Witness Name: Dr John Logan
Statement No.: WITN7451017
Exhibits: WITN7451007-012, 018-025
Dated: 16/01/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR JOHN LOGAN

I provide this statement on behalf of Lanarkshire Health Board in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 August 2020.

I, John Logan, will say as follows: -

Section 1: Introduction

1. **Please set out your name, address, date of birth and professional qualifications.**

   My name is John Logan. My address is NHS Lanarkshire Headquarters, Kirklands, Fallside Road, Bothwell, G71 8BB. My date of birth is GRO-C 1962. I am a medical doctor and my professional qualifications are MB, ChB; DRCOG; MRCGP; MPH; MFPHM. My General Medical Council registration number is 3267211.

2. **Please set out your current role at the Board and your responsibilities in that role.**

I am a consultant in public health medicine in the NHS Lanarkshire Directorate of Public Health and I am the NHS Lanarkshire lead public health consultant for blood borne viruses. I have been employed by NHS Lanarkshire in this role since 1999.

3. **Please set out the position of your organisation in relation to the hospital/other institution criticised by the witnesses (for example "ABC NHS Foundation Trust ('the Trust') operates from Hospital X and Hospital Y (formerly Hospital Z)").**

Lanarkshire Health Board is responsible for healthcare provision for the population of the Lanarkshire area.

Section 2: Response to criticism of W0328

4. **At paragraph 12 of her statement, witness W0328 states that in 2014, when she was being discharged from Wishaw General Hospital after treatment for leg ulcers, she was asked by a doctor if she knew that she had hepatitis C. Witness W0328 states that while she had been aware since 1970 that she had a form of hepatitis, this was the first time she was told that it was hepatitis C. She recalls that this conversation occurred in a public place rather than a private room and that after the statement was made, nothing further was done in relation to the diagnosis. Witness W0328 states that she was not told how to manage the infection or offered any support, and was instead sent home with morphine to treat the pain in her legs. Please comment on this.**

Mrs GRO-B 's medical notes have been reviewed to try to obtain information to enable the account given by Mrs GRO-B to be considered.

A letter dictated on 7 May 2014 (WITN7451018) by a locum consultant in rheumatology referring Mrs GRO-B to a consultant gastroenterologist refers to Mrs GRO-B being diagnosed with hepatitis C following hepatitis serology testing. The letter contains the following paragraphs:

I would be grateful if you could arrange to review this pleasant lady, who has been troubled with several years' history of appearance of a purpuric rash on her lower legs, and went on to develop ulceration. She has also been seen by Dr Wainwright for ? vasculitis.

In our work-up in clinic, I organised hepatitis serology, and this returned positive for the PCR, with a HCV Q-PCR level of 942687 IU/ml.

In the first instance, I have arranged a repeat of this blood test, and I will also organise cryoglobulins. I have written to Mr GRO-B with these results, and she will be aware of this referral to yourself.

A copy of the letter from the locum consultant in rheumatology to Mrs GRO-B is appended to this statement (WITN7451019). The letter details the following: Dictated 7-5-2014; Typed 9-5-2014; reference made to having seen the patient on 27-05-05 (which should probably be 27-05-2014); Authorised 30-5-2014. Reference is made in the letter to an attempt by the locum consultant in rheumatology to contact Mrs GRO-B by phone on 7-5-2014. There was a delay in the letter recorded as having been dictated on 7 May 2014 being authorised and posted to the patient.

The locum consultant in rheumatology also wrote to the consultant physician in geriatric medicine who was responsible for Mrs GRO-B inpatient care at Wishaw Hospital (WITN7451020) – letter dictated 9-5-2014; typed 12-5-2014 ; authorised 15-5-2014. The letter contains the following paragraph:

I understand that GRO-B is currently under your care at Wishaw General. I saw this pleasant lady for the first time in April 2014, with a question of whether she has vasculitic ulcers. I had taken some blood tests at the time, and the results were available to me only yesterday, and show that she is Hep C positive. It is likely that this rash is due to underlying cryoglobulinaemia. I have spoken to one of the doctors on the ward, Dr Ian Maitland, who kindly agreed to organise these tests while she is on the ward, and also to repeat her hepatitis serology. Mrs GRO-B not yet aware of these results, as she is not due to see me back in clinic till 27th May, but I have written to her yesterday with the results. I will copy this letter to Dr Wainwright, to keep him in the loop.

It would appear that the locum consultant in rheumatology was seeking to ensure that inpatient staff were aware that Mrs GRO-B s has tested positive for hepatitis C, would arrange to repeat the hepatitis serology test, were aware that Mrs GRO-B was not yet aware of her test results and were aware that Mrs GRO-B was due to see the locum consultant in rheumatology at the rheumatology clinic on 27 May.

A Wishaw General Hospital discharge letter dictated by a consultant physician in geriatric medicine on 28 May 2014 (WITN7451021) includes the date of

admission as being 1 May 2014 but does not specify the date of discharge, however, the Wishaw hospital interim discharge form for this admission is dated 22 May 2014 (WITN7451022). The discharge letter contains the following paragraph:

> Incidentally from previous investigations she was found to be hepatitis C positive. This has been repeated the result of which is pending. Mrs GRO-B received a blood transfusion 43 years ago following the birth of her son. At this time she was hospitalised and remembers being jaundiced. The rheumatology team felt that the rash is likely to be due to underlying cryoglobulinaemia and this has also been checked. I discussed this with Mrs GRO-B prior to discharge.

The following paragraphs are taken from a letter dictated on 27 May 2014 by the locum consultant in rheumatology who had referred the patient to a consultant gastroenterologist (WITN7451023). (In the letter "discharged from Hairmyres last Friday" should probably be "discharged from Wishaw (Hospital) last Friday" and "infusion" should probably be "transfusion":

> Mrs GRO-B attended today with her son. She was only discharged from Hairmyres last Friday with infected vasculitic ulcers. Her appointment today was merely to discus recent events regarding positive hepatitis C and positive cryoglobulins. It is likely that the rash and ulcers are secondary to cryoglobulinaemia. I have referred her to the gastro-enterologists for theirassessment. She recalls having an infusion following the birth of her first son 43 years ago and a possible needle stick injury. She has also had a blood transfusion when she was diagnosed with lymphoma in the 1980s.
>
> In any case her ongoing management is based on targeting her hepatitis C and I have explained this to her today. I will arrange a return appointment for 4-5 months to ensure she has not slipped through the net. As she has had recent blood tests I haven't repeated her bloods today.

In the paragraph above the locum consultant in rheumatology states that "her ongoing management is based on targeting her hepatitis C and I have explained this to her today."

A consultant gastroenterologist dictated a letter on 15 July 2014 (WITN7451024). Mrs GRO-B had been admitted to hospital again for treatment of her leg ulcers, on this occasion to Monklands Hospital. The letter contained the following assessment and recommendations:

Assessment
This lady is currently an inpatient in ward 15 (dermatology) at Monklands. I had found out a couple of weeks ago that she is an inpatient in Monklands and had tried to rearrange her appointment so that she could be seen there, and she has an appointment with Dr Kennedy at the end of this month. Her son was visiting from Ireland and was keen that she attended an outpatient appointment with me today, principally so that they could discuss the nature of her illness and possible treatments.

Her lab results have shown cryoglobulinaemia, although skin biopsies have not so far suggested vasculitic change. She has bilateral compression bandages on her legs. She estimates that she will be an inpatient in Dermatology for at least another couple of weeks, and subsequently may require some social care planning prior to discharge. She was in a wheelchair during the consultation today. She has a chronic normocytic anaemia with a haemoglobin of 7.7 and normal haematinics, and a raised urea at 11 but a normal creatinine, which may relate to her diuretic therapy (she has a normal echo).

We discussed the possible treatment options for Hepatitis C. Given her degree of anaemia I think she would be unlikely to tolerate a therapy containing Ribavirin, and we would therefore be best to see if we can obtain Ledipasvir and Sofosbuvir combination on a compassionate basis from Gilead, given for 8 weeks.

Recommendations
I will liaise with my colleagues in Monklands to see if we could start this treatment whilst she remains an inpatient. I discussed with her and her son that at the present time the treatment (if available) would

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be on a compassionate basis and it has not yet received a UK licence. I also gave them information on the Skipton Fund and encouraged them to apply.

Referring back to the points made above in relation to Mrs GRO-B's witness statement there seem to be three issues to address:

1. "while she had been aware since 1970 that she had a form of hepatitis, this was the first time she was told that it was hepatitis C."
2. "She recalls that this conversation occurred in a public place rather than a private room"
3. "that after the statement was made, nothing further was done in relation to the diagnosis. Witness W0328 states that she was not told how to manage the infection or offered any support"

With regards to the first point it does appear that the diagnosis of hepatitis C was made for the first time during Mrs GRO-B's admission in May 2014 to Wishaw General Hospital. There is no evidence in Mrs GRO-B s clinical records that I have been able to find to suggest that this diagnosis, of hepatitis C infection, was known to medical staff prior to May 2014 and not disclosed to Mrs GRO-B.

With regards to the second point there is no detail in the medical records as to where the conversation took place when Mrs GRO-B was given the diagnosis

of hepatitis C infection. The conversation that Mrs GRO-B refers to was probably the same conversation that the consultant physician in geriatric medicine refers to in the discharge letter: "I discussed this with Mrs GRO-B prior to discharge." Sometimes the perception that patients and health care staff have of public and private spaces can be different. For example, a patient may feel that a ward in which one or more other patients are present – whether bay screens are pulled around or not – is a public place and a health care worker may feel it is relatively private. Other factors may affect options and decision making, for example, if a patient is in bed and is or isn't bed bound; if a patient has impaired hearing and health care staff need to speak at a higher volume; or if a private room is available. Whatever the particular circumstances may have been it is regretted that Mrs GRO-B recalled that she had been given the important information about her diagnosis in a place that she did not consider to have been appropriate and that it was too public and not private enough. NHS Lanarkshire seeks to provide patient centred care so the needs and perspective of the patient need to be considered and efforts made to meet these needs.

With regards to the third point it would appear from review of the clinical notes that at the time of Mrs GRO-B being given the diagnosis actions were progressing but had stalled and information about what was planned may not have been communicated to Mrs GRO-B.

As mentioned above there was a delay in the letter from the locum consultant in rheumatology being authorised and sent to Mrs GRO-B. Also, the letter referring Mrs GRO-B to the consultant in gastroenterology (WITN7451018) was dictated on 7-5-2014, but not typed until 9-6-2014. It was not authorised until 17-6-2014.

Mrs GRO-B stated that she was not told how to manage the infection or offered any support – this may refer to the time of discharge or subsequently. Mrs GRO-B was seen at an outpatient clinic on 27 May 2014 by the locum consultant in rheumatology, five days after she was discharged.

A consultant gastroenterologist dictated a letter on 15 July 2014 (WITN7451024) – the same day that he had seen Mrs GRO-B accompanied by her son, at an outpatient appointment at Hairmyres Hospital. At that time Mrs GRO-B was an inpatient at Monklands Hospital. The consultant gastroenterologist discussed treatment options with Mrs GRO-B and her son and details in his letter that he was going to seek to obtain treatment with some of the newer hepatitis C drugs on compassionate grounds as Mrs GRO-B s clinical condition meant that it was unlikely that she would tolerate a therapy containing Ribavirin. The consultant gastroenterologist details that Mrs GRO-B s son had attended the appointment "principally so that they could discuss the nature of her illness and possible treatments."

Mrs GRO-B was subsequently successfully treated with Sofosbuvir and Simeprevir. In August 2015 following a negative 24 weeks post-treatment test for hepatitis C Mrs GRO-B was discharged from the Monklands Hospital Nurse Led BBV Clinic. (See attached letter dictated 3-8-2015, WITN7451025.)

Good communication and provision of compassionate care are two of the key areas that are focused on in the NHS Lanarkshire quality strategy and implementation plan.

NHS Lanarkshire seeks to provide the best available care to patients and carers using available resources. The approach to providing patient and carer centred care has developed significantly in recent years with all members of staff being involved in contributing to assuring the quality of care provided and taking a continuous quality improvement approach. In NHS Lanarkshire the approach to quality assurance and quality improvement is managed by a programme that is embedded across the organisation which is called the Lanarkshire Quality Approach.

Copies of the following documents are appended to this response:

- NHS Lanarkshire Quality Strategy 2018-2023 (WITN7451007)

- NHS Lanarkshire Quality Strategy Implementation Plan 2022/23 (WITN7451008)
- Annual report (2021-2022) on feedback, comments, concerns and complaints (WITN7451009)
- The Healthcare Quality Assurance and Improvement Committee (HQAIC) toolkit (WITN7451010) – this includes details of the terms of reference of this committee and the committee structure
- Care opinion (What's your story?): Annual Review of stories told about NHS Scotland Services in 2021-2022 (WITN7451011). NHS Lanarkshire promotes Care Opinion, monitors the stories, shares these with members of staff, monitors feedback and reports on this work to the corporate management team. The Annual Review includes details of each NHS Board.
- An SBAR report on the development of the NHS Lanarkshire Quality Strategy 2023-2028 (WITN7451012). This includes an updated info-graphic which summarises the aims of the quality strategy and is being used to promote engagement with the development of the new strategy. The new strategy will involve greater provision of information about the quality strategy on the NHS Lanarkshire public website.

Further information is available from the Quality Directorate by emailing: lqa@lanarkshire.scot.nhs.uk .

It is recognised that as well as having high level strategies and plans the delivery of a high quality service depends on the quality of relationships, interactions, communication and other aspects of treatment and care with every patient and their family and carers. Implementation of the quality strategy is closely monitored and reported to the executive directors of the corporate management team and to NHS Lanarkshire Board members.

It is acknowledged that the quality of care provided to patients and carers in the past may not have been satisfactory and if that has been the case this is very much regretted.

Section 3: Other Issues

5. **If there are any other issues in relation to which you consider that you have evidence which will be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference, please insert them here.**

   I understand that Mrs GRO-B died on GRO-B 2019. Should members of Mrs GRO-B 's family wish to meet with me and a member of the NHS Lanarkshire quality directorate to talk about Mrs GRO-B 's witness statement and the current approach to health care quality assurance and quality improvement, I would welcome the opportunity to arrange a meeting at a place, date and time that is convenient for them.

Statement of Truth

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

Signed GRO-C

Dated 16th January 2023

Table of exhibits:

Date	Notes/ Description	Exhibit number
07.05.2014	Letter to Gastroenterology	WITN7451018
07.05.2014	Letter to Mrs GRO-B	WITN7451019
09.05.2014	Letter to Dr Burnett	WITN7451020
28.05.2014	Discharge Letter dated 28.05.2014	WITN7451021
22.05.2014	Hospital Interim Discharge Form	WITN7451022

27.05.2014	Letter from Locum Consultant	WITN7451023
15.07.2014	Letter from Gastroenterology	WITN7451024
03.08.2015	Clinic Discharge Letter	WITN7451025
	NHS Lanarkshire Quality Strategy 2018-2023	WITN7451007
	NHS Lanarkshire Quality Strategy Implementation Plan 2022/23	WITN7451008
	Annual report (2021-2022) on feedback, comments, concerns and complaints	WITN7451009
	The Healthcare Quality Assurance and Improvement Committee (HQAIC) toolkit	WITN7451010
	Care opinion (What's your story?): Annual Review of stories told about NHS Scotland Services in 2021-2022.	WITN7451011
	An SBAR report on the development of the NHS Lanarkshire Quality Strategy 2023-2028.	WITN7451012