were accepted.

#### 3.    **Matters arising**

##### 3.1    Title of Group.

Prof. Waters suggested the title "Serious Hazards Of Transfusion" would enable an acceptable acronym for the group, this was accepted.

##### 3.2    Composition of Group.

Dr Philip Mortimer (PHLS Colindale) has agreed to join.  
Dr M. McClelland (Belfast) had agreed for Dr Audrey Todd to represent N. Ireland interests.  
Prof. Cash had intimated that he would be unable to fulfil this commitment, and had nominated Dr Brian McClelland.

##### 3.3    Reporting arrangements from other countries.

Noted: Reporting form from USA (K Sasma) AR would continue to seek information from France. Responses from Dr Leikola and Pimpson (?) awaited.

*Van Aken*

### 3.4 Other Confidential Reporting Systems.

Noted:- Information provided concerning:

Maternal deaths - Mandatory

Stillbirths & Deaths in infancy - Mandatory

Paediatric Surveillance - Voluntary

Discussion points :

- \* Any such documentation liable to be commandeered in the event of legal proceedings.
- \* Success of voluntary systems success would be dependant on assurance of confidentiality should this be wished.

Dr Robinson would explore confidentiality/mandatory aspects with Dr. J. Metters.

**ACTION : AR**

Dr Skacell will seek opinion of RPMS solicitor.

**ACTION : PS**

### 3.5 Fractionated blood products.

It was assumed these would be covered by the "Yellow Card" reporting system for CSM.

✓ **ACTION : AR TO CONFIRM**

PS drew attention to a possible European initiative requiring manufacturers to notify incidents arising from use of their products.

**ACTION : AR TO FOLLOW UP WITH DR CLIVE DASH**

### 3.6 Linkage with Tissue Banks etc.

Response from David Pegg. Agreed to keep other Groups (which might also include UKTSS) informed of Groups activities but active cooperation not appropriate.

### 3.7 Guidelines for Investigation of Serious Reactions.

Draft Definition of "reportable events" to be drawn up.

**ACTION : PS**

### 3.8 Bacterial Infection

MSBT committee has been notified of establishment of this Working Group. Appointment of Kate Soldan and her term of reference noted.

Draft protocol of investigation prepared by MSBT to be circulated to members for comments.

**ACTION : LW**

### 3.9 Viral Infection.

A prolonged and rather inconclusive discussion!

Agreed approach :

- ⊗ Need for means of promoting awareness of need to notify (GP News, BSH Communications, R. Coll. Pathologists Bulletin etc.)

**ACTION : DEFER UNTIL NEARER LAUNCH DATE.**

- ⊗ Possible role of Kate Soldan to be explored.

**ACTION : LW TO DISCUSS WITH JOHN BARBARA**

- ⊗ AR to approach Dr. Diana Walford about possibility of making greater use of information reported to PHLS. \*

**ACTION : AR**

- ⊗ PM to discuss issue with Julia Hepenstall.

**ACTION : PM**

### 3.10 TRALI

Investigation Protocol and case definition provided by A.W. Local views (e.g. ITU Anaesthetists) regarding this would be welcomed.

**ACTION : ALL MEMBERS AS APPROPRIATE**

### 3.11 TA-GVHD

Case definition Paper provided by AT.

### 3.12 Mechanism of Reporting

AW reported R.C.P. may be happy to provide mail box function if invited by this Group. Response from Marcela Contreras on behalf of R. Coll. Path. noted.

**ACTION : LW TO WRITE TO DR. ANTHONY HOPKINS  
AND TO REPLY TO DR. CONTRERAS**

AT: "CRAG (Scotland) may be able to contribute to funding". RCP(E) may be able to provide "office" facilities. AR: NBA may also be prepared to contribute some funds.

Agreed that primary notification should be the responsibility of the Clinician (usually haematologist) locally.

Whilst appropriate collaborative investigations (eg. involving the BTS) would normally be appropriate it should be emphasised that assured confidentiality would be an option. In the final instance notification would be to a central collator (subject to review). Further comments invited regarding draft notification form prepared by AT.

**ACTION : ALL MEMBERS**

**4. Any other Business**

- \* The reporting arrangements would not cover donor incidents (Ref. M.C. letter).
- \* The Group could ideally work under the auspices of the R. Coll. Path. Views of other interested parties (Other Royal Colleges, R.C.N., B.B.T.S. etc) could be sought.

**ACTION : NOT RESOLVED AT THIS STAGE**

**5. Date and Time of next meeting**

Provisionally same venue. April 18th (alt. April 11th). Kate Soldan to be approached.

**ACTION : LW**