Sheffield Children's NHS

NHS Foundation Trust

IN THE MATTER OF THE INFECTED BLOOD INQUIRY

WITNESS STATEMENT OF JEFFREY PERRING

I, Dr Jeffrey Perring, whose address for the purpose of this statement is c/o Sheffield Children's Hospital, Western Bank, Sheffield, S10 2TH, will say as follows:

1. I, Jeffrey Perring, am the Medical Director, currently working at the Sheffield Children's NHS Foundation Trust. My GMC number is 3291319.

2. I make this statement in relation to the request from the Infected Blood Inquiry on 14 February 2020.

3. I can confirm that a thorough physical search of the haematology area was conducted by Dr Jeanette Payne, Consultant Paediatric Haematologist, in September 2018 following the initial request for documents for the inquiry. The current haematology area has been occupied by medical, nursing and admin staff in haematology during the period of interest from 1970 onwards. Each room occupying the footprint of the area was searched and every box file, folder and filing cabinet was searched for relevant documents.

4. The only information that was identified at this time was a list of patients tested for hepatitis A, B,C and HIV with some results recorded but no further details and a list of patients exposed to batches of blood products during the period 1980-2001. This information appears to have been collated in 2004. These documents have been shared with the Infected Blood Inquiry. Some are lists of patients exposed to infected batches of factor concentrate and there is some incomplete documentation of test results and treatment. Dates on the documents suggest the lists were compiled some time from 1990 to the present time most likely as part of a 'look back' exercise.

5. The electronically stored information is on the shared electronic drive H:\INFOAREA which was created in 1998. The only information of relevance is in a folder titled Hepatitis C look back and Thrombosis\General Haemophilia Information\Hepatitis C look back. The folder was created in 2012. It contains an electronic version of the paper patient list found. There is also a copy of the 2011 UKHCDO report on Hepatitis C look back exercise. These reports are freely available on the internet.

6. Michelle Scott, Blood Bank Service Lead, conducted a search in September 2018

and confirmed that they may hold a list of components/ products given to patients on the old LIMS system (electronic system) but they would need a list of infected patients to identify these. The old LIMS system would not indicate which components were infected. A search was conducted of all the offices, laboratory spaces and filing cabinets and no physical documents were found in relation to the inquiry.

7. It was identified that information was kept on the Telepath 2000 system. Prior to Telepath 2000 we used the Trent system. Patient blood groups (not sample information) were copied from the Trent system to Telepath 2000. Blood components (not batched products) transfused (but not issued and unused) data from Dec 1983 was copied from the Trent system to Telepath 2000.

8. We still have access to the old Trent System and this also contains information copied from a prior computer based system and a paper cryo log book spanning July 83 to May 89. From the old Trent system we can obtain recipients of batched products (Factor concentrates) and recipients of blood components (red cells, platelets etc), patient transfusion record (all components transfused and factor concentrates given). If we are given patient details we can provide the batch numbers and unit numbers of products and components given since 1983. If we are given a batch number or unit number we can search for recipients of that product or component. We do not hold any product, component or patient microbiology results.

9. We have found no documents or information from the time of the infected blood problem pertaining to policies or procedures. During the review for relevant documents it was established that we do not have any local policies relating to infected blood products. Precautions with products are such that any risk of infection is really of unknown infections (ie ones that donors are not screened for and management would be not clearly defined). If exposed to an infected blood product we would follow policies and procedures from NHSBT if it was from a blood product and if a commercial drug then from the manufacturer as well as the UK haemophilia doctors organisation (UKHCDO). It wouldn't be just our centre that was affected so a nationally directed approach is appropriate.

10. Blood transfusion laboratory documents were sent to Crown archiving from 1980. A list of the types of documents sent by the Trust was kept. This was reviewed and no relevant documents were identified

11. We are unable to confirm what, if any, documents have been destroyed in line with our document retention and destruction policies. No documents in relation to destruction of records have been found but that is not to say documents have not

been destroyed. We can, however, confirm that since the Inquiries request no relevant records have been destroyed.

I believe the facts contained in this statement are true to the best of my knowledge.

Signed ..... GRO-C .....

Dated ..... 11/3/2020 .....