

Witness Name: Caroline Leonard

Statement No.: **WITN3449116**

Exhibits: **WITN3449117** **WITN3449121**

Dated: 18 March 2024

## **INFECTED BLOOD INQUIRY**

---

### **WRITTEN STATEMENT OF CAROLINE LEONARD, ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST**

---

I provide this statement on behalf of the Belfast Health and Social Care Trust in response to a request for a written statement under Rule 9 of the Inquiry Rules 2006, dated 16 August 2023. This was following a Rule 13 Notification sent to Belfast City Hospital, the Royal Victoria Hospital and the Belfast Haemophilia Clinic, managed by Belfast Health and Social Care Trust ("the Trust") on 26 June 2023 notifying the Trust of significant criticisms of the Hospitals by a witness to the Inquiry. The criticism has been made by a witness with Inquiry reference number W2778 in relation to her brothers' treatment at the above hospitals between 1979 and 2022.

I, Caroline Leonard, will say as follows: -

#### **Section 1: Introduction**

- 1.1 My name is Caroline Leonard. My date of birth is known to the Inquiry. My professional address in respect of this statement is BHSCT HQ, 2nd Floor, Non Clinical Support Building, Royal Victoria Hospital, 274 Grosvenor Road, Belfast, BT12 6BA.
- 1.2 I was the Director of Cancer and Specialist Services at Belfast Health and Social Care Trust (BHSCT) until my retirement on 25 August 2023 and as such, I had responsibility for services provided at the NI Cancer Centre, some medical specialities, renal transplant surgery, laboratories and pharmacy. The Regional Haemophilia Comprehensive Care Centre fell within my Directorate, and as such, I was nominated

by my Chief Executive, Dr GRO-D to undertake a coordinating role in support of the Infected Blood Inquiry on behalf of BHSCT. On retirement from the NHS, I have been engaged by BHSCT to continue my coordinating role as outlined above for the duration of this Inquiry.

## **Section 2: Response to Criticism by Witness W2778**

- 2.1 In order to address the criticisms of BHSCT referenced in the Rule 13 request dated 26 June 2023 and the Rule 9 request of 16 August 2023, I have spoken with BHSCT staff with knowledge of the care of the brothers of Witness W2778 and reviewed any relevant records. I have attempted to answer the criticisms as far as I can based on the information I have been able to obtain from the sources indicated and from my own knowledge and experience of BHSCT and the matters referred to in the statement of Witness W2778.
- 2.2 In drafting this statement, I have also referred to previous statements and exhibits supplied to the Inquiry. In particular, I would refer to my statements to the Inquiry WITN3449002 of 16 October 2019 and WITN3449028 of 1 October 2021. I would also refer to the statements of Witness WITN332001 of 16 October 2019, Witness WITN3178002 of 6 November 2019, WITN3322002 of 18 December 2019, WITN5559001 of 22 September 2021 and that of WITN4027001 of 19 March 2021.
- 2.3 Responses to the Paragraphs identified by the Inquiry in the Rule 13 dated 26 June 2023 and the Rule 9 request of 16 August 2023 containing criticisms are outlined below. The paragraphs are reproduced in chronological order; the majority are reproduced in whole whilst I have taken the relevant extract of the criticisms from other paragraphs in line with the Inquiry Terms of Reference.

### **Paragraph 96, page 21**

***“.....these people are very aware that my brother Eddie is walking around with Liver Cancer .They have been blocking his opportunity for treatment .....”***

***“.....I believe they knew Seamus had Liver Cancer for at least 4 years before he died and they didn't tell him.....”***

- 2.4 I would refer to statements made to the Inquiry by Witness WITN3178002 of 6 November 2019 and Witness WITN3322002 of 18 December 2019 that detail the

efforts made by the Hepatology Team to provide care to the living brother of Witness W2778. His last attendance at an appointment with the Regional Haemophilia Team was on 11 March 2022. He received a further appointment for 13th January 2023 and did not attend. He received another appointment for 8th September 2023 which was cancelled by the patient. The team will continue to offer him appointments. He has not attended scan and outpatient appointments scheduled in Altnagelvin Hospital, part of the Western Health and Social Care Trust (WHSCT). Later in this statement, I will outline recent events regarding the interaction of Witness W2778 with BHSCT staff and the resultant difficulties that have arisen in assuring the brother of Witness W2778 receives the care he requires.

- 2.5 I would refer to the statement made to the Inquiry by Witness WITN33220001 of 16 October 2021 in relation to the treatment and care of the deceased brother of Witness W2778. This gentleman was initially assessed at the RVH Hepatology clinic on 6 October 2016 for suitability for treatment of Hepatitis C, using directly acting anti-virals without the requirement for Interferon, having previously had a failed attempt at treatment with Interferon in 1995. It was arranged for him to receive appointments for a Fibroscan (to assess if there was underlying damage to his liver) and to undergo an ultrasound scan of liver (to exclude liver cancer).
- 2.6 A Fibroscan, performed on 15th November 2017, confirmed definite liver cirrhosis and as a result, it was arranged for him to be prioritised on the waiting list for treatment of hepatitis C. He attended for a pre-treatment visit on 5 January 2018, blood tests including alpha-fetoprotein (AFP – a tumour marker for hepatoma) were performed and an ultrasound scan arranged to be performed prior to initiating the hepatitis C treatment.
- 2.7 The AFP blood result was markedly elevated at 2156 (normal range 0 – 10) and indicated a high probability of hepatoma. An ultrasound scan on 10 January 2018 led to a CT scan of chest, abdomen and pelvis on 20 January 2018. This confirmed the presence of a multi-focal hepatoma. Hepatoma is a form of primary liver cancer associated with liver cirrhosis.
- 2.8 Witness W2778's brother attended an outpatient appointment unaccompanied with the Consultant Hepatologist and the viral hepatitis nurse specialist on 23rd January 2018 where his diagnosis was explained to him. Given the severity of his liver disease and the extent of the hepatoma, treatment options, such as surgical resection were very

limited. He was advised that the treatment of his hepatitis C would be paused until a clear plan was in place for management of the hepatoma.

- 2.9 His case was discussed in the specialist cancer meeting (Hepatopancreatobiliary Multi-disciplinary team Meeting (HPB MDM)) on 26th January 2018 and an MRI scan of liver was planned. It was agreed to defer a decision on treatment until following the MRI scan of liver. The HPB MDM comprises surgeons, radiologists, oncologists, physicians and clinical nurse specialists. The MRI scan was performed on 1st February 2018 and was followed by further HPB MDM discussion on 9th February 2018. This established that given the extensive hepatoma, his only treatment options would be systemic chemotherapy with Sorafenib or palliative care.
- 2.10 This gentleman was then reviewed in the liver clinic on 16th February 2018 by the Hepatologist in the presence of the HPB clinical nurse specialist (HPB CNS). He was initially unaccompanied. The outcome of the MDM was explained at length and reasons why liver transplant, surgical resection, TACE and SIRT were not options in his case were discussed. The option of treatment with chemotherapy, Sorafenib, at the Belfast City Hospital Cancer Centre was discussed. Based on the side effect profile and uncertainty regarding whether it would prolong survival in his case, he was very clear that he did not wish to pursue the option of Sorafenib. He was keen to understand his prognosis and was advised it was poor and was likely to be less than 6 months. In addition, the recommendation is that hepatitis C treatment is not offered unless prognosis is greater than 12 months on grounds of futility and therefore this was no longer an option for him.
- 2.11 Witness W2778's niece, her brother's teenage daughter, was in the waiting area and the team brought her into the consultation room to advise her of the diagnosis in a form she could understand. Her father declined an onward referral to the palliative care team at that time but agreed to have ongoing discussions with the HPB CNS regarding this, who offered them a card with the HPB CNS contact details to offer emotional support with a further review arranged for 4 weeks' time.
- 2.12 This would prove to be his last clinic attendance in BHSCT, as he did not attend the scheduled review clinic on 21 March 2018. The team wrote to him explaining they would be happy to arrange a further review on request, with the HPB CNS having spoken with him on 21 February and 6 March 2018. As referenced in my statement to the Inquiry WITN3449022 of 16 October 2019, his local Western Health & Social Care

Trust (WHSCT) provided care in the latter stages of his life and sadly, he passed away on 28 May 2018 some 4 months post diagnosis.

**Paragraph 118 page 26**

***“The Royal Victoria Hospital’s liver unit has failed to look after Eddie, he has refused to attend our local hospital as they don’t have a liver clinic. Eddie is currently looking to move to a London clinic. But like ourselves, we are finding this an impossible task.”***

2.13 I would refer to statements made to the Inquiry by Witness WITN3178002 of 6 November 2019 and Witness WITN3322002 of 18 December 2019 that detail the efforts made by the Regional Hepatology Team based at the Royal Victoria Hospital to provide care to the living brother of Witness W2778. BHSCT has no knowledge of any efforts made by the brother of Witness W2778 to access care elsewhere in the UK.

**Paragraph 122, page 27**

***“....At one point there was no Haemophiliac Consultant for adults in N Ireland. We think that the Belfast Clinic knew that Seamus was ill as far back as 2008 or 2009....”***

2.14 I would refer to witness statements WITN5559001 of 22 September 2021 and that of WITN4027001 of 19 March 2021 that outline the detail of the employment history of Consultant Haematologists who provided care to NI Haemophilia patients. I can confirm as outlined in the statements referenced above that there were always arrangements in place in the BHSCT and legacy organisations to provide Consultant Haematologist cover for NI Haemophilia patients.

2.15 In regard to Witness W2778’s brother’s condition circa 2008, a review of the deceased’s medical records illustrates he was reviewed at the Haemophilia clinic on 30 January 2007 where it was advised he be reviewed by Hepatology. It was noted he had commenced a short trial of alpha interferon in 1995 that was poorly tolerated. The long-term effects of his chronic Hepatitis C infection were explained by Dr Jones, who advised he needed to commit to treatment to clear the virus. The patient then did not attend 4 other appointments scheduled in 2007 (05.06.07 DNA, 14.09.07 DNA, 12.11.07 DNA, 23.11.07 DNA) and a further 2 appointments in 2008 (02.05.08 DNA, 16.06.08 DNA) before attending the Haemophilia outreach clinic in Altnagelvin Hospital

on 1 July 2008. At this review appointment, significant joint disease in his knees, particularly the left knee, was noted with wasting in thigh muscles, he was encouraged to attend future appointments. He did not attend several further appointments in 2008 (15.08.08 - outpatient appointment and ultra sound scan (USS) DNA, 05.09.08 (USS) DNA, 06.10.08 DNA, 04.11.08 DNA) before attending clinic on 21 November 2008 where the team arranged for an ultra sound scan (USS) of his abdomen and completed a review of his blood parameters. It was annotated in the notes that the deceased was interested in treatment for his Hep C however it was explained that this would require him to attend all clinic appointments for up to 24 weeks. The USS upper abdomen was reported on 28.11.2008. The findings note: "the liver is slightly increased in echogenicity in keeping with mild fatty change. No evidence of cirrhosis. No focal lesion in liver." On review of bloods, anaemia was noted, therefore the GP was written to prescribe oral iron tablets. He attended a further review appointment in Altnagelvin on 06.01.09.

**Paragraph 123, page 27**

***"In his notes, she stated that to look after Seamus, as they were concerned about his Liver. There are medical notes that allude that in 1980, he had Hepatitis C (WITN2778036; blue pen is my own handwriting). He was only 6 years old."***

- 2.16 I refer to my previous statement to the Inquiry WITN3449028 of 1 October 2021 wherein I discuss the advice from BHSC Regional Virology Laboratory colleagues regarding the history of the development of antibody testing and Polymerase Chain Reaction (PCR) testing for the Hepatitis C virus (HCV).
- 2.17 The first antibody assays for HCV were available from 1992. PCR assays to detect viraemia (active infection) were not routinely available in the early 1990s and were then only used in a research capacity; due to issues with sensitivity and specificity clinical advice at the time was to consider the pattern of results over time. Towards the end of that decade saw reliable commercial HCV PCR assays in regular use with HCV antibody assays.
- 2.18 Given that reliable HCV laboratory testing would not be in routine use until the mid-1990s, it is impossible to conclude with certainty that Witness W2778's brother had Hepatitis C in 1980.

**Paragraph 124, page 27**

***“WITN2778039 shows any bloods in his notes up until now, up until and including 1979 which didn't show asterisks (an asterisk is a sign of abnormalities). But all bloods in his notes from 1980 were riddled with asterisks and readings well outside normal range. This would indicate that what medical professionals were stating was incorrect and the year Seamus was infected with hepatitis was 1980. So, when he died aged 45 he had been left with untreated hepatitis C and B infection for 39 years.”***

2.19 Clinical colleagues advise that laboratory test results are routinely highlighted to indicate when a result lies outside an expected range known as a “reference range”. A reference range is calculated statistically, by taking the average value for a large group of healthy individuals and allowing for natural variation around that value (plus or minus 2 standard deviations from the average). In this way, reference ranges quoted by laboratories represent the values found in 95% of individuals in the chosen “reference” group. In other words, even in a “normal” population, a test result will lie outside the reference range in 5% of cases (1 in 20). Thus, an outlying result does not always indicate a cause for concern, and such results must be subject to interpretation by an appropriately qualified clinician who has, with awareness of the clinical context, requested the tests to further inform the clinical picture and management plan. Blood results undertaken at the time of a patient’s clinical review can serve as a marker to monitor trends and changes over time. These results are interpreted alongside the clinical assessment of the patient on the day and are often an important aspect of the overall assessment but should not be viewed in isolation.

**Paragraph 125, page 27**

***“In his medical notes from 3 November 1995 from the Royal Victoria Hospital, Dr Butler took Seamus’s blood at the children’s unit (WITN2778038; the handwriting is my own). Seamus again had abnormalities and numerous asterisks beside his AST and ALT results. These are a sign of liver disease. We were always told that the bloods would show everything, however when Seamus was consistently showing signs of liver disease in his bloods, nothing was done about it.”***

2.20 As indicated in paragraph 2.19 above, an outlying result does not always indicate a cause for concern and such results must be subject to clinical interpretation by an appropriately qualified clinician who has requested the tests to inform a diagnosis and treatment plan. However, clinical colleagues advise that AST and ALT results being elevated and/or outside of the defined clinical range would not have been unexpected in this case in 1995, given they are indicators of liver function, and that at that time,

Witness W2778's brother was known to have chronic Hepatitis C, with Dr Butler documenting her explaining HCV positivity to him on 11 November 1992.

**Paragraph 126, page 28**

***“In his hospital notes (WITN2778037) from a 2014 admission to hospital it states ‘Hep C (1980)’. This is shocking that they actively knew since he was 6 years old that he was infected. It seemed to be common knowledge that Seamus had been infected with hepatitis in 1980. My parents were definitely not told at that time, it was not until years later.”***

2.21 I would refer again to my previous statement to the Inquiry WITN3449028 of 1 October 2021 regarding the history of the development of antibody testing and Polymerase Chain Reaction (PCR) testing for the Hepatitis C virus (HCV). From this account that confirms reliable antibody and PCR assays for HCV were only available from the mid-1990s it is impossible to say that Hepatitis C infected the brother of Witness W2778 in 1980.

2.22 Exhibit WITN2778037 submitted by Witness W2778 in her statement of 26 June 2023 from her deceased brother's Altnagelvin Hospital medical record appears to be a summary note taken by a doctor charged with “transfer clerking in” the patient to a ward at 23.30hours on 2 October 2014. I note the annotation “PMHx” therein. This is a medical abbreviation for Past Medical History. In the absence of any further information, it is possible to speculate that the annotation highlighted by Witness W2778 is a reference in the past medical history taken on admission that the patient had been infected with Hepatitis C as a result of contaminated blood products in the 1980s.

**Paragraph 127, page 28**

***“WITN2778007 shows that Seamus had Hepatitis C in 2008, and in 2009 it notes that he recently had attended the Belfast City Hospital, where there were no reports of evidence of cirrhosis, but there are notes of ‘Hep C’ at the bottom of his medical notes. We think his doctor (Dr Maine) at the time found out he had Hepatitis C in 1980 but did not inform Seamus or our parents until late 1980s or early 1990s.”***

2.23 Again, I would refer to my previous statement to the Inquiry WITN3449028 of 1 October 2021 as outlined in the preceding paragraphs 2.16 - 2.18. From this account that confirms reliable antibody and PCR assays for HCV were only available from the mid-1990s in Belfast it is impossible to say that Hepatitis C infected the brother of Witness



W2778 in 1980 and that anyone could have determined that diagnosis in 1980 and chosen to withhold that information.

**Paragraph 170, page 37**

***“On another medical note from 2018 (WITN2778021), these are from Egress, they again show abnormalities in his bloods. I did not have access to these notes before the Inquiry supplied them to me. All these abnormalities should have been treated and he should have been looked after.”***

- 2.24 I refer again to paragraph 2.19 in the statement above in relation to the reference range of blood results. I can confirm that 5 Subject Access Requests (SARs) were processed by the BHSC medical records department in respect of supplying the medical records of the brothers of Witness W2778. All these requests were classified as complex, with records that cross over one or more service, more than one volume/file of records and historical information requested. Complex Subject Access Requests have a target of 90 days for processing.
- 2.25 In relation to the living brother of Witness W2778, the first SAR was received on 20 November 2018 from the patient himself and records were issued on 5 February 2019. The second SAR was received on 14 October 2019 from Collins Solicitors with records issued on 13 November 2019. The third request was from the Infected Blood Inquiry Team.
- 2.26 In relation to the deceased brother of Witness W2778, the first SAR was received on 20 November 2018 from another sibling of Witness W2778 and records were issued on 5 February 2019. The second request was from the Infected Blood Inquiry Team.
- 2.27 The Trust received a Rule 9 request from the Inquiry on 9 November 2021 in respect of supplying the medical records of the two brothers of Witness W2778 and responded on 16 February 2022 with a full copy of same. I can confirm that the records supplied to the Inquiry via the Egress system are identical to those supplied to the requestors following the SARs referenced in the paragraphs above. In addition, copies of clinic appointments generated from the Patient Administration System were supplied to the Inquiry. It may be of assistance to outline that given that the brothers of Witness W2778 resided in the Western HSC Trust catchment area, other medical records relating to their treatment and care are likely to also be held there.

**Paragraph 177, page 39**

***“We had asked the Belfast Trust on 20th November 2018 for medical notes, for Seamus and Eddie. This took months to be given to us. The Haemophilia clinic was in Belfast City Hospital, and they would then be seen 6 monthly in Altnagelvin Hospital, Derry. When Seamus was dying we went to Altnagelvin; you went to your local hospital. There are notes from Altnagelvin that are missing from Belfast, some are also changed. For instance, in Benson’s statement, he states, he had sent bloods. I know that doctors hand write notes, and so many notes were missing.”***

2.28 I would refer to the account of the SARs processed by the Trust in respect of the brothers of Witness W2778 outlined in the paragraphs above. Medical records are generated and held by individual Trusts in relation to the care and treatment provided to their patients therein. I referenced in my previous statement to the Inquiry WITN3449022 of 16 October 2019 that the Western Health & Social Care Trust (WH SCT) provided care in the latter stages of Witness W2778’s brother’s life in 2018, this being his Trust of residence. I would advise that medical records pertaining to this care would be held by that organisation, however, Belfast Trust would not have access to, nor hold these records; save for being able to view any electronic record posted on the NI Electronic Care Record Information system (NIECR). I am not aware if Witness W2778 or the Inquiry secured medical records pertaining to the treatment and care of her brothers in the WH SCT; if not this may account for the concern that records are missing.

2.29 On behalf of BHSCT, I strongly refute the allegation that any Trust medical record pertaining to the treatment and care of the brothers of Witness W2778 was changed.

**Paragraph 209, page 46**

***“....however at the very bottom of the page was one line, reading ‘liver function bloods not reported.’ Absolutely unbelievable, the liver function was the one blood test that is done as standard. I believe that it was by design that they left Eddie’s LFT bloods out.”***

**Paragraph 210, page 47**

***“I contacted Helen Manson, the Haemophilia nurse at the Belfast City Hospital and asked “where are Eddie’s liver functions results?” She replied saying “we do our best and that it was a different system.” But it’s not a different system; they’ve been carrying out the clinical bloods in Altnagelvin for years. I believe the bloods have been done and they have not been given to us.”***

**Paragraph 211, page 47**

***“This resulted in a very heated phone conversation, with Hellen Manson. I told the Haemophilia nurse that I believed the haemophilia clinic was up to no good, I also told her that Eddie will not be going back to the haemophilia clinic. The clinic have been repeatedly harassing Eddie, sending him a letter through the Department of Vehicle Licensing Agency, (DVLA), stating he has to go to his GP and have his Liver function bloods done. But the DVLA have not done LFTs for years; they only do blood tests CDT by their own people and the blood test is only for people who have been convicted of drink driving.”***

Paragraph 212, page 47

***“This clinic has no respect, this had really upset Eddie as he doesn’t drink alcohol and hasn’t in 15 years or more and he doesn’t even drive anywhere, due to the pain of his haemophilia joints. They have also refused to respect his and the families wishes that no one from the Belfast Trust is to contact him without a family member being present, as they continue to cause him great distress for their own gain.”***

Paragraph 213, page 47

***“They sent a letter to Eddie in May 2022 from Dr [GRO-D] Consultant of the Belfast haemophilia clinic, has really disturbed us, but it has also given us some answers. Dr [GRO-D] wrote in his letter, that while they are a haemophilia clinic they are not liver specialists (WITN2778025). Therefore, why on earth is this clinic allowed to get away with misleading patients into thinking they are safe when they are not safe? Why are they allowed to tell patients not to worry? “We see everything in the bloods.” They say “your livers are safe and you don’t need liver scans.”***

Paragraph 214, page 48

***“In June 2022, the haemophilia clinic contacted a social worker connected to Eddie's GP practice, and sent him out to visit Eddie without informing us. They were trying to imply they were concerned about Eddie and that he could be at risk from his own family. Then again, in September 2022. The GPs social worker who attended Eddie’s home found a very well taken care man, living in a beautifully appointed clean home with a well-stocked fridge full of healthy food. I spoke to the social worker after this and explained what our family was dealing with. The social worker said he had no concerns about Eddie’s care by his family.”***

Paragraph 215, page 48

***“A few weeks later, Eddie received another letter from Dr [GRO-D] In this letter, Dr [GRO-D] had set up an appointment for Eddie to attend Dr Ferguson's clinic in Altnagelvin for his liver surveillance. Again, Dr Ferguson is not a liver specialist, and his clinic is not a liver unit. I know that Dr Ferguson was unaware of these appointments being sent out on his behalf. He was only aware of doing 3 MRI scans for Eddie.”***

2.30 Paragraphs 209 to 215 relate to issues that arose following an appointment Witness W2778’s brother attended at the monthly Haemophilia outreach clinic at Altnagelvin Hospital in March 2022. The brother of Witness W2778 has received ongoing care from the NI Haemophilia Team who travel monthly to Altnagelvin Hospital to provide

this clinic to patients from this local area to avoid the need for them to travel to Belfast for treatment and care.

- 2.31 In addition, as per the statement of Witness WITN3322 of 18 December 2019 to the Inquiry, Witness W2778's brother had been referred to a Consultant Gastroenterologist, Dr Ferguson, in Altnagelvin Hospital for ongoing scans to monitor his liver; this was at the request of Witness W2778's brother who advised he found travelling to Belfast difficult. However, the Haemophilia team had been made aware of the patient, and his sister, cancelling his scan and outpatient appointments.
- 2.32 An error occurred in the requesting and processing of the blood samples of Witness W2778's brother, taken at the 11 March 2022 Haemophilia outreach clinic. The result of this error was that Liver Function Tests were not carried out.
- 2.33 To investigate what happened, the blood test request form was located and checked in Altnagelvin Hospital, which indicated that the blood sample bottle was received by the laboratory, but not all tests required were ticked on the request form. The cause of this was human error, in that a difference was noted in the laboratory test request profiles in the Belfast City Hospital (BCH), where the Haemophilia Team are based, compared with Altnagelvin Hospital. A single Profile test request in BCH automatically includes liver function tests but in Altnagelvin Hospital, liver function has to be requested separately by ticking the request form; this did not happen.
- 2.34 When the error was noted, the team attempted to put arrangements in place to have another blood sample taken for the tests to be carried out. The Consultant Haematologist present at the clinic that day, Dr **GRO-D**, wrote to Witness W2778's brother on 26 May 2022 to apologise and explain what had happened and to reassure him that the team had learned from the issue and further training had taken place to prevent a reoccurrence. Exhibit WITN2778025 from Witness W2778's statement of 26 June 2023 is a copy of that letter. Dr **GRO-D** in this letter also took the opportunity to outline the importance of monitoring his liver function and strongly encouraged Witness W2778's brother to attend the liver clinic and any of the scans recommended by that team.
- 2.35 Dr **GRO-D** also wrote to Dr Ferguson on 26 May 2022 to follow up on securing an appointment for Witness W2778's brother. Dr Ferguson then replied on 16 August 2022 to advise that on receipt of Dr **GRO-D**'s letter, he had expedited an appointment

for Witness W2778's brother for 1 August 2022. However prior to the appointment Witness W2778 had been in contact with his secretary and advised her brother did not wish to attend for tests or scans through the Gastroenterology team in Altnagelvin. Dr Ferguson had not arranged any further appointments however copied his letter to the patient's GP for information. Exhibit **WITN3449117** and Exhibit **WITN3449118** are copies of these letters

2.36 On 30 May 2022 the Haemophilia Nurse, received a telephone call from Witness W2778 who, along with another nursing colleague who was in the office with her, made a note of the discussion. This note was emailed to myself, as Witness W2778 had asked that Dr **GRO-D** or myself respond to her concerns. Exhibit **WITN3449119** is a copy of the email.

2.37 This telephone conversation raised a number of clinical and adult safeguarding concerns for the welfare of Witness W2778's brother, which the team discussed.

- Firstly, Witness W2778 advised that her brother does not have capacity ('Very vulnerable state and mind') and she acts on his behalf and insisted that the team do not phone him or send any letters to him.
- Secondly, it was important that the blood testing for liver function be rearranged; Witness W2778 had advised she 'had it in hand and it was nothing to do with us'. She advised that the blood test had been completed and 'the results are very interesting.' There were no test results logged or reported on the NI Electronic Care Record (NIECR) for the team to review.
- Thirdly, Witness W2778 expressed that her brother would not be attending Altnagelvin Hospital for his liver scan, as the Consultant Gastroenterologist is not a Hepatology Doctor, despite assurances that they were able to manage the hepatology care he required at this time.
- Finally, Witness W2778 stated she wished to remove her brother from the care of the Belfast Haemophilia Centre.

2.38 The team had serious concerns that Witness W2778 was adversely affecting her brother's care, possibly without his knowledge or agreement, and wondered did he knowingly make all the multiple appointment cancellations noted. An adult safeguarding referral was therefore made to his local WHSCT Adult Safeguarding Team. The Adult Safeguarding investigation was concluded with no concerns.

- 2.39 The Consultant Haematologist linked with the General Practitioner (GP) of Witness W2778's brother to discuss his case and to ask them to do an assessment of his mental capacity. The General Practice Social Worker undertook a home visit and concluded following assessment that he did have capacity; this finding was communicated back to the Haemophilia team in September 2022.
- 2.40 Given the difficulties in communicating directly with the brother of Witness W2778, the Haemophilia team then asked his GP if they would act as a conduit between the team and the patient - encouraging him to attend appointments; however they declined.
- 2.41 On 9 September 2022, Witness W2778 arrived at the Haemophilia Outreach Clinic at Altnagelvin Hospital and hand delivered a document to the Haemophilia Nurse. Exhibit WITN2778043 to Witness W2778's statement of 26 June 2023 is a copy of the document that indicates that Witness W2778 be the sole point of telephone contact for her brother. I then received correspondence from Witness W2778 via email on 12 September 2022 containing confidentiality statements relating to herself and her two children and advising that the Trust under no circumstances was to make contact with Witness W2778. I sought advice from the Trust Information Governance manager and replied indicating that, as W2778's care and that of her two children had transferred to another UK Trust, we would not be in a position to enact the statements and would advise she share them with her GP for action. Exhibit WITN2778043 submitted by Witness W2778 in her statement of 26 June 2023 is a copy of that correspondence.
- 2.42 As her brother was deemed to have capacity following assessment as outlined in paragraph 2.35 above, from a data governance perspective the team needed formal feedback from him on his communication preferences. A form was issued to the brother of Witness W2778 for completion on several occasions asking for him to return to the team in order they could be clear on how he wanted to be communicated with and to whom he gave consent to the Team contacting on his behalf. Exhibit **WITN3449120** is a copy of a letter from Dr Gooding to the brother of Witness W2778 in March 2023 asking him to complete the form and referencing the form previously sent. A completed form was not received by the Trust.
- 2.43 The correspondence that Witness W2778 gave the Trust on behalf of her brother on 9 September 2022 was not clear on his communication preferences. Witness W2778's phone number was given as the main contact however; the Trust cannot contact

Witness W2778, given she asked the Trust not to make contact with her in her correspondence to me of 12 September 2022. Since this exchange, and in the absence of receiving a form outlining communication preferences, the Haemophilia team have had no choice but to continue contacting Witness W2778's brother directly as their patient until they can have a conversation or reply from him directly on how he wishes to be communicated with.

- 2.44 When Witness W2778 attended the Haemophilia outreach clinic on 9 September 2022 in Altnagelvin Hospital, an incident ensued with several members of the clinical team. Witness W2778 advised she was there to accompany her brother on his appointment however, the team were aware that the appointment had already been cancelled by the patient. An exchange then ensued wherein Witness W2778 expressed that she was not happy that the team "had sent out a Welfare check" on her brother; she accused the Haemophilia nurse of deliberately not performing liver function blood tests on her brother at his last clinic review and suggested they were "complicit in a cover up." This exchange involved Witness W2778 shouting at several members of staff, and other staff nearby contacted security for support in the situation as they could hear the altercation.
- 2.45 Witness W2778 left the clinic building before security arrived to intervene. The staff involved reported feeling very threatened and distressed by the incident. The WHSCT Outpatients Sister requested from the visiting Haemophilia team that if the individual concerned was attending further appointments at the Haemophilia Clinic in her department that they inform her, as she would be requesting a security presence throughout the duration of the clinic to safeguard staff and patients.
- 2.46 Following this event, staff reported the incident and completed witness reports in keeping with the Trust's policy on "A Zero Tolerance approach to the prevention and management of Aggression and Violence towards staff in the workplace." Exhibit **WITN3449121** is a copy of that policy.
- 2.47 This matter was escalated to me by the Service Manager responsible for the Haemophilia team, who reported that managing the Altnagelvin outreach clinic had become increasingly stressful for the multidisciplinary team as a whole. They reported that the pattern of Witness W2778's behaviour in unsolicited aggressive phone calls, and attending clinic without appointment to, as they described, target specific members of the team was extremely disruptive to the clinic running. Staff reported feelings of

dread in having to staff the clinic, of being attacked verbally and having one's professional practice called into question without valid reason. Some team members reported they worry that Witness W2778 could approach individuals outside the clinic setting and frequently check the car park and the roads on the way back to Belfast. They advised that whilst that action may seem irrational, it is a reflection of the threat that is felt and that the continued possibility of further incidents contributes to each individuals' anxiety.

- 2.48 On receipt of this information, and in keeping with the "Zero Tolerance Policy" in operation in both Trusts, I wrote to Witness W2778 as described later in this statement at paragraph 2.54 in response to paragraph 220, page 49 of Witness W2778's statement to the Inquiry.

**Paragraph 216, page 48**

***"They don't want him back in the Belfast Liver Unit. Belfast Trust sent a letter to Eddie stating that he is no longer welcome as a patient at the Liver Unit, RVH because of the GMC investigation."***

- 2.49 As referred to previously, WITN3322 in his statement to the Inquiry of 18 December 2019 advised Witness W2778's brother had been referred to a Consultant Gastroenterologist in Altnagelvin Hospital for ongoing scans to monitor his liver; this was at the request of Witness W2778's brother who advised he found travelling to Belfast difficult.
- 2.50 On several occasions Witness W2778 raised complaints on behalf of her relatives which when consent was sought to investigate from the relatives the complaints were withdrawn. In any event, given their serious nature, a review of the care and treatment of her brother was undertaken by the then BHSCT Deputy Medical Director in 2019 who concluded there were no issues of concern. On conclusion of this review, a meeting with the Deputy Medical Director to discuss concerns was arranged for 13 February 2019, 3 April 2019 and 8 May 2019 however, all were cancelled by Witness W2778. On the last occasion of the meeting being cancelled in May 2019, Witness W2778 advised the Trust that she did not wish to speak with the Trust as she felt she would only be told lies and would be speaking with the Infected Blood Inquiry and this would address her concerns.



- 2.51 A referral was made to the General Medical Council (GMC) by Witness W2778 in 2021 in relation to Witness WITN3322's conduct and professional care of her brothers and a preliminary investigation was opened. The BHSCT Medical Director, as the Responsible Officer for the doctor concerned received correspondence in June 2021 from the GMC. The GMC advised that the concerns raised about Witness WITN3322 did not appear to raise a question as to whether their fitness to practise is impaired under one of the grounds listed in Section 35C(2) of the Medical Act 1983 and closed their provisional enquiries with no further action being taken.
- 2.52 Witness W2778 continued to contact BHSCT advising that her brother had since changed his mind and she now wanted him to have an appointment in the Regional Liver Unit. This prompted the correspondence from the Medical Director submitted as Exhibit WITN2778023 in her statement of 26 June 2023. Safe and appropriate arrangements have been made for W2778's brother to receive ongoing monitoring and follow up by a Consultant Gastroenterologist in Altnagelvin Hospital close to his home, as he does not require input of the Hepatology Unit at this time. If however this position were to change, BHSCT would of course put arrangements in place to have another Consultant Hepatologist from the Unit provide care.
- 2.53 The Trust remains concerned that Witness W2778's brother has not attended for any scans or appointments in Altnagelvin Hospital since March 2022 however as he was assessed as having capacity in September 2022 we are not in a position to compel his attendance.

**Paragraph 220, page 49**

***"When I left there were no waiting patients nor did delays happen because of my attendance, the conversation took less than five minutes. I am not an aggressive person, nor have I ever attacked anyone verbally or otherwise. However Caroline Leonard sent me a letter (WITN2778041; WITN2778042) claiming that I was with the staff and I am no longer welcome at the Haemophilia Centre. I am not allowed to take Eddie to the Hospital anymore. This is just another attempt to tarnish my reputation and intimidate me and my family because we have been speaking to the Infected Blood Inquiry.***

- 2.54 I can confirm Exhibits WITN2778041 and WITN2778042 are a copy of the letter I sent to Witness W2778 on 31 October 2022 following the incident that occurred on 9 September 2022, at the Haemophilia Outreach Clinic at Altnagelvin Hospital, WHSCT.

2.55 I drafted this letter based on the accounts of the witnesses to the incident, the follow up feedback from the Haemophilia team in respect of their concerns and in keeping with section 4.1 of the Trust's policy on "A Zero Tolerance approach to the prevention and management of Aggression and Violence towards staff in the workplace" (Exhibit **WITN3449106** refers). I refute any suggestion by Witness W2778 that this course of action was in any way related to their participation in the Infected Blood Inquiry. The Trust has consistently committed to supporting the work of the Inquiry.

### Section 3: Other Issues

3.1 The Trust is mindful of the distress described by Witness W2778 in her statements to the Inquiry regarding her brothers and wider family circle.

3.2 It is important to note her concerns have been investigated as appropriate both within the Trust and by the GMC, with no concerns for the practice of the doctors and clinical staff identified in relation to the care of her brothers.

3.3 The Trust has a duty of care to its employees to ensure that they can perform their duties in a safe and supportive working environment. It is a matter of concern that the NI Haemophilia Comprehensive Care Team advise that they do not feel safe as a result of the behaviour of Witness W2778 which has the effect of undermining staff confidence, wellbeing and their professional integrity.

### Statement of Truth

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

Signed GRO-C

Dated 18 March 2024

**Table of exhibits:**

<b>Date</b>	<b>Notes/ Description</b>	<b>Exhibit number</b>
26 May 2022	Letter from Dr <b>GRO-D</b> to Dr Ferguson	<b>WITN3449117</b>
16 August 2022	Letter from Dr Ferguson to Dr <b>GRO-D</b>	<b>WITN3449118</b>
30 May 2022	Email from Helen Manson to colleagues	<b>WITN3449119</b>
22 March 2023	Letter from Dr <b>GRO-D</b> to Edward Conway enclosing a Communications Preference form	<b>WITN3449120</b>
7 August 2019	BHSCT Zero Tolerance Policy – Prevention and Management of Aggression and Violence towards staff in the workplace.	<b>WITN3449121</b>