

**From:** [Johnston, Paula](#)  
**Sent:** 23 August 2019 14:29  
**To:** [Jackson, Karin](#); [Ritchie, Ivan](#)  
**Subject:** RE: Infected blood inquiry missing documents  
**Attachments:** [FW: For action : RP2858 - Letter to HSC Chief Executives - Infected Blood Inquiry](#)

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Karin / Ivan,

Re the "missing records" referred to in the email below:

During the search of the plant room documentation not relevant to the Infected Blood Inquiry was categorised and has been retained in the plant room – nothing of any business relevance was disposed of.

A second search of these records has been conducted to ensure that anything relevant to IBI has been extracted.

The PTH files Dr Morris refers to were not found in the plant room.

The files are in fact labelled as follows CASE NUMBER:YEAR – as such, the file for case number 1 in the year 2000 would be 01/00.

Staff are currently searching through the records held in Dr Morris' office, if the PTH files are there they will be located.

Records stored in the plant room were not well organised or categorised. They were in fact disorganised to the point of being chaotic.

Some records may have been placed loosely in buff folders, others were simply stacked into drawers. As such, records were removed from their locations and sorted into categories relevant to IBI, e.g. Hepatitis, HIV, CJD, Plasma etc.

The records relating to the product recall and subsequent meetings would have most likely been sorted into the CJD or Plasma categories.

Dr Nicky Anderson has commenced her review of the CJD records, when this is complete we can carry out a search of the inventory for the records in question.

There are also categories relating to Plasma and Minutes where these records may be located.

When work commenced to search the records held in the plant room staff were instructed to sort records into those that were relevant to IBI and those that weren't. records that were not relevant were not to be disposed of for several reasons:

- They may need to be rechecked for the Inquiry.
- Even if we were certain something wasn't relevant, we simply did not have time to review each non-relevant record, determine its retention period and log anything to be disposed of.

In addition, on 24<sup>th</sup> August 2018 we received the attached email from the Department of Health with a notification of retention / non-destruction of records issued by Sir Brian Langstaff. This was at the very early stages of searches and staff were informed of this and reminded nothing was to be disposed of.

Regards,

Paula

Paula Johnston  
Information Governance Manager  
Ext. **GRO-C**

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**From:** Jackson, Karin  
**Sent:** 23 August 2019 12:27  
**To:** Ritchie Ivan <Ivan.Ritchie@**GRO-C**>; Johnston Paula <paula.johnston@**GRO-C**>  
**Subject:** FW: Infected blood inquiry missing documents

Ivan/Paula  
Please see below.

Karin

Karin Jackson

Chief Executive  
Northern Ireland Blood Transfusion Service

Tel: **GRO-C**



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**From:** Morris Kieran  
**Sent:** 28 December 2018 14:32  
**To:** Johnston Paula <paula.johnston@**GRO-C**>; Ritchie Ivan <Ivan.Ritchie@**GRO-C**>;  
Jackson, Karin <Karin.Jackson@**GRO-C**>  
**Cc:** Maguire Kathryn <Kathryn.Maguire@**GRO-C**>  
**Subject:** Infected blood inquiry missing documents

Dear Paula

I trust the holiday season finds you well and I wish you all the very best for a happy and healthy 2019!

All boxes identified as potentially relevant for the infected blood inquiry have been reviewed by the medical team of consultants Dr Kieran Morris and Dr Kathryn Maguire. I have confirmed this detail with Chris Ainley this morning in your absence.

The list of issues which have been prepared to help with the inquiry's investigative work list relevant topics for the blood services which are: knowledge of risk; policy making, decision making and actions; regulation.

There are two sets of documents and files which I have not come across. The first relates to post transfusion hepatitis files for the period 01 April 2000-28 February 2006 when I was consultant in donor medicine.

A number of referrals were received from a variety of sources informing of patients who were diagnosed with hepatitis B infection and had a history of transfusion. The actions required on the part of the blood service include identifying linked donation(s), reviewing test results, retrieval of archive for repeat testing, recall of donor as appropriate and issue of final report to referring clinician.

Each referral generated a file which was coded PTH (post transfusion hepatitis) followed by the last two numbers of the year and sequential number of case, for example 00/01 indicates the year 2000 and case number 1. PTH files for the period 1980-2000 when Dr Chitra Bharucha was consultant in donor medicine and for the period 2006-2013 when Dr Joanne Murdock was consultant in donor medicine have been identified and will be uploaded and scanned to the infected blood inquiry team. The files which relate to the interim period 2000-2006 appear to be missing. We need to complete a forensic search to confirm whether or not this is the case. I can show you directly in which drawer, in which filing cabinet in the plant room these files were stored securely by me.

The second set of documents relates to a product recall by the Scottish National Blood Transfusion Service of plasma products manufactured from a pool of donations including a donor who subsequently died of variant CJD. The products were manufactured in the period 1996-1998 and the recall was notified after 2000. There was a series of meetings during the period 2000-2003 with colleagues in the Belfast Health and Social Care Trust to discuss relevant issues, identify recipients and consider implications. There are two large buff folders each containing approximately between 50 and 100 sheets of paper including personal contemporaneous notes which I have recorded.

The existence of these documents and files can be independently verified. It is probable the Scottish National Blood Transfusion Service (product recall) and the Belfast Health and Social Care Trust (post transfusion hepatitis referrals) will have made disclosures to the infected blood inquiry already. It is likely that other Health and Social Care Trusts will also make disclosures.

I think the important next steps are:

- Complete a forensic search to locate missing documents and files

- Complete an electronic search for emails which may have been sent to me from a number of correspondents in relation to post transfusion hepatitis referrals. The majority if not all of the referrals were by letter.
- Make an appropriate disclosure to the infected blood inquiry team.

Please note the second and third steps are only relevant if the documents and files cannot be found.

I had hoped to discuss this at the infected blood inquiry meeting yesterday but Ivan informed Alison Carabine and 1030 the meeting would not be going ahead.

I will be absent for the next scheduled meeting as I am on annual leave next week.

Kind regards.

Kieran

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