Witness Name: STEPHEN THOMSON
Statement No.: WITN4150002
Exhibits: WITN4150003
Dated: 9th October 2020

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF STEPHEN THOMSON

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1. I, Stephen Thomson, Associate Director of Integrated Governance for Taunton & Somerset NHS Foundation Trust will say as follows: -

2. Taunton & Somerset NJS Foundation Trust merged with Somerset Partnership NHS Foundation Trust on 1st April 2020 to become Somerset NHS Foundation Trust.

Section 1. Searches, including search terms used

3. The relevant documents provided to comply with the Rule 9 request were not electronic, therefore it is not possible to state any "search terms". The paper records were historical records filed with the Haematology Department under "Haemophilia Centre". All relevant documents (including reports, reviews, briefings, minutes, notes and correspondence which were potentially relevant to the Inquiry's terms of reference) were scanned and provided as pdf files. No departmental records have been destroyed within the Haematology Department.

4. In addition, from a list of 269 relevant patients who had received blood products (not all of who were Musgrove Park Hospital patients), 215 records have been retained and marked “do not destroy”. Of the rest, some patients had no notes (and some were not on the Trust’s patient administration system) and some had notes that had already been destroyed in line with the time periods in national guidance and Trust policy.

5. Taunton & Somerset NHS Foundation Trust was asked in 2018 to search all documents relating to the Taunton Haemophilia Centre. Because of the timescale when this was in operation, none of the records were stored – all documents were typewritten / hand written. Therefore, no “electronic” searches were made at the time, so there were no search terms used.

Section 2. The Trust’s information repositories (from 1950 to present day) such as local authorities, University archives and The National Archives

6. The only relevant information that the Trust holds is within its own departmental files and medical records. There are no additional information repositories.

7. I can confirm that the Trust does not use any other information repositories for storage of departmental files and medical records.

Section 3. Repositories and archives searched

8. Not applicable.

Section 4. This section should only be used if documents have been destroyed. Please explain briefly and exhibit copies of the relevant document destruction record or policy to the statement.

9. Records are kept in line with the Records Management Code of Practice for Health and Social Care. This means that medical records and pathology will normally be kept for 8 years after the last seen date or date of death (or 26th birthday for a child's records). Certain records, such as those for CJD, will be kept in line with the specific requirements (30 years after the patient was last seen, or 8 years after death, for CJD).

10. Please see the Trust's retention schedule included at exhibit WITN4150003.

Statement of Truth

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

Signed GRO-C

Dated 9th October 2020