Witness Name: Colin Wasson
Statement No.: WITN3349002
Exhibits:
Dated: 28 June 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF COLIN WASSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28 June 2019.

I, Colin Wasson, will say as follows: -

Section 1: Introduction

1. My name is Colin Wasson of Stockport NHS Foundation Trust, Stepping Hill Hospital, Poplar Grove, Stockport, Cheshire SK2 7JE. My date of birth is GRO-C GRO-C 1968. My professional qualifications are BSc, MBChB, FRCA, FFICM.

2. My current role is Medical Director at Stockport NHS Foundation Trust. I have been in post since April 2016. My responsibilities are to provide advice to the Chief Executive and Board of Directors on all professional medical issues, and taking lead on medical engagement within the organisation through the leadership and management of the medical work force in its provision of a quality service to patients.

3. I have not been a member past or present, of any committees or groups relevant to the Inquiry's Terms of Reference.

4. My response pertains to the care given to Mr. Peter Burney by Stockport NHS Foundation Trust in 2010.

Section 2: Responses to criticism of Mrs Christine Burney reference paragraphs 8 to 10 of her statement

5. I have been asked to respond to the references Mrs Burney makes with regard to Stockport NHS Foundation Trust in her statement. For clarity, I can confirm that both doctors referred in the statement have left the Trust.

6. In Paragraph 8 of Mrs Burney's statement she has stated that: *His consultant went on holiday, then Dr* GRO-D *came to Peters room one day around December 2010. He asked me "has Dr Das ever spoken to you about Peters illness?" I said "No" and he asked to see the family for a meeting. I told my son, Christopher that we had a meeting with the doctor. So me, Sam and Christopher went. There was a secretary taking notes. Dr* GRO-D *said to us, "Peter's very very poorly, and we don't expect him to survive." And we're sort of looking at each other, and obviously it's breaking my heart. He went on to say "and in these circumstances, we put a DNR against his name" So, I'm crying, screaming. Christopher was crying and he ran out of the room. The doctor went and got a nurse: I asked what I was going to tell Peter and she said to wait until we'd all calmed down a bit. They never asked us to sign anything. The doctor told us he needed to get to the MRI, a liver specialist hospital. I asked how long it would take and they said a couple of weeks Within 4 hours he was there. A couple of the family had come down because I had told them. He was wondering what was going on with all the family there, he thought they were coming to visit mum who was in the same hospital. He wasn't even yellow, was talking to us all, making jokes. The day after my mum died. Talking to the funeral fellow, I was telling him that it might be a double funeral. Peter was gutted he couldn't come to the funeral. We buried my mum on 27 December 2010. Peter was too poorly to come.*

7. I can confirm that within Mr Burney's health records there is a DNAR form which is dated the 16 December 2010. The consultant identified as being Mr

Burney's' consultant on the form is Dr GRO-D who was the consultant under whom Mr Burney was admitted when he came into Hospital on 10 December 2010.

8. Within Mr Burney's health records, dated 16 December 2010, there is an entry made by the foundation year 1 doctor who was supporting Dr GRO-D on his ward round. The entry states, "Discussion with the family, explained the advanced disease, transplant – illness has gone too far, needs transfer to MRI, made no promise that this would happen, if continues without intervention-may not live to Christmas. DNAR is being considered by the family."

9. On the DNAR form, in the section relating to the decision discussed with next of kin / family aware of decision: the box "yes" has been ticked; "Wife". The DNAR was completed on the 16 December 2010. There is no requirement for NOK/family to sign a DNAR form.

10. At 11:40, 16 December 2010, the foundation year 1 doctor has written "needs TIPPS now – to re-fax Dr GRO-D at MRI." The fax was sent urgently to MRI and confirmation of the receipt of the fax was received at 13:10 on 16 December 2010. At 16:30, 16 December 2010, nursing staff have documented that a bed is available for Mr Burney at MRI and he is then transferred to their care.

11. I am sorry that the sudden agreement to transfer Mr Burney came as a surprise, and seemed at odds with the oxpectation outlined above. Clear communication and information is extremely important in any health care setting, but even more so when changes happen quickly. I am sorry that the clinicians did not communicate the reasons for the change of plan more effectively at this difficult time.

12. In paragraph 9 of Mrs Burney's statement it states: *In January 2011, Peter pinched his file and called me and asked me "what's this about the DNR" We had always discussed what we wanted to happen in that situation, and we said we don't want to be a cabbage. He went absolutely berserk. I told him:*

we're not doing away with you yet and he calmed down. When he went back in January to the TIPPS-the doctor told him that he wasn't going to do it because his vitals/signs had come up a little bit. None of the doctors ever spoke to me about the DNR again. I thought because he'd improved that they'd take it off his file, but they never did.

13. On the DNAR form in the section relating to discussion with the patient / patient aware; the box "no" is ticked. There is no apparent reason why a conversation could not have been held with Mr Burney around the completion of a DNAR form as there is no documented lack of capacity throughout this admission. I would like to offer my apologies to Mr Burney that this was not discussed with him.

14. The DNAR form states SECTION ONE (C) setting a review date: The box "no" has been ticked. I can confirm that there are no reasons supplied as to why a review of the DNAR is unnecessary. I can confirm that the form was signed by the Registrar, Dr GRO-D The box "verbal consent given by consultant" has been ticked. There is no date or time against this section of the form.

15. I would like to offer my apologies to Mr and Mrs Burney for the poor completion of the DNAR form and the lack of conversation and explanation of the decision making process surrounding this.

16. Since 2010 the Trust has improved the standard of the completion of DNAR forms through training and audit. Compliance with the guidance of completing the forms is audited and monitored by the Quality Governance Group, which is chaired by the Medical Director. Poor compliance is managed with individual staff members.

17. In Paragraph 10 of Mrs Burney's statement it states: *He had to sign an alcohol free thing in the June 2010. Back in July 2010, Dr Das asked Peter about whether he had had any transfusions, injections, tattoos, gay sex. But he never explained why he was asking. Then it was just about appointments. Nothing was discussed until March/April 2011 about hepatitis C. There was no*

discussion of risk to family members, lifestyle changes. There was never a mention of his hepatitis C. We just thought you got it because your liver was poorly. There was no connection made to the transfusions.

18. Within the health records there is a letter written by Dr Das to Dr GRO-D general practitioner and copied to Mr Burney at his home address. The letter is dated 29 October 2010 and states "The course of this liver disease is suspected to be a combination of hepatitis C which has also come to light only recently. He does not give any history to exposure of needles. There is a history of blood transfusion in the remote past. He is very strongly positive for Hep C RNA with a viral count of 17630 iu/ml, log 4.25. There is also a history of alcohol excess in the past until a few years ago."

20 I can confirm there is an entry within the health records, 08 December 2010, made by Dr Das on his ward round. The entry states, "suspicion of HCV cirrhosis, source of infection likely blood transfusion previously." The reference to HCV is made as Hepatitis C is a liver infection caused by the Hepatitis C virus. To this effect the HCV is made reference to.

21 In the letter sent to Dr GRO-D and Dr GRO-D 16th December 2010, the Foundation Year 1 doctor writes "He has end stage liver failure secondary to Hepatitis C and possibly an 8 year period of alcohol dependence in the 1990's."

22 However, the source of the infection is not referenced in the letter of the 16 December, which, at this stage, was considered likely to be due to a previous blood transfusion. There are two entries in the health records to this fact.

23 I am sorry that the communication about Mr Burney's diagnosis was not clear.

Statement of Truth

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

Signed _ GRO-C

Dated ____28.06.2019_____

Table of exhibits:

Date	Notes/ Description	Exhibit number