

Witness Name:
Statement No:WITN2792001
Exhibits:WITN2792004
Dated: February 2019

INFECTED BLOOD INQUIRY

EXHIBIT WITN2792004

Harrogate and District **NHS**
NHS Foundation Trust

8 July 2016

Mr Andrew Patrick

GRO-C

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Our ref: 16/17-8826

RECEIVED

25 JUL 2016

Dear Mr Patrick,

Further to the correspondence from Dr Ros Tolcher, Chief Executive on 20 June 2016 I am now able to provide a draft response to your concerns relating to the conflicting information regarding your blood transfusion history.

As you know, Elizabeth Watkins, Radiology Services Manager investigated the issues you raised. Elizabeth has produced a draft report which documents the findings of our investigation, and explains any action we will take to address the issues you raised. Please can you review the enclosed draft report to ensure this does address the concerns that you raised as we want to ensure we have resolved the issues to your satisfaction.

If you have any concerns or queries about the content of the draft report please do not hesitate to contact me on the above number. Alternatively I will contact you by telephone at the end of July to discuss.

It is clear from our investigation that we did not always communicate effectively with you and I am very sorry for this. Had we done so, I am sure this would have helped to improve the experience for you.

Yours sincerely

GRO-C

Anne Dell
The Patient Experience Team

Harrogate and District **NHS**
NHS Foundation Trust

Meeting the requirements of The Local Authority Social Services and National
Health Service Complaints (England) Regulations 2009

29 June 2016

Our reference: 16/8826

**Complaint Report for Mr Andrew Patrick regarding complaint about conflicting
information provided following request for information about blood
transfusion.**

The person who investigated your complaint was:
Elizabeth Watkins - Radiology Services Manager,

During the investigation Elizabeth Watkins gathered information from:

Mr **GRO-D** Pathology Manager
Mrs **GRO-D** Transfusion Manager
Reviewing records in Blood transfusion, patient notes

We agreed we would investigate the following issues and respond to you by 20th
July.

**1. Why was different information given to Mr Patrick and his GP about his
blood transfusion history in 2009 and 2016?**

In 2009 you contacted the Trust to ask if you had received a blood transfusion
following an admission to the Hospital with a fractured right tibia and fibula (lower
leg) on 15/6/1981.

The blood transfusion records were manual entries in a Blood Bank Register at the
time. It can clearly be seen that 3 units of 'O positive' blood was cross matched for
you (serial no's 811671 expiry date 17.6.81, 815341 expiry date 24.6.81, 815330
expiry date 24.6.1981).

The register shows that the blood above was returned to stock and not used during
your care. This was common practice in the register, with many cross matched units
returned to stock.

When the request came to Mrs **GRO-D** in 2009, Mrs **GRO-D** reviewed the information in the
Blood Bank Register and wrote a letter to you confirming the blood which had been
cross-matched for you, was not used. A copy of the letter is in your patients notes.

On 22/4/16 Mrs **GRO-D** received a phone call from Ms **GRO-D** from Leeds Road
Practice asking if your records could be reviewed to see if you had received a blood
transfusion in 1981. Mrs **GRO-D** did not remember she had provided this information
previously to you, and there is no central record of the contacts made for this

information. Mrs [GRO-D] spoke to you to confirm your identification and details of the request.

Mrs [GRO-D] assistant Mrs [GRO-D] helped by collecting the Blood Bank Register for the appropriate year, and scanned the pages with your record.

Unfortunately Mrs [GRO-D] then wrote a letter to [GRO-D] with two errors. Firstly, the fact 4 units were prepared and not 3, she had attributed a unit to you from the patient's record above yours. Secondly, she incorrectly stated the blood was administered when it was not. This was because she did not review the end of each row to clarify if the units of blood were either U (used) or N (not used). Mrs [GRO-D] is very sorry she made these errors, and has reflected on the way this happened.

The reason that two letters with conflicting information was provided to you and the GP practice was because Mrs [GRO-D] provided a photocopy of the record, this was cut (for confidentiality purposes) and then stuck below the headings to show the meaning of each piece of the text. In doing so, she incorrectly stuck the end column and the U (used) from the above record was included. This information was then posted to the GP practice.

It can clearly be seen and identified that the 'U' is different handwriting to the information pertaining to your record, and this can be shown to you if you wish to review it. Mrs [GRO-D] apologises for this further error, and for the distress it has caused you.

2. Which is the correct information and what is the evidence to support this?

To provide evidence to support the blood was not given to you I checked the register to see if the blood which was cross matched had been used for another patient. The records show 815341 (expiry date 24/6/81) and 815330 (expiry date 24/6/1981) were documented as used on other patients. The bag which had expiry date of 17/6/81 was not documented as used, and was most likely destroyed once it had reached its expiry date.

3. If it is the case that Mr Patrick did not have a blood transfusion in 1981 following his accident, please explain why a transfusion was not necessary.

I reviewed the Blood Bank Register and your patient's notes from the time of the admission. The notes show 3 units of blood were requested for cross match, and that your Hb (haemoglobin) was 14.7 g/dl prior to surgery.

There is an entry which shows dextrose saline was given by IV infusion overnight after the operation. The next day the notes record your Hb as 12 g/dl.

Whilst the Hb trigger has changed following research (the current Hb trigger is 7-8g/dl) at that time the Hb trigger was likely to have been 10g/dl. With a pre op Hb of 14.7g/dl and a post op Hb of 12g/dl a blood transfusion was not clinically indicated using either historical or current transfusion triggers.

I hope this explains the reason for a blood transfusion not being required was because your haemoglobin levels did not indicate a transfusion being necessary.

4. What processes have now been put in place to ensure the correct information is shared with patients about their blood transfusion history?

Information requests of this nature are infrequent; as such there was no formal documented process in place to follow. Reflecting on the errors that occurred has enabled the department to take action to improve this and implement such a process. A Standard Operating Procedure document has been written to outline the process above for the communication of patient's blood transfusion history.

The process going forward is:

1. All requests must be in writing.
2. Any request for information will be added to a database to ensure there is a record of repeated requests
3. All requests will be double checked by two people so errors can be picked up before reply sent to requestor.
4. There will be a signed copy of the response placed in the patient notes and sent to subject access department and the patients GP
5. The register will not be photocopied, but the requester will be offered an opportunity to come into the department and be shown entry in the register of their history.

Conclusion

Thank you for raising your complaint with us, this has enabled us to learn from the mistakes which unfortunately occurred due to human error.

We are truly sorry for the distress this has caused you. I hope you feel reassured with my investigation and that we have taken appropriate action to mitigate against this error in future.