Witness Name: Eileen Patricia Dyson
Statement No.: WITN2130002
Exhibits: None
Dated: 1 December 2022

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF EILEEN PATRICIA DYSON

I provide this supplementary statement following my first written statement which was provided in response to a request under Rule 9 of the Inquiry Rules 2006 dated 5th November 2018 to provide further information which may be relevant to the Inquiry.

I, Eileen Patricia Dyson, will say as follows: -

1. Since providing my first statement, I have been provided with the response of Dr Morris to my statement and oral evidence and I wish to make further comments in light of this. The response is dated 10 November 2021 but was not provided to my solicitors until 20 October 2022. The Inquiry reference of the response is WITN GRO-D . I also have some further information to provide to the Inquiry in light of the response of Dr Marc Turner of the SNBTS dated 27th June 2019. The Inquiry reference for Dr Turner's response is WITN3530002.

2. I wish to reaffirm my recollections of how I was informed of my infection of Hepatitis C virus as detailed in both my written statement and my oral evidence. As so many of my medical records were destroyed and so little remains, the few documents cited by Dr Morris cannot be relied upon to give an accurate and full account of the management of my healthcare needs from 1993-2000. The references Dr Morris makes to other doctors mentioned in the medical

records he has selected only reinforces my recollections of being treated as an "interesting lady" by the eight doctors who attended my hospital bed in 1993 while I was an inpatient and also the number of other doctors in the room when I was given my diagnosis of Hepatitis C in 1994. Dr Morris states in his response that the likelihood of him meeting me in 1993/1994 is very low indeed. My clear recollection, and that of my husband, is that it was Dr Morris who told me of my diagnosis in 1994.

3. In response to the points raised by Dr Morris regarding the operational policies of GRO-D from 1993 to 2000 when I last attended the outpatient department, I wish to describe what I observed during these years as an outpatient as follows:

    a. The outpatient department was a place of total chaos and disarray. Clinics were very poorly managed with patients waiting 2 or 3 hours after their arranged appointment time. There were exceptionally large numbers of patients in very cramped unventilated areas. Often, I would witness nurses announcing that a clinic had been cancelled with no explanation and would see the distress and strain this would cause patients. Nurses would often complain of doctors not turning up and medical records not being available for patient's appointments. The management of the clinics did not improve during these years and this mismanagement and lack of patient centred care had a very detrimental effect on me and on other patients who expressed their concerns to me during the lengthy waits we had to endure, at so many clinic appointments.

    b. Medical staff were impersonal, they did not introduce themselves. When calling you forward for your consultation, nurses would refer to other medical staff, in a general way as "doctor" or "consultant" and doctors would not give their name. So, it was assumed that you were speaking to a consultant, as there was no way to know if the doctor's position could in fact be registrar or senior registrar, in the same way you would not know the different nursing titles.

c. As regards the assessment and management of my needs as an inpatient and outpatient it was not person centred care, there was no openness or support, and this was clearly demonstrated by the unwillingness to answer my questions and concerns or respond in a supportive manner to the obvious impact the Hepatitis C diagnosis was having on my life and my family's.

d. Dr Morris refers to "patient specific pathways and protocols and a major emphasis… on accurate verbal and written communication delivered in a supportive environment". This never transpired. There was no referral to a specialist nurse or psychological support. I never received any information sheets giving details of websites that he refers to and definitely did not benefit from the healthcare environment which he describes, which is that "At all times we recognised the emotional, psychological and social impact of the diagnosis of Hepatitis C"

e. My response to Dr Morris's statement demonstrates another flaw in the management of patients by GRO-D because it clearly shows there was no value placed in patient feedback to establish whether new policies were actually delivering their intended outcomes. My witness statements to the Inquiry show just how severely they failed me; my family and I suspect so many other patients.

4. This additional witness statement in response to Dr Morris's statement, has given me the opportunity to offer in greater detail the serious and detrimental mismanagement I witnessed at GRO-D during the period 1993-2000 so that the Inquiry may more fully understand the behaviour of NHS staff and the distressing impact their actions had on my life and my family's. There was a total disregard for the person before them.

5. I would also like to add that Dr Morris refers to accessing information about me on the Hepatitis C database. I do not know what information is held about me on that database and have not given consent for my information to be held on such a database.

6. Finally, my solicitors have tried to trace the blood component numbers for my blood transfusions Bellshill Maternity Hospital in April 1988, Hairmyres Hospital in May 1988 and Monklands Hospital in February 1989. Marc Turner of SNBTS responded to my statement about the way I was treated when I contacted SNBTS shortly after my diagnosis to try and find out batch numbers of the blood I received. The response has the Inquiry reference WITN3530002. He stated that the SNBTS would be willing to carry out a reverse lookback if these numbers could be traced. My solicitors have been advised by the solicitors for the Health Board that the unit numbers for the two units of red cells transfused on 14 May 1988 at Hairmyres hospital have been identified, as have the numbers for four units of red cells transfused for a GI bleed at Monklands hospital in February 1989. Regarding the Monklands hospital units, my solicitors have been advised that the units don't appear to have been signed out the ledger that they were taken but that it is possible that in an emergency the lab staff may have taken them to theatre themselves. Not all of the units transfused at Monklands have been identified (in paragraph 6 of my first written statement, I stated that I received 16 units) and none of the units from Bellshill Maternity hospital have been identified. This is evidence of the deficiencies in record keeping in respect of blood component numbers. The possibility of a full reverse lookback has been frustrated by the lack of good record keeping on the part of the hospitals and the attitude of the SNBTS at the time of my original enquiry.

Statement of Truth

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

Signed GRO-C

Dated Dec 1, 2022