

ANONYMOUS

Witness Name: Dr [GRO-B]

Statement No: WITN7463001

Exhibits: WITN7463002 – WITN7463016

Dated: 15 August 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF Dr [GRO-B]

I provide this written statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 24 October 2022

I, [GRO-B], will say as follows:

1. My name is Dr [GRO-B] and my date of birth is [GRO-B] 1973. I live in London and my full address is known to the Inquiry.
2. I intend to speak about my late father, and the experiences of my family and I related to confirming the source of infection once my late father was confirmed to have active Hepatitis B after emergency blood transfusions at Homerton Hospital. I will also speak about our negative experiences related to the Parliamentary Health Services Ombudsman (PHSO) and General Medical Council (GMC). The attached exhibits of our experiences also confirm our positive experience of the Medicines and Healthcare products Regulatory Agency (MHRA).
3. I can confirm that I have chosen not to have legal representation and that the Inquiry Investigator has explained the anonymity process to me. At this time, I do wish to be anonymous.

4. The Inquiry Investigator has explained to me the 'Right to Reply' procedure, and I understand that if I am critical of a medical professional or organisation, they will have the right to reply to that criticism. The organisations named in this witness statement, and which I would want to respond are: Homerton Hospital NHS Foundation Trust, the PHSO, the MHRA, the GMC, and the Care Quality Commission (CQC). Although no negative criticisms of the MHRA are made, suggestions are made for increasing MHRA functions to which it may want to reply.
5. I wish to acknowledge that naturally as time passes, memories can fade. I have been able to provide approximate timeframes for matters based on life events. However, these timeframes should be accepted as 'near to' rather than precise dates. Although, some dates I have provided are exact based on written evidence which I have attached to this statement as exhibits.
6. I have constructed this statement with the benefit of having read my father's medical records and from my own experience.

Section 2. How Infected

7. My late father was a retired pensioner (a welder by trade) and he lived in London together with me and my mother and sister.
8. My father and I are not sure how my late father became infected with Hepatitis B, but we are certain that both Homerton Hospital NHS Foundation Trust and the Parliamentary Health Service Ombudsman failed to provide honest and lawful responses to arising medical care and public health matters and our enquiries.
9. In April 2007, my late father received multiple blood transfusions as an inpatient at Homerton Hospital University Hospital, Homerton Row, London E9 6SR. Shortly after or in the midst of multiple transfusions within a circa ten-day period, whilst still an in-patient, my father was found to be Hepatitis B positive and with active Hepatitis B.

10. Homerton Hospital did **not** report the infection to the MHRA via the formal Serious Adverse Blood Reactions and Events (SABRE) reporting procedure (WITN7463002).

Section 3. Other Infections.

11. Infection with any other blood-borne virus was possible. We are not able to comment further.

Section 4. Consent

12. I don't know if consent was ever requested or given. However, in context, my late father received emergency blood transfusions in a life-or-death scenario, and subsequent matters of health care for my late father and public health care duties, including to my late father's close contacts, were not properly disbursed.

Section 5. Impact.

13. On 24 May 2007, Homerton Hospital's own pathology laboratory gave an **explicit written alert** to the medical team to treat my father and test and treat all close contacts because of active significantly high Hepatitis B infection (WITN7463003). Homerton Hospital did **not** begin standard tablet-based Hepatitis B treatment for my father until **20 months later**, and did **not** alert the family to be tested.
14. **Over a decade later**, we urgently ourselves arranged to be counselled and tested by our GP once we saw the documentation after a response to a Subject Access Request and upon our sifting through over 1,100 pages of scanned documents provided to us as a mass of information without Homerton Hospital signposting critically important information since 24 May 2007 that we needed to be tested and possibly treated for Hep B infection (WITN7463003).

15. During a formal complaints procedure process, Homerton Hospital gave multiple replies which were (a) weeks to months late and (b) included multiple levels of serious unlawful mistakes or/and multiple levels of dishonesty.
16. My family and I submitted a formal complaint against Homerton Hospital on 26 September 2018 [Exhibits WITN7463004, WITN7463005 and WITN7463006 *(these three exhibits are a letter plus two annexes to that letter)*].
17. [Exhibit WITN7463007] Homerton Hospital's Chief Executive (Ms Tracey Fletcher) formally replied weeks to months late on 29 January 2019 and on page 1 final paragraph, *within section entitled "Points 2 & 3"*, stated that my late father had been transfused with 3 units of blood. This was **illegally false** as information later released in response to a Subject Access Request included blood transfusion prescription forms with serial numbers for different units of transfused blood which showed that at least 5 different units of blood were prescribed and signed for as actually transfused to my father whilst he was an in-patient in May 2007 [Exhibit WITN7463008] - *a 2-page document*].
18. Clinical records from my late father's hospital notes released after a Subject Access Request also confirm that medical doctors including a Consultant Gastroenterologist running a specialist liver clinic (**Dr Shidrawi**) noted and highlighted the fact that my father was hepatitis B positive with high levels of activity and liver damage (Exhibit WITN7463009 **pages 1 to 4 out of 5 pages; 21 May 2007, 24 May 2007, 25 June 2007, 24 September 2007, 17 March 2008 and 16 June 2008**), and that the explicit risk of chronic liver failure (whilst the 1,000-fold increased risk of primary hepatocellular cancer is also well-known), was formally highlighted in the written clinical record within Homerton Hospital to alert medical colleagues within Homerton Hospital (Exhibit WITN7463003 **Homerton Hospital Blood Virology Report from Pathology Lab dated 23 May 2007**), yet Homerton Hospital NHS did not start **essential anti-Hepatitis B treatment** until **20 months** later even though Hepatitis B was mortally damaging my father and the treatment was in the form of tablets that he could take at home (Exhibit WITN7463009 **page 5 out of 5 – Dr Gadah's**

clinic notes dated 19 February 2009 state Hepatitis B treatment “started one month ago”).

19. **Would Homerton Hospital specialist clinicians have withheld Hepatitis B treatment in this way if it was their father's case? Would Homerton Hospital specialist clinicians have endangered their own families in this way? They must explain why they did this.**
20. This short summary for the purpose of the Infected Blood Inquiry does not include many other errors highlighted with evidence to Homerton Hospital and the PHSO. Astonishingly, Homerton Hospital and the PHSO joined forces and the PHSO commended and supported Homerton Hospital's illegal errors.
21. The PHSO in support of Homerton Hospital emphasised in a letter dated 14 August 2019 that it would be impossible to trace details to determine if my late father had received blood infected with Hepatitis B in 2007 because circa a decade had elapsed (**WITN7463010, pages 2 to 3, section headed “April 2007 Hepatitis B infection”**).
22. During **correspondence** regarding my late father, Homerton Hospital also declared that it would refuse to reply to any further correspondence from me.
23. In an emailed 4-page letter dated 1 September 2019 (**WITN7463011**), I refuted the PHSO's position as unlawful and not ‘fit for purpose’ with:
 - a. my own knowledge from working as a hospital doctor in London that even in the 1990s electronic pathology databases were used
 - b. reference to **The Blood Safety and Quality Act (2005) Sections 8 and 9** which obliged Homerton Hospital and blood services to keep auditable records for at least 30 years of the pathway from blood collection, storage, transfusion, and post-transfusion
 - c. knowledge that Homerton Hospital were meant to have reported the incident to the MHRA, and
 - d. pinpointing and refutation of multiple other flaws in the PHSO's approach.

24. As per (WITN7463011), the extent of Homerton Hospital's and the PHSO's dishonest collusion over this is indicated to not be accidental by other examples from within one set of complaints. For example, jumping ahead to 2018, a Consultant (Dr Cianan O'Sullivan) claimed that it was my mistake and my family's mistake that we believed that the Consultant had said that during his last stay as an inpatient (in 2018) my terminally ill late father had been referred to palliative care services in the community.
25. The PHSO sided with Homerton Hospital and the Consultant. However, date- and time-stamped electronic contemporaneous medical history notes dated 21 February 2022 (WITN7463012) for my father that were written and signed by Dr O'Sullivan himself confirmed that he had indeed informed us that my father had been referred to Palliative Care in the Community.
26. The PHSO and Homerton Hospital knew the truth. Relevant to this issue of blood transfusion, it indicates the level of dishonesty from Homerton Hospital in collusion with the PHSO that, contrary to irrefutable documentary evidence that the PHSO itself possessed, the PHSO rejected the part of our complaints over my late father having been discharged to our home when he was terminally ill under that Consultant's express reassurance that Palliative Care arrangements at GRO-B Hospice had been made, when, in fact, no arrangements had actually been made, and which we only discovered at the point of dire need.
27. I confirmed that in 2007, not only did Homerton Hospital hugely delay by 20 months starting my late father on anti-viral treatment after confirming he had active Hepatitis B, and failed to report it to the MHRA, Homerton Hospital also did not alert my family that we urgently needed to be tested for Hepatitis B (WITN7463003).
28. When, more than a decade later, my family and I were tested for Hepatitis B (spouse and 4 biological children) we were all confirmed as negative for

Hepatitis B, which is inconsistent with my late father having been infected prior to multiple blood transfusions in 2007.

Section 6. Treatment/Care/Support

29. Despite our objections, and despite my being a published medical science author for the Royal College of Psychiatrists

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the PHSO sided with a

biased and racist conclusion based on a British Medical Journal (BMJ) case report of just one patient aged in his 40s known to be Hep B-positive from birth after being born to a mother known to be Hep B-Positive who died from Hepatitis B complications, as being materially the same to the case of my father who had lived into his late eighties, had had no previous record of Hepatitis B, whose own mother (my paternal grandmother) had had no history of Hepatitis B and herself had lived at least into her eighties, and my father's spouse and 4 biological children all being Hepatitis B negative (when Hepatitis B is an incredibly infectious pathogen). The only potential commonality was a brown skin colour.

30. After we complained to the PHSO about the unacceptable racist conclusions of the PHSO sham investigation (conducted by Mr Andrew Robertson), the PHSO Director of Quality (Mr Karl Banister) contacted me on 6 July 2021 and declared that he intended for the PHSO to publish its 'investigation' of our complaints as an example of PHSO 'best practice', despite the currently undetermined appeal against the PHSO's racist decision and other fundamentally flawed decisions contrary to the evidence against Homerton Hospital. This was astonishing, and we refuted this proposal in our reply dated within 24 hours of Karl Banister's email (WITN7463013).

31. What else could be done? My family and I complained to the **General Medical Council (GMC) Complaint Reference Number** GRO-B but our complaints, based on date-stamped contemporaneous secure electronic medical notes were at first quickly rejected by the GMC without investigation, and then blocked after we applied for a 'Rule 12' Review. The GMC complaint

since 2 May 2022 remains blocked, even though investigation to irrefutably confirm that the Consultant had indeed lied to the PHSO would take less than 15 minutes to confirm from inspecting date- and time-stamped medical notes authored and signed for by the Consultant himself and comparing with his responses through Homerton Hospital and the PHSO (WITN7463014, WITN7463015 and WITN7463016).

Section 7. Financial Assistance

32. No member of the family has ever attempted to seek financial assistance as a result of the late Mr. GRO-B: F s infection.

Section 8. Other Issues

33. This summary was written in a short time. I am not a solicitor and have no legal qualifications or expertise in medical law. My family and I are not relinquishing any legal rights if we omit anything significant in the course of quickly submitting this summary of matters to the Inquiry.

34. My family's experiences, evidenced by contemporary documentation provided to this Inquiry, flags as serious issues that:

- a. The PHSO is not 'fit for purpose', at least in respect of breaches of the Blood Safety and Quality Act (2005), and that as a disabled amateur member of the public I performed a more competent and lawful processing of blood safety legal matters than the PHSO
- b. Well into the 21st century a London NHS Foundation Trust can frustrate legal obligations for Blood Safety and obstruct revelation of the truth.
- c. The GMC's inability should also be processed by the Inquiry
- d. There is wilful zero competence or dishonesty when there is competence, zero accountability, zero respect and blatant negative racial bias when it comes to NHS and responsible authorities (except the MHRA – see paragraph 35 below) and the matter of infected blood incidents and investigations.

35. The MHRA and its blood departments have been honest and dutiful to my family and I, and are, perhaps, under-resourced to deal with legal breaches. Based on my family's emphatic experiences which we have evidenced to this Inquiry, we would support the PHSO being disbanded and the MHRA, which is the "Competent Authority" on the safety of blood products, being given more power and resources.

36. I have tried contacting the Care Quality Commission (CCQ), but to no avail. It should be independently assessed:

- e. What is the difference between the CCQ's remit versus the PHSO's remit
- f. Why is the complaining public directed by NHS Foundation Trusts to the PHSO and not the CCQ or the MHRA, aggravated by strict timescales applied to grieving and devastated next of kin? From my family's experience, the PHSO is not 'fit for purpose', and it is unjust and wasteful to direct complaints to the PHSO.

37. There is no explanation as to why complainants are directed to the Parliamentary Health Services Ombudsman and not to the Care Quality Commission. This should also be processed by the Inquiry, or at least flagged as another serious issue.

38. We recommend that:

- g. Complainants of blood safety matters, whether explicitly or if the details of a complaint relate to matters of blood safety, should be provided with details of the MHRA including the SABRE department
- h. NHS services receiving such complaints should be obliged to forward those complaints to the MHRA and SABRE department, and to copy that correspondence to complainants
- i. There be a national campaign targeting both authorities and the public to establish awareness and competence of blood safety legislation
- j. The Inquiry confirms whether or not the PHSO continued to support breaches of the Blood Safety and Quality Regulations (2005), including those raised by other complainants, even after (a) the PHSO as an

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organisation and (b) Mr Karl Banister as Director of Legal Quality and Clinical and Deputy Ombudsman were explicitly alerted as shown in **WITN7463010** and **WITN7463011**

- k. The Inquiry recommends against the PHSO being rebranded as part of the MHRA, or for PHSO departments to be redeployed to the MHRA as this would taint the quality of the MHRA

39. It may be that my late father was not infected by Hepatitis B from an infected blood transfusion. But if this is what my family and I encounter in trying to determine the truth, how will people fare who do not have research skills, medical knowledge, knowledge of medical care systems, and any access to administrative facilities to repeatedly write and email organisations whose real job appears to be to frustrate justice?

40. I live in **GRO-B** London and would very much like to give as much assistance as possible to upshots from this Inquiry. For example, I personally could do a better job than the PHSO and would properly overhaul it. Although, I am a disabled person with multiple sclerosis, and also have carer responsibilities, this is an incredibly important matter, and justice is being blocked.

Statement of Truth

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

Signed

GRO-B

Dated 15 August 2023

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EXHIBITS:

EXHIBIT	DATE	DESCRIPTION
WITN7463002	25.03.2021	MHRA confirms Homerton Hospital legal failings after post-transfusion Hepatitis B positive finding
WITN7463003	24.05.2007	Homerton Hospital's own Pathology service explicit written alert and advice re Hep B positive actions for patient and family which Homerton Hospital acknowledged yet ignored
WITN746004	26.09.2018	Letter of Complaint (Signed by Dr GRO-B GRO-B and Mrs GRO-B) to Homerton Hospital Chief Executive
WITN746005	Email Chain 28.12.2017 onwards	Annex A to Letter of Complaint dated 26.09.2018 to Homerton Hospital Chief Executive
WITN746006	Email Chain 21.02.2018 onwards	Annex B to Letter of Complaint dated 26.09.2018 to Homerton Hospital Chief Executive
WITN746007	21.01.2019	Formal Complaint response Ref GRO-B from Homerton Hospital Chief Executive Ms Tracey Fletcher
WITN746008	May 2007	2-page document of 2 screenshots of blood transfusion prescriptions confirming at least 5 units of blood were transfused to my father as an in-patient in May 2007
WITN746009	21.05.2007 24.05.2007 25.06.2007 24.09.2007 17.03.2008 16.06.2008 &	Consultant-led Specialist Liver Clinic at Homerton Hospital observing and recording active hepatitis B infection with explicit and highlighted evidence of liver damage yet withholding well-known life-saving oral tablet treatment for 20 months.

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	19.02.2009	
WITN7463010	14.08.2019	PHSO Letter pages 2 to 3 of which confirm incompetence/dishonesty regarding The Blood Safety and Quality Regulations (2005) Sections 8(2)(b) and (9)(d)(f)(g)(h) and collusion with Homerton Hospital
WITN7463011	01.09.2019	Explicit letter to Mr Andrew Robertson (PHSO) confirming PHSO incompetence and unlawful stance regarding The Blood Safety and Quality Regulations (2005) Sections 8(2)(b) and (9)(d)(f)(g)(h) , awareness of current Public Inquiry into the NHS and Blood Safety and collusion with demonstrably dishonest Homerton Hospital responses
WITN7463012	21.02.2018	11-pages of medical notes evidence showing Page 1 which PHSO itself highlighted with yellow brackets and used biased irrelevant discussion between a junior doctor and GP versus page "6" line 8 in which the Consultant himself recorded his false advice to the family that palliative care arrangements (GRO-B Hospice) in the community had been made prior to discharge.
WITN7463013	06.07.2021	Mr Karl Banister, PHSO Director of Legal, Quality and Clinical and Deputy Ombudsman wrote notifying complainants that the PHSO investigation into our complaints would be used as an exemplar of PHSO performance, and our immediate response also on 06.07.2021 that the PHSO already had a formal complaint that its investigation had been grossly deficient, contradictory of its own principles, unlawful,

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		dangerous with respect to blood safety, and racist.
WITN7463014	20.06.2022	GMC confirmed that our complaint against the Homerton Hospital Consultant would be processed eventually. It also acknowledged on page 2 paragraph 5 that it would consider the point that staff in its Information Access Team should <u>not</u> be operating with anonymity when interacting with the public (!)
WITN7463015	18.10.2022	GMC succinctly and explicitly formally approached in writing that processing the complaint against the Homerton Hospital would take barely 15 minutes yet it is blocked by the GMC and it being foreseeable that the Consultant will retire before the GMC processes the Complaint. As at 09.01.2023 , the Complaint lodged on 02.05.2022 has still not been processed by the GMC.
WITN7463016	25.05.2023	Rule 12 outcome letter from the GMC attaching the Assistant Registrar's Decision