Witness Name: Dr Alex Crowe
Statement No: WITN4198001
Exhibits: WITN4198002 –WITN4198034
Dated: 14.2.21

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ALEXANDER CROWE

I provide this statement on behalf of Warrington and Halton Teaching Hospitals NHS Foundation Trust ("the Trust") in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 June 2020.

I, Dr Alexander Crowe, will say as follows: -

Section 1: Introduction

1. My name is Dr Alexander Crowe and my date of birth is GRO-C 1966. My professional address is Warrington & Halton Teaching Hospitals NHS Foundation Trust, Lovely Lane, Warrington WA5 1QG.

2. I am a Consultant Nephrologist and my professional qualifications are as follows: MBBS, FRCP, MD.

3. I am the Executive Medical Director of the Trust. I joined the Trust as Deputy Medical Director in December 2016, became Medical Director in October 2017 and the substantive Executive Medical Director in June 2020. I am also the Trust's Chief Clinical Information Officer and a current appraiser for NHS England.

4. Warrington Hospital is one of three health facilities owned and operated by the Trust, in conjunction with Halton General Hospital and Cheshire and Merseyside Treatment Centre. The Trust was created on 1 December 2008 and was formerly known as North Cheshire Hospitals NHS Trust.

Section 2: Response to Criticism of W1889

5. Below I have covered each of the points raised in questions 4 to 9 of the rule 9 request. I have referred to the patient, the subject of W1889, as 'the patient' rather than by name, purely to maintain anonymity and no discourtesy is intended by this.

6. I understand Dr Linaker was a Consultant Physician in Internal Medicine and Gastroenterology employed by the Trust between March 1981 – April 2007 and treated the patient in the 1990s. Dr Linaker is referred to at paragraphs 10, 18, 23 – 29, 35 - 36, 38 - 39, 47, 52, 60 and 86 (b) of the patient's statement and has responded directly to the criticisms concerning him separately.

7. I am aware that contact has been made with Mr McNicholas, Consultant in Trauma and Orthopaedic Surgeon (employed at the Trust between 2001 and 2013) and that the patient mentions him at paragraphs 18, 54, 56 - 57 of their statement. Mr McNicholas' responses are included within this statement.

Concern raised by the Inquiry - The patient received no information at the time of blood infusion about possible risk of infection from the procedure.

8. I have been advised by my colleagues, a Consultant Microbiologist and a Consultant Gastroenterologist, specialising in various aspects of liver disease (including fatty liver disease, viral hepatitis, chronic liver disease/ fibrosis, cirrhosis and complications) that in 1980, the risk of possible infection with Hepatitis C Virus ("HCV") from a blood transfusion was not known. Therefore, there will not have been any discussion about the risks of HCV infection at the time of the patient's surgery in December 1980.

9. By way of background, which I am sure the Inquiry is aware of, HCV was first identified in 1989, with the first tests commercially available in November 1989 (Penrose Inquiry Report, chapter 31; paragraph 31.19. http://www.penroseinquiry.org.uk/). From September 1991, HCV testing was widely introduced throughout the UK by NHS Blood Transfusion and was used for testing blood donors to ensure blood units supplied were HCV negative.

10. The patient is without doubt that they must have been infected by the blood transfusion in 1980 because there were no other routes for infection. Many of the patient's GP

scanned, handwritten records from the 1980s are unfortunately illegible. The Trust has also searched through all available blood transfusion records and has not been able to identify any records that confirm any details around the patient receiving a blood transfusion on 7 December 1980.

11. The patient refers to receiving a blood transfusion after being involved in an accident. The patient states that they slipped on some ice at an event which resulted in severe lacerations to their right arm and significant blood loss. The patient states that they had surgery to repair the wounds and they received a blood transfusion.

12. A letter to the patient's GP, from the Orthopaedic Registrar, dated 16 December 1980 confirms that the patient was admitted through casualty on 7 December 1980, sustaining laceration on the medial side of the right cubital fossa from a glass window. The letter describes:

"[the patient]" was taken to theatre where exploration of the wound was done. The median nerve was found to be bruised, but in continuity, but there was severance of the medial cutaneous nerve or the forearm and this was sutured back into position."

The letter states that *"post operatively, the patient was comfortable… had been sent home and will be seen in clinic on 17th December 1980."*

13. The letter does not make any reference to the patient receiving a blood transfusion during the admission. Please see the attached letter at **Exhibit WITN4198002.**

14. A letter to the patient's GP from a Registrar dated 24 October 1991 states:

> *[the patient] has stopped drinking completely now. [The patient] still complains of early morning problems which I think are due to alcohol withdrawal. [The patient] complains of pain in the right hypochondrium. I have checked [the patient's] hepatitis screen, ultra sound scan of the abdomen, LFTs and INR. If the blood tests are still Hb normal we will consider doing a liver biopsy… [The patient] will be reviewed in 4 weeks' time.*

15. There is no reference within the letter dated 24 October 1991 to the results of this hepatitis screen. Please see the letter attached at **Exhibit WITN4198003.**

16. The notes state that the patient's GP made a referral in October 1991 due to the patient complaining of nose bleeds, vomiting red and brown colour blood from time to time and

having lost 4 stones in weight in three months. Investigations were underway at this time and the patient was admitted on 20 November 1991 for a liver biopsy. During this admission, the patient's medical records include a blood transfusion prescription. I attach a copy of the form at **Exhibit WITN4198004,** however the form has not been completed fully. For example, the amount of blood, or time of administration have not been documented. The patient was discharged on 26 November 1991.

17. The patient was re-reviewed in the clinic on 20 December 1991 and was informed that their liver biopsy confirmed micronodular cirrhosis. It is noted that the importance of abstaining from alcohol was reinforced to the patient.

18. The patient was admitted via A&E on 17 January 1992 with history of melaena and PR bleeding. The patient underwent a sigmoidoscopy. The notes state: *"colonic biopsy; large bowel mucosa and muscularis mucosae, showing no significant histological abnormality. OP appointment after Barium enema".* During this admission, the patient's medical records include a blood transfusion prescription. I attach a copy of the form at **Exhibit WITN4198005,** however the form has not been completed fully. Again, the amount of blood, or time of administration have not been documented. It is documented within the notes that the patient may go home on 22 January 1992.

19. The patient was followed up by the surgical team on 26 February 1992. It was noted that the patient was doing very well and not complaining of any symptoms. The patient was advised to take a high fibre diet with plenty of fluids. It was noted that the patient was due to see Dr Linaker in April 1992 regarding the patient's liver pathology and that they would be re-reviewed in surgery clinic if their symptoms worsened. There is no reference within the letter to the patient having received a blood transfusion during their admission in January 1992.

20. A letter to the patient's GP from Dr Linaker dated 24 April 1992 states:

> *"Unfortunately this patient is still getting right upper quadrant pain which tends to be colicky in nature. [The patient] is also getting faint if [they] bend and then stands up. [The patient] tells me that [they] has been teetotal for 8 months. [The patient doesn't look very healthy, but is not icterus. [The patient] is tender in the right upper quadrant, but there is no hepatosplenomegaly. Unfortunately, this patient's main notes are missing and we are going to have to repeat [their] investigations. I am repeating [the patient's] ultrasound scan, LFT's, Alpha Feta*

Protein etc., and if there is any doubt about the diagnosis we may have to repeat [the patient's] liver biopsy. I will review in 8 week's time."

21. From the records, the patient attended Dr Linaker's clinic in June and August 1992.

22. On 24 November 1992, the patient was admitted with severe abdominal pain, following a GP referral. The patient's blood test, taken on 24 November 1992, confirms their Hb haemoglobin levels as 17.1gm/dL. This is within normal range. The laboratory has advised that blood tests taken in 1980 are no longer available. Please see the attached record at **Exhibit WITN4198006.**

23. In the attendances detailed above that followed after the patient's admissions in November 1991 and January 1992, there are no references within the notes to the patient having received a blood transfusion.

24. The Trust has not been able to identify any records that confirm that the patient received a blood transfusion during any of their admissions. In June 2008, when the patient underwent knee replacement surgery, the patient received a celltrans autologous blood transfusion (which is where patients receive their own filtered blood and is not received via a donor).

Consent to blood transfusion in 2020

25. The Trust's Consent to Examination, Treatment or Autopsy Policy at **Exhibit WITN4198007** sets out the standards and procedures within the Trust. These aim to ensure that health professionals are able to comply with the requirements for valid patient consent. The policy refers to the UK Serious Hazards of Transfusion (a national, independent, professionally-led haemo-vigilance scheme) and their annual reporting of significant errors in practice predominantly due to human errors. The Trust has developed clear policies and procedures for all aspects of transfusion and effective haemo-vigilance systems are in place.

26. Patient consent for a blood transfusion is documented in the 'Administration of Blood Policy'. This is documented on page 22 of the policy and the Trust's Standard Operating Procedure ("SOP") can be seen as an appendix at page 55. A blood transfusion must be treated like a drug. The patient has the right to be fully informed of the process and the right to refuse treatment. Please see the policy and SOP at **Exhibit WITN4198008** and **Exhibit WITN4198009**.

27. I have sought assurance on the consent process for blood transfusions, as set out in the Administration of Blood Policy, from my colleagues in the blood transfusion team at Warrington Hospital. They have described the process of obtaining patient consent for a blood transfusion and have confirmed that this is taken by the Clinical Team before a blood transfusion can take place. As part of the consent process, the Clinical Team must:

a. Explain the reason for the blood transfusion to the patient;
b. Explain to the patient the risks and benefits of the blood transfusion along with any possible alternatives;
c. Show the patient the NHS Blood and Transplant: 'Will I need a Blood Transfusion?' leaflet, which is available on all wards. The patient should sign to say they have received it (or as part of the other information they receive) and that they have been made aware of the risks and benefits/alternatives to a blood transfusion. The leaflet details that "*the likelihood of getting an infection from a blood transfusion is very low. All blood donors are unpaid volunteers and the risk of an infected unit entering the UK blood supply continues to decrease. Donors and blood donations are screened for a number of infections which can be transmitted through blood, but it is not practical or even possible to screen all donations for all infections, therefore, there will always be a small risk associated with having a blood transfusion.*" Please find this leaflet attached at **Exhibit WITN4198010;**
d. Take a blood transfusion history which should include but is not limited to: whether the patient has been transfused before? When did this take place? Did they experience any problems? Any transfusion alert cards?;
e. Tell the patient that if they feel unwell during the blood transfusion to contact the nurse looking after them immediately. The importance of immediately reporting any adverse effects must be emphasised.
f. In the event of a patient refusing a blood transfusion the 'Refusal of Blood/Blood Components' policy should be followed. This is located on the Trust's Policy Database. Please find this policy attached at **Exhibit WITN4198011;**

28. The above is documented on the 'Transfusion Prescription/Record Form' by the clinician at the time the blood component is prescribed. When the blood transfusion is completed, it is returned to the laboratory, scanned into the Trust's computer system and the patient's record changed to 'confirm transfused'. This is then locked down as

a permanent record of blood transfusion. Please find a copy of this form attached at **Exhibit WITN4198012.**

29. Where a patient lacks mental capacity to consent to a blood transfusion, this is documented on the 'Transfusion Prescription/Record Form' (which can be seen attached at **Exhibit WITN4198012**) and a decision is made in their best interests, taking into account any previous wishes and/or feelings and the views of those who care or have an interest in the welfare of the patient.

30. For patients with capacity to consent to a blood transfusion and who are undergoing a surgical procedure, the risks and benefits of a possible blood transfusion are explained and consent is documented on the Trust's consent Form 3: "Patient/Parental agreement to investigation or treatment for procedures where consciousness is not impaired." A copy of this form is attached at **Exhibit WITN4198013.** At the time of the blood transfusion, consent must be documented on the "Transfusion Prescription/Record form" (which can be seen attached at **Exhibit WITN4198012**).

31. If the patient has consented to a blood transfusion and is transfused in theatre when they are not aware of the actual blood transfusion taking place, the Clinical Team should explain to the patient when they are out of theatre and have come round from surgery that they have received a blood transfusion.

32. The discharge summary now includes a section that asks if the patient was transfused during this admission. If the answer is yes, then further details are provided. A copy of the discharge summary is sent to the patient and their GP.

33. Many blood transfusions are performed each year across the country in a safe and professional manner, saving patients' lives or enabling patients to have an improved quality of life. The Trust has policies in place to ensure safe practice. Yearly blood transfusion updates are mandatory for members of staff involved in the blood transfusion chain to ensure that they are up to date with current practice.

34. The blood transfusion process is set out in the Administration of Blood/Blood components SOP (which is attached to my statement at **Exhibit WITN4198009**). This is summarised as follows:

    a. Pre-administration checks are completed, which includes checking that the patient has consented to the blood transfusion;

b. The blood products are requested;
c. When the blood products arrive, they are checked at the bedside next to the patient;
d. Identification checks are performed at the bedside next to the patient. If there are any discrepancies, the process stops and the blood transfusion team are contacted immediately;
e. The five point check list on the compatibility label is completed. The blood transfusion is started and documentation completed;
f. The patient is asked if they don't feel well and told tell a member of staff;
g. A blood transfusion observation (the 15 minute observation) is performed 14 - 30 minutes into the blood transfusion which includes taking and documenting the patient's pulse rate, blood pressure, temperature and respiratory rate;
h. The patient is monitored throughout the transfusion visually, by talking to the patient and checking the flow rate;
i. When the blood transfusion has ended, a further transfusion observation is completed which includes taking the patient's pulse rate, blood pressure, temperature and respiratory rate.

35. It is good practice to perform the pre-transfusion set of observations within 30 minutes prior to the start of the transfusion, the 15 minute observations as near to 15 minutes into the transfusion as possible and the post transfusion set of observations within 30 minutes from the end of the transfusion, as stated within the policy.

36. Blood transfusion information training is delivered to all junior doctors during their induction at the Trust. This includes training on obtaining consent as per the consent process outlined from paragraph 25.

Records

37. In order to respond to the patient's statement, I have reviewed the patient's medical records from the Trust. These historical records are incomplete – they do not contain full administrative records, correspondence, clinical or nursing notes or prescriptions and administration of medicines for each of the patient's admissions prior to 1992. This has compromised the ability to respond to the concerns raised in the patient's statement. As a result, a request was made to the patient's GP practice to obtain the patient's GP records. The GP records confirm that the patient was referred to the Trust in September 1980 with haemorrhoids. It is noted that the patient was advised in

relation to a high residue diet. The GP records further confirm that the patient was seen in the Orthopaedic clinic on 16 July 1981, following right open total medial menisectomy on 7 July 1981. The patient was further seen in the Orthopaedic clinic on 21 July 1981, 20 September 1983, 3 November 1983 and 14 June 1988.

38. There is a letter within the Trust records dated 16 December 1980 which notes that on 7 December 1980, the patient sustained a laceration on the medial side of the right cubital fossa from a glass window and was admitted through the Accident and Emergency Department. The other notes around this admission are very difficult to read.

39. The patient's complete records prior to 1992 cannot be located. Under The Blood Safety and Quality Regulations 2005, the Trust has to keep blood transfusion records for thirty years, however this was only made a legal requirement in February 2005. The Trust has full traceability via electronic means from 2003 onwards, when the MOLIS IT system was installed within the laboratory. Prior to 1992, there was a paper records system and any records from the 1980s will have been destroyed.

40. Please see attached at **Exhibit WITN4198014** copy of the Trust's current medical records policy. Currently no destruction of medical records is taking place. This is due to the on-going Independent Inquiry into Child Sexual Abuse and the Independent Inquiry into Contaminated Blood Products. This was agreed and discussed in the Information Governance and Corporate Records Sub-Committee in September 2018. Please see attached the agenda item which confirms this at **Exhibit WITN4198015.** The Trust has updated the Medical Records Policy to state that no records are being destroyed. The policy was ratified on 22 December 2020.

41. Ordinarily and when ongoing Independent Inquiries are concluded, the retention periods adopted by the Trust will apply as set out in the Medical Records policy (attached at **Exhibit WITN4198014**). These are in line with the retention periods outlined within the national NHS Records Management Code of Practice for Health and Social Care 2016.

Concern raised by the Inquiry - Knowledge of HCV in November 1992

42. I have been advised by my Consultant Gastroenterologist colleague at Warrington Hospital who specialises in hepatology that:

a. The standard 'liver function test' panel also known as a liver profile, consists of Bilirubin, Aspartate Aminotransferase (AST), Alanine Aminotransferase (ALT) and gamma-Glutamyl Transpeptidase (GGT). This was the same test in 1992.

b. HCV testing is not part of the 'liver function test' panel. Testing for HCV has to be specifically requested.

c. The majority of people with HCV have no symptoms or mild symptoms when they become infected. 18-34% of infected people spontaneously clear the virus but 60-80% of people go on to develop mild, chronic infections. This chronic carrier state can last for years without people developing symptoms. Some people notice vague symptoms like lethargy, poor appetite and arthralgia. Chronic HCV is a slow progressive condition, due to persistent hepatic inflammation. About 5-20% of chronically infected people develop serious liver disease (cirrhosis) over 20-30 years. Many co-factors increase an individual's risk of developing fibrosis and cirrhosis. These include being older than 40 years of age at the time of infection, alcohol use, male gender, obesity, insulin resistance, type 2 diabetes, co-infection with HIV or Hepatitis B and immunosuppression. (Sources: "Natural history of Hepatitis; Journal of Hepatology 2014 Vol.61; G Dusheiko et al" and "EASL recommendations on Treatment of Hepatitis C; Journal of Hepatology 2018").

d. The usual disease progression ranges from between 20 – 30 years to reach a cirrhotic liver disease stage due to HCV. There are records from 1991 that Micronodular cirrhosis was confirmed on the patient's liver biopsy in 1991. This is evidenced in the letter from the Consultant, dated 28 November 1991, which confirms that the patient was admitted for a liver biopsy and the letter from the Registrar, dated 20 December 1991, which confirms micronodular cirrhosis. Please find copies of these letters attached at **Exhibit WITN4198016**. At the point of diagnosis, when the first liver biopsy was undertaken, the patient already had chronic cirrhosis and advanced liver damage. Drinking alcohol does contribute to the development of cirrhosis and where patients have co-existing problems i.e. cirrhosis contributed to by alcohol and inflammation caused by HCV inflammation, patients can develop problems much earlier.

e. There are records within the patient's notes of upper quadrant pain during the patient's admission in December 1992. This can be evidenced in a letter from the Consultant, dated 24 April 1992, which comments on right upper quadrant

pain. Please find a copy of this letter attached at **Exhibit WITN4198017.** A diagnosis of post herpetic neuralgia for right upper quadrant pain radiating to right shoulder was diagnosed and the patient was admitted to hospital from 24 November 1992 to 11 December 1992.

f. In this case, there are multiple entries in the hospital notes and GP records of the patient consuming excessive amounts of alcohol. Please see the chronology detailing the entries in the patient's records referencing alcohol intake attached at **Exhibit WITN4198018**.

g. It is highly unlikely that cirrhosis would develop solely from HCV infection that has gone untreated for 11 years (from 1980 – 1991) unless there were other issues.

h. When assessing a liver function test, it is important that clinicians ask patients about their alcohol intake as part of collating the patient's clinical history. This is standard practice.

43. From the patient's records, a HCV test was ordered following a ward round with the Senior House Officer on 25 November 1992. There is reference to a 'hep screen' on the investigation request form. This has been ticked. This is also documented in the nursing notes dated 25 November 1992 and this also refers to a hepatitis screen. Please find these notes attached at **Exhibit WITN4198019.** There also a documented letter from the Registrar to the patient's GP, dated 24 October 1991, which confirms that the hepatitis screen was checked in clinic. Please find this letter attached at **Exhibit WITN4198020.**

44. From the records, the patient was discharged by the Consultant on 11 December 1992 for follow up in 3 months. The positive HCV test result was reported on 16 December 1992. Please see a copy of the positive HCV test result at **Exhibit WITN4198021.**

45. The patient was reviewed by Dr Linaker on 15 March 1993 and discharged from the clinic with recommendations to monitor liver function tests. Please see a copy of this letter at **Exhibit WITN4198022.**

46. The patient was admitted on 14 July 1993 with right upper quadrant pain and was diagnosed with post herpetic neuralgia. This eased and the patient was discharged on 20 July 1993.

47. On 15 August 1994, the patient's GP wrote to Dr Linaker with the patient's latest liver function test results. On 22 September 1994, Dr Linaker wrote to the patient's GP to confirm that he hadn't seen the patient in the last 18 months when the patient was discharged from clinic. Dr Linaker's plan was to obtain the patient's old notes and obtain further liver function studies.

48. The records confirm that the patient was reviewed again in the Consultant's clinic on 11 October 1994, 12 December 1994, 11 January 1995, 2 February 1995 (following liver biopsy which confirmed *"appearances are a little worse than last time… but the activity seems to be decreased, and hopefully this condition will now stabilise"*), 1 June 1995, 19 January 1996, 18 September 1997, 18 March 1998, 15 September 1998, 8 December 1998, 21 December 1999, 23 January 2001 (Patient did not attend), 10 May 2001, 26 February 2002 and 7 August 2003. The patient was discharged from the clinic on 7 August 2003. It is documented that the patient's LFTs and alpha feta protein levels were all within normal range. Please see a copy of this discharge record at **Exhibit WITN4198023.**

49. Having reviewed the available medical notes in detail, there is no evidence that the positive HCV test, as documented in the laboratory report dated 16 December 1992 (attached at **Exhibit WITN4198021**), was diagnosed by the clinical team or communicated to the patient. This should have been undertaken and I apologise for this. Had the patient been diagnosed, they would have been treated for HCV infection.

50. It is important that I reference the NICE guidelines from 2012. Please find these guidelines attached at **Exhibit WITN4198024.** These guidelines confirm that early diagnosis and treatment can clear infection and reduce the risk of long term complications, such as cirrhosis. For patients with chronic hepatitis C, early therapy is associated with increased and sustained virological response rates. The NICE Clinical Knowledge Summary was updated in 2020. Please find this summary attached at **Exhibit WITN4198025.** This confirms that complications of chronic hepatitis C infection can include cirrhosis, liver failure and carcinoma.

51. The test result (attached at **Exhibit WITN4198021**) is signed by two individuals, one of whom was an employee of Public Health Microbiology Laboratory at Aintree Liverpool. We have checked with our HR and medical records teams but have not been able to identify the other individual that signed the HCV report to clarify if they have recollection of this incident. We are only aware of the individual's surname and the

Trust does not hold any records from 1992. The HR department within the Trust retains staff records for 6 years. Records held on the ESR (electronic staff record) system (the system HR use to see if somebody is still employed at the Trust) are kept indefinitely, however the system only dates back to 2008. The test result also states as a comment: 'positive anti-HCV, confirmation to follow. No evidence of Hepatitis B infection at any time.' There is no record within the medical notes to confirm the diagnosis, following the test results.

52. There were two missed opportunities to diagnose HCV:

a. A member of the medical team has signed the test result as being read but not actioned the diagnosis or communicated this to the patient; and

b. The test result has been filed in the notes by the administrative team and not picked up at further follow up reviews by the medical team.

53. I am truly sorry for these missed opportunities.

54. I have checked with my pathology colleagues who have reviewed the test results report. They have advised that in 1992, the request from Dr Linaker would have been sent directly to Aintree Liverpool and the laboratory test report, along with the results would have been returned on paper to the requesting doctor, Dr Linaker. The standard process in 1992 was that the test results were signed by a member of the medical team as having been read and then a member of the administrative team would file the laboratory report in the notes. I understand that Dr Linaker has provided a separate statement detailing his response to the concerns raised by the patient.

55. Had the positive test result been correctly and appropriately identified by medical staff, I would have expected to see the diagnosis being clearly documented in the medical notes and appropriate treatment for HCV infection given, as well as communication with the patient about their diagnosis.

56. I am so sorry that the diagnosis of HCV infection was not made until 2014 by Dr McClements and for the distress that this has undoubtedly caused the patient and their family. I understand that the patient's distress will have been affected not only by the delay in reaching that diagnosis but also by the fact that their HCV positive status was documented in the Trust's medical records and that no treatment was offered. For this, personally and on behalf of the Trust, I am truly sorry. I understand that the patient was successfully treated with interferon and ribaviron for HCV infection on 5 November

2014. Following blood tests in 2017, it was confirmed that the patient remained Hepatitis C RNA not detectable. The patient also underwent a fibroscan in 2019 and an ultrasound on 9 January 2020. The findings of this confirmed that their liver was coarse and this was in keeping with infiltration and cirrhotic changes. It was also noted that no focal lesion was seen.

The current diagnostic process

57. The Trust's Diagnostic Testing Policy can be seen attached at **Exhibit WITN4198026.** This confirms that the requester of the test must obtain patient consent, as appropriate for the proposed test.

58. The Trust recognises its obligations to explain clearly to patients the activity for which consent is being obtained, including the risks and wider implications. If patients have an abnormal liver, a standard liver disease screen will usually be performed. This comprises of a series of blood tests including a viral screen (testing for hepatitis C and B). Patients are informed about the reasons for the liver disease screen and what is involved, and verbal consent to perform the screening tests is obtained from the patient.

59. The Trust's Pathology Department has a SOP in place which can be seen at **Exhibit WITN4198027.** This details the detection of HCV antibodies in serum specimens. It confirms that diagnosis of patients infected with HCV can be performed using two categories of virology tests: indirect tests and direct tests. Indirect serology tests are third-generation enzyme immunoassays that detect antibodies to HCV. The antigens used in the tests to detect antibodies are from the structural and non-structural regions of the HCV10 (capsid, protein, cofactors, polymerase, etc.). The presence of anti-HCV antibodies indicates that an individual may have been infected with HCV in the past, or may have an ongoing HCV infection. To confirm the presence of active HCV infection, a positive serology test can be completed using direct tests (e.g. molecular assays that detect RNA genomes). The results will be used to guide patient management and determine the optimal duration of treatment.

60. There is now a Trust system in place called Sunquest ICE ("ICE") where diagnostic tests are requested. The Trust's Diagnostic Testing Policy (attached at **Exhibit WITN4198026**) sets out that a requester must 'review the results of the diagnostic test'.

61. The majority of diagnostic test requests for inpatients are made electronically via ICE. If a request is made on paper, it is still sent via the ICE system and all results are sent back to be reviewed electronically via ICE. Outpatients' results are available electronically and on paper.

62. When the diagnostic test is performed and the result is ready, endorsement of the result, by any clinician, through ICE is facilitated by a 'prompt to file' text box. To allow audit trail for verification of the result, all diagnostic results must be clinically evaluated. This prompt occurs whenever a patient's result is viewed for the first time. Results of investigations requested in the outpatient setting are sent to the relevant Consultant's secretary for signing. All results must be reviewed by an appropriate clinician and signed, to show that the result has been noted and the correct course of action taken where appropriate.

63. The clinician who requested the test is responsible for the acknowledgement, action and follow up of the results.

64. Clinicians are responsible for reviewing, endorsing and acting upon diagnostic test results, within a timescale that is not expected to adversely affect patient care. When a clinician endorses a result, they accept responsibility to ensure it is interpreted and acted on appropriately (this may include seeking senior opinion, or delegation of responsibility). Endorsement of the result by any clinician through Sunquest ICE is facilitated by a 'prompt to file' text box to allow audit trail for verification of result. In addition, as a minimum, Consultants must endorse all results within 14 days of being available on the message centre.

65. In line with the Diagnostic Testing Policy (attached at **Exhibit WITN4198026**), the default position is that a clinician who orders a test is responsible for receiving (and taking action on) the results once available. Any delegation of this responsibility, within, or between clinicians and teams, must be clear, and flexible enough to manage planned and unplanned absences of various team members, including the responsible consultant. This is in line with GMC Good Medical Practice which sets out under Continuity and Coordination of Care:

44: You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

i. *share all relevant information with colleagues involved in your patients' care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.*

66. If a result is potentially immediately life threatening, the diagnostics team completing the test will telephone the clinician in line with the Trust's diagnostics testing policy.

67. The Royal College of Pathology guidance, "The communication of critical and unexpected pathology results" dated October 2017, sets out that more rapid communication of test results should take place where there is '*a markedly abnormal test result that may be deemed urgent or critical is one that may signify a pathophysiological state that may be life threatening or of immediate clinical significance'*. It confirms that the classification and definition of such results should be agreed at local level. This guidance is attached at **Exhibit WITN4198028.**

68. I understand from the Trust's pathology department that:

a. The Trust has several SOPs in place that set out the process for testing and communicating HCV test results. Unqualified staff are not permitted to give Hepatitis (A or B) results over the phone to the clinical teams. Details of these calls confirming test results are logged on the laboratory computer system.

b. If HCV antibody is detected by the initial screening and confirmatory tests, this will be shown to a Consultant Microbiologist before further test requests associated with HCV or referrals to a Hepatology clinic are made.

c. HCV is not acutely life threatening and so any abnormal results would not ordinarily be telephoned through, but would be triggered to the requesting clinician via ICE, in line with the process detailed above.

Communication with patients

69. It is the responsibility of the authorised person requesting the test to ensure the patient is informed of the result and of all options for treatment. This may be via GP letter, attendance at an outpatient clinic or as an inpatient. The Trust's Diagnostic Testing Policy (attached at **Exhibit WITN4198025**) confirms that this should be documented in the notes.

70. Consideration is given to the sensitivity of the test/result for the patient, including the clinical picture and setting, and any specific communication needs of the patient. The policy sets out the following:

a. Ensuring the patient is provided with their results in a way that they can understand, and be given the information they want or need to know about their results, including diagnosis, prognosis, treatment plan etc;

b. Systems are in place to allow patients to be informed of test results (or their implications) within timeframes that are predictable, and that do not expect to compromise patient care. As a minimum, Consultants must endorse all results in their message centre within 14 days of receipt.

c. When implications of results are serious, complex, or sensitive, patient communications are documented in the patient's electronic medical records or notes.

71. This is in line with the GMC Good Medical Practice at paragraphs:

32 You must give patients the information they want or need to know in a way they can understand. You should make sure that arrangements are made, wherever possible, to meet patients' language and communication needs.

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

Concern raised by the Inquiry - In 2010 a registrar said to the patient "why don't you just go in the corner and die quietly?"

72. At paragraph 64 of their statement, the patient refers to being admitted to A&E after experiencing a dizzy spell whilst at the dentist in approximately 2010. It is recorded in the notes that the patient attended A&E on 11 June 2013 after experiencing chest pain whilst being sat in the dentist's chair.

73. There is no record of the alleged discussion with the patient in the medical or nursing notes. I apologise for the distress caused to the patient. There are also no other records that describe or make reference to the patient's complaints in paragraph 64 and 65 of their statement. The notes are attached at **Exhibit WITN4198029**. It is documented that the patient did raise care concerns including the lack of blankets, not being looked after and alleged failure to take repeat bloods. It is documented that blankets were provided, bloods taken and a noisy patient was relocated.

74. The discharge summary, dated 14 June 2013, was sent to the GP and is included within the notes. This is attached at **Exhibit WITN4198030**. This describes that the patient was admitted to Ward A1 on 11 June 2013 and the estimated date of discharge was 12 June 2013. It confirms that the patient's diagnosis was chest pain and that the patient took their own self discharge before cardiac nurse review. The discharge summary details the follow up arrangements for the GP to refer the patient to the rapid chest pain clinic if their symptoms persist. No continued or discharge medications are included within the form.

Processes currently in place regarding patient complaints

75. Processes are in place through which patients can raise complaints. The first stage is to raise a complaint or concern at ward level. In this case, the patient's concerns were resolved by the ward and it is documented that the patient thanked nursing staff. Where complaints cannot be resolved at ward level, site managers are available as well as the Patient Advice and Liaison Service (PALS) and formal complaints process. Please see attached at **Exhibit WITN4198031** a copy of the complaints leaflet and policy.

76. Incidents and complaints are robustly monitored and triangulated. Triangulation meetings concerning medical issues are chaired monthly by myself. The Trust's Chief Nurse chairs the Triangulation meetings concerning nursing and AHP issues.

77. The Trust has developed customer services training which can be seen at **Exhibit WITN4198032.** The Trust has also developed individual development offers as detailed below:

    a. The Trust's Customer Service – Creating Positive First and Lasting Impressions. Pre-March 2020 Customer Service Training sessions were running once a

month – alternating between Warrington and Halton Sites. This is a 3 hour training session which looks at:

i. Understanding what excellent, good and bad customer experiences look like;
ii. Visualising the customer experience and "walk in their shoes" – Discuss patient feedback;
iii. Discussing communication techniques and identify how to put them into practice- including listening skills and communication models;
iv. Understanding what can influence our behaviour – Transactional Analysis;
v. Exploring what our emotional intelligence is;
vi. Pledging to be "Outstanding".

b. In addition, 1 hour bespoke team sessions were offered. Prior to COVID-19 the Trust had delivered bespoke team sessions to HR & OD, Emergency Department, Maternity and Perceptees. Each session is adapted to suit the specific team's needs but the overall content focuses on:
   i. Understanding what excellent, good and bad customer experiences look like;
   ii. Exploring how to maintain and improve Customer Service;
   iii. Visualising the customer experience and "walk in their shoes";
   iv. Exploring what our emotional intelligence is;
   v. Pledging to be "Outstanding".

78. Due to the COVID-19 pandemic, all sessions have been postponed. Sessions were planned to resume in October 2020, however due to the second and third wave of the pandemic, these sessions are now planned to resume virtually. The customer service training offer consists of a 1 hour session and focuses on the topics covering emotional intelligence, kindness, civility and respect, with an overarching theme relating to Trust values and behaviours. In addition bespoke sessions are offered to teams. The customer service training is also part of the re-designed internal suite of training offers previously known as essential managers' programme. This re-launched at the end of November 2020 under the new title of "How am I Developed Programme" which also included coaching conversations training, appraisal training, storytelling to build empathy, recruitment training, absence management and courageous conversations. Unfortunately following the re-launch and first session,

this training has had to be postponed again due to the current operational pressure and the focus on critical work in response to the COVID-19 pandemic. The programme is ready to be relaunched as soon as circumstances allow and currently it can be booked for March 2021.

79. The Trust is also in the process of launching a self-compassion at work programme that looks at the importance of being kind to yourself and the impact of the actions on others, along with compassionate leadership which forms part of the Trust's risk assessment training as part of the COVID-19 recovery work. This programme was rolled out on 12 October 2020 and it continues to be promoted across the workforce. The Trust are also offering a compassionate coaching leadership programme to senior leaders. The first cohort started in December 2020 with further sessions rolled out in January and February 2021.

80. The Trust has developed bite size videos that can be accessed by all staff on the internal extranet. These include compassionate leadership, coaching skills, resilience, storytelling, apprenticeship offers and customer services skills amongst others.

81. The Trust also provides Courageous Conversations training sessions. This is part of individual learning and usually takes place once a month but has had to undergo some rescheduling, due to the COVID-19 pandemic.

82. One-to-one coaching sessions are also offered as part of individuals' phased return to work following disciplinary investigation relating to attitude towards patients.

83. The Trust has also started a larger piece of work focusing on kindness, civility and first impressions. However, this has also unfortunately been postponed due to the current operational pressures brought about by the third wave.

Concern raised by the Inquiry - The patient and Dr McClements 'faced significant difficulties' when they attempted to gain access to the patient's medical notes in April 2014.

84. On 28 July 2014, the patient registered a formal complaint to the Chief Executive of the Trust in respect of Dr McClements and the patient's request for medical records made in April 2014.

85. On 19 August 2014, a response was sent to the patient from the Chief Executive confirming that no medical records request from Dr McClements had been received by the Trust's Outpatient & Medical Records Services.

86. A further letter of response was sent to the patient on 24 September 2014 notifying the patient that the Trust was looking into the matter and discussing it with members of staff who were involved to provide the patient with a comprehensive explanation.

87. On 3 October 2014, the Trust sent the patient a Data Protection Form required to release a copy of the medical records.

88. The Data Protection Form signed by the patient is dated 6 October 2014.

89. On 21 October 2014, the patient attended the Trust to collect two copies of their medical records held by the Trust. The copies contained medical records that the Trust holds on file for the patient and are from the period from 1993 – October 2014. The charges in place for requesting medical records at that time were waived as it was recognised that there was a delay in responding to the patient's complaint. The patient confirmed that they were happy for the complaint to be closed.

90. The following day, the patient contacted the Trust's Patient Experience Team and expressed dissatisfaction that they had not received medical records from birth. It was explained to the patient that if the Trust held any other medical records, they would have to request these from the Medico-legal team.

91. In November 2014, the Parliamentary and Health Service Ombudsman ("PHSO") contacted the Trust following a complaint made to them by the patient in respect of how the complaint was handled.

92. The Trust wrote to the patient on 7 January 2015 having liaised with the PHSO and the matter was brought to a conclusion.

Concern raised by the Inquiry - Mr McNicholas, expressed concern in a number of letters that he could not access the patient's medical records, despite practising within the Trust (22.1.08 & 14.3.08)

93. Contact has been made with Mr McNicholas to seek his recollection and input given that the patient has named him within the statement. Mr McNicholas has commented as follows:

a. *"I accept that, as stated in those areas there was an issue with medical records being available, at the time there was a hybrid system with electronic records and paper records and one of the weaknesses of the use of paper records is that it can be difficult to have them available in clinic. It would be unusual for somebody to have records missing on 2 consecutive visits as occurred with this patient, however, it is not my opinion that there was any particular systemic difficulties with the Records Department at Warrington Hospital."*

b. *"It did give rise to a difficulty with [the patient] in that I was unable to identify how ill [they] had been with [their] liver problem whilst the patient had reportedly been under the care of Dr Barry Linaker, Consultant Physician, some time previous to my interactions with [them]. As stated in the correspondence [within the medical records] it is important to look after the whole patient and liver difficulties can give rise to complications. Dr Ramakrishnan, another Consultant Physician who was working at Warrington Hospital at the time was kind enough to check over the patient's records and was able to reassure me that the treatment plan I had for conservative management of [the patient's] osteoarthritis was appropriate and that the degree of hepatic impairment that [the patient] had was such that it would be safe for us to proceed to total knee replacement, which we ultimately did do."*

c. *"I do not recall any specific systemic issue with the availability of notes, a hybrid system of electronic and paper notes will occasionally have difficulties with the paper notes being available for each clinic, it was not common that notes were not available. I do not recall any system issues."*

94. I am advised by the Medical Records Team that all records are now registered on the Trust's Patient Administration System (PAS) at patient registration. PAS was first rolled

out at the Trust in December 1997 and a second phase roll out took place in December 1998.

95. In order to ensure accurate availability of medical records, the Medical Records Team have confirmed that detailed tracking must be recorded on PAS (i.e. notes in drawer, filing cabinet etc.). Users are responsible for tracking medical records themselves immediately upon moving the patient record. Existence of volumes and temporary notes must be recorded on the Medical record Tracking comment field. When medical records are moved they must be tracked and delivered immediately to that location.

96. It is the responsibility of all persons who move/handle medical records to ensure that they are tracked to their new location. Usually, it is the filing clerks who receive a list from the outpatient system and the admissions system of the notes which to obtain from the location that they are tracked to. The list is normally generated around a week before a patient's outpatient appointment or their admission. Case notes are stored in the Trust's filing areas or off site at the Trust's external storage facility. These are then retrieved for patients attending the Trust or a copy of the notes are requested. Please see attached at **Exhibit WITN4198033** the processes in place for preparing notes for clinic, locating and creating case notes.

97. I am advised by the Medical Records Team that when patients attend an appointment within the Trust, the Medical Records Team aim to collate the records one week in advance. The person requesting a record must be an authorised Trust employee and must follow the procedure whereby records are requested on an urgent or routine basis and made available within agreed time limits, urgent requests being acted upon immediately. Record requests are by email. Medical Records must be tracked as soon as they are retrieved by the Medical Records staff.

98. The Trust now provides Medical Records retrieval services for emergency admission 24 hours daily and seven days weekly (24/7). Immediate access to electronic records is also available to medical staff 24/7.

99. Individual records which are being transported between departments should be hand-delivered and must not be placed in the internal mail system. Individual records must be transported in a sealed envelope, addressed to a named member of staff and showing the address of the receiving department.

Concern raised by the Inquiry - Mr McNicholas suggested that the records provided insufficient information about the patient's past history and treatment of cirrhosis

100. As above, Mr McNicholas has provided his comments as follows:

a. *"With regards the information that I considered insufficient about the patient's past history of cirrhosis. I am not a Hepatologist, I would need information with regards the history of cirrhosis to be able to formulate a professional correspondence to a Physician who would be professionally qualified to guide me upon whether the degree of liver damage that had occurred was such that it would affect my ability to offer [the patient] a safe total knee replacement. I wrote to Dr Ramakrishnan who was the Physician with a special interest in liver issues who kindly reassured me that it would be safe to proceed total joint replacement for this patient."*

101. As set out above, the patient's records are incomplete which has unfortunately compromised the ability to respond to the concerns raised in the patient's statement. However, the following records about the patient's past history and treatment of cirrhosis were available for review:

a. Dr Linaker's consultation documentation;
b. Dr Linaker's letters to the patient's GP;
c. The pathology results;
d. Positive HCV test result;
e. Ultrasound scan report;
f. GP records provided by the patient's GP practice.

Concern raised by the Inquiry - The patient believes Trust was attempting to withhold some of their records including the 1992 diagnosis and cannot be certain that their medical records are complete and would like the Trust to comment on this.

102. The complaints team have outlined when copies of the patient's records were provided to the patient. I have detailed this below:

a. On 21 October 2014, two copies of the medical records (dated from 1993 to October 2014) were provided to the patient.

b. On 1 August 2018, the patient's solicitors requested a copy of the patient's records, and a copy was subsequently provided (including electronic, paper and ICE reports) on 6 September 2018.

c. No further requests for copies of the patient's medical records have been received by the Trust.

103. As detailed above, within the Trust's complaint file, from 2014 - 2015 there is correspondence, including from the Parliamentary and Health Services Ombudsman, of the patient requesting a copy of their records from birth. As described above, the patient's complete records prior to 1992 cannot be located and it is understood that these may have been destroyed. All Trust records that we have been able to locate (including those from 1992 and before) have been provided to the patient.

104. Searches have been undertaken by the Trust and no further records have been located.

105. Medical records can consist of laboratory results, x-ray results, and appointment details, which are now generally available electronically. Single Assessment Processes, care plans, provider information, and referrals largely remain on paper. Other health information may be maintained on various other media types such as film, video, or an imaging system.

106. Scanning records into the electronic patient record system began at the Trust in 2015. Any original record that is scanned into the Trust's electronic patient record system, is also filed in the patient's paper records. This has been discussed at information governance meetings and managers asked to cascade to their teams.

107. The majority of services use at least one electronic system to record information, although all health records would be deemed hybrid. Staff must therefore always check both paper and electronic records.

108. As detailed above, the tracking of patient's records must be recorded on PAS (i.e. notes in drawer, filing cabinet etc.).

109. Clinical staff are aware of the process to raise incidents via the Trust's incident reporting system, Datix and do this when there are issues with notes being available

for clinics where necessary. If any sets of notes are missing, the Medical Records clerks highlight this to team leaders before the patient's clinic or admission and thorough searching is carried out across the Trust to ensure that the records are available.

Section 3: Other Issues

110. I have also addressed the following points for completeness, as although these have not been referred to directly by the Inquiry, I note they are referenced in the patient's witness statement.

Patient's witness statement: complaints against a nurse

111. There are allegations made within the patient's witness statement at paragraphs 60 – 63 about a nurse employed within the Daresbury Wing of Warrington Hospital and also in the Halton Hospital possibly in the mid-2000s and more recently around 2014. It is noted that the patient was admitted to the Trust as follows during this time period:

a. Arthroscopy of the left knee with a partial medial menisectomy on 8 January 2002.
b. The patient was due to undergo left hamstring ACL reconstructive surgery on 10 March 2003. However this was cancelled and rescheduled to 9 April 2003 due to separate investigations that the patient was undergoing.
c. Removal of Meibomian cyst (right upper eye lid) in January 2004.
d. Medial menisectomy & ACL debridement on 25 February 2004.
e. Hi-Flex total right knee replacement on 25 June 2008.
f. Right upper lid incision and curettage of cyst on 9 August 2011.
g. Admitted with chest pain in June 2013.
h. Bilateral L4/5 FESI foraminal epidural steroid injection under local anaesthetic in June 2014.
i. Bilateral Decompression Lumbar Spine L45 on 6 January 2015.

112. No nursing entries made by the name of the nurse, that the patient mentions in paragraphs 60 – 63 of their statement, have been identified.

113. As set out above, the Trust's HR department retain staff records for 6 years. Records held on the ESR (electronic staff record) system are kept indefinitely, however the system only dates back to 2008. The Trust's HR and Medical Staffing teams have investigated and have not been able to locate a nurse by that name on their systems as being currently employed at the Trust.

114. Investigations have also confirmed that there are no records that show that the nurse worked at the Trust via an agency.

115. Enquiries have been made with Mr McNicholas who has confirmed that he does not recognise the name of the nurse mentioned by the patient at paragraphs 60 – 63 of their statement. He has also commented that he cannot remember anything specifically about the incident that the patient raises and he does not have any recollection of it.

116. We have also asked a nurse, who is still employed with the Trust, who made entries within the patient's notes on 30 June 2008 whether she recalls working with the nurse mentioned by the patient at paragraphs 60 – 63 of their statement. The nurse we asked does not recall ever working with the nurse named by the patient at paragraphs 60 – 63 of their statement.

Patient's witness statement: complaints about liver biopsies

117. Dr Linaker has responded in a separate statement to the concerns raised by the patient at paragraphs 38 – 41 of their statement.

Patient's witness statement: complaint against orthopaedic doctor

118. The patient raises additional concerns at paragraphs 54 – 59 of their statement.

119. The patient's medical records refer to the registrar named by the patient attending them on 29 June 2008. There is also a nursing entry that records that the patient was most upset stating that the registrar suggested that the patient was an 'addict' and they did not wish to be spoken to in such a manner. When attending the patient the next day, another doctor expressed regret over the incident and reassured the patient that it would be escalated to the patient's Consultant. Please see these notes attached at **Exhibit WITN4198034.** There are no records of any formal complaint made to the Trust in respect of this. The Trust's HR team have undertaken a review of the system

and the Trust do not currently employ anyone of the name referred to by the patient. I can only apologise to the patient for the upset caused.

Statement of Truth

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

GRO-C

Signed

Dr Alex Crowe, Executive Medical Director

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Dated 14.2.21

Table of exhibits:

Date	Notes/ Description	Exhibit number
16 December 1990	Letter to Dr GRO-B from Orthopaedic Registrar	WITN4198002
24 October 1991	Letter to Dr Tandon from Registrar Dr A Alam	WITN4198003
20 November 1991	Blood Transfusion Form	WITN4198004
17 January 1992	Blood Transfusion Form	WITN4198005
24 November 1992	Triage Notes	WITN4198006
30 December 2019	Consent to Examination, Treatment or Autopsy Policy	WITN4198007
19 July 2018	Administration of Blood and Blood Components Policy	WITN4198008
19 July 2018	Administration of Blood/Blood Components SOP	WITN4198009
01 June 2016	Patient Information Leaflet: 'Will I need a Blood Transfusion?'	WITN4198010
01 April 2020	Refusal of Blood/Blood Components Policy	WITN4198011
Undated	Blood Component Prescription / Record Form	WITN4198012
Undated	Consent Form 3: Patient/Parental Agreement to Investigation or Treatment	WITN4198013
22 December 2020	Medical Records, Record Keeping Standards and Alerts	WITN4198014
Undated	Agenda item at the Trust's Information Governance and Corporate Records Sub-Committee in September 2018	WITN4198015
28 November 1991 – 20 December 1991	Correspondence Letter Exchange Between Dr Tandon and Dr Linaker / Dr GRO-B and Dr Batty	WITN4198016
24 April 1992	Letter from Dr Linaker to Dr Tandon	WITN4198017
01 October 1991- 10 June 2019	Chronology of Entries in Patient's Records Referencing Alcohol Intake	WITN4198018
25 November 1992 – 28 November 1992	Nursing Note and Clinical Note Referencing Hepatitis Screen	WITN4198019
24 October 1991	Letter from Dr A Alam to Dr Tandon	WITN4198020
16 December 1992	Serology Report Confirming Positive HCV Result	WITN4198021
15 March 1993	Letter from Dr Linaker to Dr GRO-B	WITN4198022

07 August 2003	Letter from Dr G Polo to Dr Bannon	WITN4198023
12 December 2012	'Hepatitis B and C testing: People at risk of infection', Public Health Guideline	WITN4198024
April 2020	NICE Guidelines: Hepatitis C	WITN4198025
05 October 2020	Diagnostic Testing Policy and Appendix One: Diagnostic Testing SOP	WITN4198026
Undated	Pathology Department: Detection of Hepatitis C Antibodies in Serum Specimens	WITN4198027
October 2017	The Royal College of Pathologists: The Communication of Critical and Unexpected Pathology Results	WITN4198028
13 June 2013 – 12 June 2013	Single Patient Documentation Record of Multi-Disciplinary Interventions	WITN4198029
14 June 2013	Discharge Medication Request	WITN4198030
30 November 2019	Complaints and Concerns Policy	WITN4198031
January 2019 – March 2020	Customer Service- Creating Positive First and Lasting Impressions Attendance Figures	WITN4198032
Undated	Locating and Creating Case Notes	WITN4198033
02 July 2008	Patient Care Inquiry: List Patient Notes	WITN4198034