Witness Name: Dr Patricia Hewitt
Statement No.: **WITN3101003**
Exhibits: **NIL**
Dated: 18 June 2019

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF DR PATRICIA HEWITT

I, Patricia Hewitt, provide this further statement to supplement my initial statement (4th June 2019) and in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 June 2019.

This supplementary statement is intended to answer two questions raised during Mr L's evidence on 7th June 2019, and to clarify certain areas in my initial statement which appear to have been misinterpreted or misunderstood.

1. In paragraph 9 of my statement of 4th June 2019 I made specific reference to responding to the first letter from Dr Phil Rice in 1999 by making an enquiry to the Consultant Haematologist in charge of the blood transfusion laboratory at St Helier Hospital, to ask for the transfusion records relating to Mr L. The transfusion laboratory is the repository of the primary records relating to all blood transfusion within the hospital. It is therefore best practice to request the records direct from the hospital blood transfusion laboratory. It is not good practice to rely on entries in the patient medical records, as these are not the primary records and cannot be guaranteed to be complete. The point was made by Mr L that he was treated within the Intensive Therapy Unit (ITU), where staff are trained in, and familiar with, the need to document all events and actions. Nevertheless, there is no guarantee that the medical records are accurate with respect to blood transfusions. Mr L demonstrated that his medical records contained labels which had been attached to the individual blood components which were transfused to him during his stay on ITU. Neither he, nor anyone else, can be certain that these labels represent a complete and accurate record. This is why it is important to always obtain the primary records from the hospital blood transfusion laboratory.

2. It may be helpful to explain the nature of hospital blood transfusion laboratory records. The blood transfusion laboratory receives all blood components from the issuing blood centre. Each blood component is identified using a unique donation number (batch number) which can be traced through blood centre records back to the originating donor, and the component type (red cells, platelets, fresh frozen plasma [FFP] or cryoprecipitate). In the hospital blood transfusion laboratory, the donation number and component type is recorded together with the date of receipt from the issuing blood centre. Thereafter, every movement of the blood component is recorded so that there is a complete audit trail from date of receipt to date of final disposition, which would most usually be date of transfusion to a named patient, but

in some situations would be "wasted" or "discarded not used". Nowadays all hospital blood transfusion laboratory records are computerized and can be easily interrogated: either by donation number to obtain a complete audit trail from receipt to final fate for the blood component in question, or by patient name to obtain a full transfusion history (listing of all blood components transfused) for a named patient.

3. Although I cannot know for certain, I believe that it is highly unlikely that the transfusion records at St Helier Hospital were computerised in 1990/91. I base this statement on my general knowledge of the status of blood transfusion laboratory records at the time. Prior to computerization, all records were held on paper, often in the form of work books. When I made my initial enquiry to the blood transfusion laboratory in 1999, I gave the date of transfusion which had been given to me (September 1991). A manual search of paper records would have been carried out. Without knowing how that laboratory organized the records, I am unable to comment on how such a search would have been conducted. It is possible that a search would have relied upon the reported date of transfusion. As has already been established, that date as supplied to me, and then supplied to the Consultant in charge of the blood transfusion laboratory, was September 1991. If there was no facility to conduct a search by patient name, and the search was purely by date of transfusion, then this could explain why no records were located, as the wrong time period would have been searched. The answer to this question could only be provided by someone with a detailed knowledge of the laboratory records at St Helier Hospital in 1990/91.

4. I would like to emphasize that I did not, at any time, apply for Mr L's medical records. This would have been inappropriate in the case of establishing the full transfusion history, for the reasons given above. It would also have been inappropriate since I had no authority to apply for confidential medical records, nor would the Medical Records Department have allowed me access to those records, at least without signed patient consent.

5. Mr L was asked at the Inquiry whether he had been shown my letter to Dr Rice in 1999. He confirmed he had not seen the letter. Since Dr Rice did not have clinical care of Mr L, I took the precaution of copying my letter to Professor MacGregor, who was identified to me as having clinical responsibility for Mr L. I asked that Mr L was made aware of the contents of my letter. It is clear this did not happen. I have no doubt that, if Mr L had been shown my letter, he would have challenged the information and matters might then have been very different. As Mr L himself stated, by the time that Dr Tibbs took up the matter in 2004, another 5 years had elapsed.

6. There remains the issue that in his statement (paragraph 3), Mr L stated that "I have copies of the labels from the 137 bags of blood I received". In his letter to me, dated 5th October 2004, Dr Tibbs noted that Mr L had obtained a complete copy of his notes from St Helier Hospital and that "I think there is adequate evidence from the St Helier notes that he was transfused". He went on to state: "I enclose from his records the photocopies of the labels **of all the blood transfusions** (my highlighting) he had so that....." In my letter to Dr Tibbs in 2005, in response to his letter of 2004, I noted that the copies of labels provided to me from the blood packs used on Mr L

represented exposure to 17 different blood components over the period 9/3/90 to 9/4/90. At the Inquiry on 7th June 2019, Mr L stated that there were in excess of 160 labels. I am at a loss to understand this discrepancy in numbers. Examination of the copies by an individual with blood transfusion expertise could certainly be helpful in solving this puzzle.

7. It is therefore appears to me that I was provided with incorrect or incomplete information on two separate occasions: an incorrect date of transfusion in the initial enquiry in 1999, and an incorrect date and incomplete number of components transfused in the further enquiry in 2004.I can only act upon information provided to me. I am distressed to see that I am criticized for failing to locate records which were not under my control and for which I had been given incorrect details.

8. I have also been asked to comment on the use of the term "routine" when referring to the "routine screening of blood donations". The adjective "routine" is used according to the dictionary definition: "performed as part of a regular procedure rather than for a special reason". In this context, "routine screening" means that every donation is screened as a matter of course, without any decision about whether, or which, donations will be screened. This could also be referred to as "universal screening". Routine HCV screening of blood donations commenced in the UK on 1st September 1991. Earlier in the same year there had been pilot studies of the recently introduced "second generation" hepatitis C antibody screening assays produced by a number of different manufacturers, to assess their performance in practice and to determine which were best suited to use within the blood service. These pilot studies took place in a number of English blood centres in the early months of 1991, and this screening continued in those centres once the pilot studies had been completed. It is therefore the case that some blood donations were being screened for the presence of HCV antibodies prior to 1st September 1991, but no such screening took place at any time in 1990. I can therefore state with confidence that no donations transfused to Mr L during the early months of 1990 were screened for hepatitis C, although a number would have been obtained from blood donors who continued to donate after 1st September 1991, and were therefore screened for HCV on a subsequent donation. As I have previously stated, if any such donor had tested positive for hepatitis C, we would already have carried out a lookback to identify recipients of previous blood donations made before the introduction of HCV screening, so that such recipients would have been notified and offered testing.

9. I hope that this supplementary statement has given a clearer understanding of areas of my initial statement which have led to further questions. As before, I am anxious to assist the Inquiry in whatever way I can to ensure there is a clear understanding of the matters I have described.

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

Signed GRO-C

Dated 18th June 2019