Witness Name: Timothy Ho
Statement No.: WITN5698002
Exhibits: Nil
Dated: 21 December 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF
TIMOTHY BOON LEONG HO

I, **TIMOTHY BOON LEONG HO**, of Frimley Health NHS Foundation Trust, Frimley Park Hospital, Portsmouth Road, Frimley, GU16 7UJ (the "**Trust**") **WILL SAY AS FOLLOWS:-**

1. I am a Consultant Chest Physician, Medical Director of the Trust and Executive Director on the Trust's Board. I joined the Frimley Park Hospital NHS Foundation Trust (the predecessor to the current Trust) in 2004 and was appointed as Medical Director in December 2013. Further information about my clinical background is set out in my statement dated 12 October 2020, which addresses the issues raised in the Infected Blood Inquiry's Request for a written statement under Rule 9(1) and 9(4) of the Inquiry Rules 2006 dated 14 September 2020, and which dealt with information about the Camberley (Frimley Park) Haemophilia Centre.
2. The historical background of the Trust is also set out in my statement dated 12 October 2020 and is therefore not repeated here. The Inquiry should also note that the Trust has previously provided a statement to the Inquiry, dated 24 April 2019, in relation to some anomalous patient records that were identified beyond their relevant retention date.
3. In this statement I address the issues raised in the Infected Blood Inquiry's Request, dated 16 October 2020, for a written statement under Rule 9(2) of the

Inquiry Rules 2006. The questions asked were as follows and I respond to them in turn:

(1) Please provide us with a schedule of any complaints, claims and incidents to the Frimley Health NHS Foundation Trust (including its predecessor organisations), which concern, wholly or in part, the issue of infection caused by or connected to treatment with blood products and blood transfusions, by the NHS

(2) Please provide us with a schedule of any other referrals to the complaint, claims and incidents team of the Frimley Health NHS Foundation Trust (including its predecessor organisations), with potential relevance, wholly or in part, to the Infected Blood Inquiry's Terms of Reference with particular reference to the following:-

(i) Whether and to what extent complainants have faced difficulties or obstacles in obtaining adequate treatment care and support; and

(ii) The wider social impact and/or discrimination faced by complainants, including the stigma associated with a diagnosis of HIV and/or Hepatitis C.

(3) Please can you provide us with a schedule of material sent to the Surrey History Centre

Request 1. Schedule of any relevant complaints, claims and incidents to the Trust

Complaints

4. The Trust has carried out a detailed search of its records and systems in relation to this request, using the search terms contained in the spreadsheet enclosed with the Inquiry's Request for Information dated 16 October 2020. The Trust can confirm, based on its searches, that there have been no complaints which concern, wholly or in part, the issue of infection caused by or connected to treatment with blood products and blood transfusions, by the NHS within the last 10 years (please note that this is the relevant retention period for complaints).

5. The Trust was made aware, by a letter from the Inquiry dated 26 November 2020, that it had received a written statement from witness W1950, dated 14 February 2019. As the Inquiry will know, this witness has written in relation to a patient who had received a blood transfusion in 1979, and subsequently passed away in

2005 from complications possibly caused by Hepatitis C. The witness states that the ambulance that provided the transfused blood to this patient came from St Peter's Hospital in Chertsey. The Trust can confirm that St Peter's Hospital was and is part of Ashford and St Peter's Hospitals NHS Foundation Trust, and not Frimley Health NHS Foundation Trust (or its predecessor organisations). In 1979, there were no linkages between St Peter's and the Trust's predecessor organisations as this predates any laboratory network arrangement. [The only situation whereby a patient at St Peter's Hospital would have received blood products issued at Frimley would be a clinical emergency whereby St Peter's Hospital did not have the appropriate stock at the time, or if the patient was an emergency transfer from Frimley to St Peter's Hospital. However due to the passage of time since this incident in 1979, we are unable to comment further on the arrangements that the ambulance services had for obtaining blood.

6. The Trust has carried out a detailed search of its records and systems in relation to the above patient and the patient's family, and can confirm that it has not received any complaints or legal claims in relation to the above patient. In relation to any records, the Trust's Information Governance team has confirmed that in line with relevant retention periods, deceased patients' records are destroyed 8 years after death (even if they have had a blood transfusion), and so this patient's records would have been destroyed in 2013. The Trust does note that it has previously provided a statement to the Inquiry, dated 24 April 2019, in relation to some anomalous patient records that were identified beyond their relevant retention date, as set out in paragraph 2 above, but that this was a one-off incident insofar as the Trust is aware.
7. The Inquiry has, via its letter dated 26 November 2020, approached the Trust in relation to the above written statement for a response, and the Trust shall notify the Inquiry of its intention to respond in line with the Inquiry's deadline in relation to this matter.

Claims

8. The Trust has carried out a detailed search of its records and systems in relation to this request, using the search terms contained in the spreadsheet enclosed with the Inquiry's Request for Information dated 16 October 2020. The Trust can confirm, based on its searches, that there have been no claims which concern,

wholly or in part, the issue of infection caused by or connected to treatment with blood products and blood transfusions, by the NHS.

9. The Trust has received two separate requests for medical records for two individuals. Both of these requests for medical records relate to concerns that the patients contracted Hepatitis C following blood transfusions. However the Trust does not have any evidence that these patients contracted the infections from blood transfusions carried out at the Trust. As the Trust has not heard anything further following these requests for medical records which was some time ago, it assumes that the concerns raised were not conclusive.

Incidents

10. The Trust has carried out a detailed search of its records and systems in relation to this request, using the search terms contained in the spreadsheet enclosed with the Inquiry's Request for Information dated 16 October 2020.
11. The Trust can confirm that four relevant incidents have been identified and these are attached in the schedule at **Exhibit TH/1.**
12. In order to assist the Inquiry, we have also set out below further details in relation to these incidents and we have referred to these below by their incident numbers as set out in their exhibited schedules:

    (i) WPH46016 – these were 2016 incidents involving adult emergency blood being transfused to neonates in an emergency situation, which was not Hepatitis E (HEV) negative. However, national guidance in existence at the time did not mandate the use of HEV negative blood in neonates, and in addition, HEV negative blood was not necessarily required in an emergency situation. Despite this, these incidents were reported to the relevant organisations by the Trust. Following these incidents, consideration was given to holding a neonatal emergency unit of blood in theatres. Previously, this had not been considered appropriate as adult emergency blood was rarely required to be used for neonates. Going forward however, the HEV negative requirement was dropped nationally in May 2017, because as of April 2017, all blood donations were tested by the National Blood Service and all components issued since that date are HEV negative.

(ii) WPH33971 – this was a 2009 incident concerning an inappropriate transfusion by a junior clinician that was not clinically indicated. This potentially exposed the patient to blood infection and transfusion risks. A review was carried out by the Trust and the outcome involved the treating clinician undertaking further training. Additionally, the Trust added further relevant education/training to junior doctors' induction programmes and additional mandatory training sessions.

(iii) WPH35566 – this was a 2009 incident involving the transfusion of blood which was possibly infected with HIV. A standard National Blood Service alert and recall procedure would have been in place here, whereby the National Blood Service would have notified the Trust of the possibility of HIV and requested the Trust to trace, inform and test the recipient who received the blood. The recipient of the unit in this case was traced, contacted and tested for HIV at three months and at six months after the transfusion, with negative results. Usually an incident such as this would relate to the finding of an unexpectedly reactive HIV antibody test in a donor who was previously HIV antibody negative, so the recipients of any previous blood products from that donor must be traced. This is the normal national policy instituted by the National Blood Service and this is the policy that remains in existence now.

(iv) FPH62343 – this was a 2011 incident involving a pregnant patient who received a blood transfusion. The patient was meant to receive CMV negative blood but she was given random blood units instead. CMV is generally harmless and over half the adult population in UK will have had CMV infection at some time. Acute CMV infection in a pregnant patient can cause severe consequences to the unborn fetus, however the risk of acute CMV as a consequence of transfusion from a donor who has past CMV infection is very low. However, all blood components (other than granulocytes) in the UK now undergo leucodepletion, which provides a significant degree of CMV risk reduction. It has been concluded that the use of leucodepleted blood products in the majority of at-risk patient groups (haemopoetic stem cell transplant, organ transplant and immune deficient patients including those with HIV) is adequate at reducing the transmission of CMV. In addition, the following groups of patients should

continue to receive leucodepleted and CMV negative blood components (RBC/Platelets):

a. Pregnant women undergoing elective transfusion (not delivery) and for urgent transfusion if CMV negative blood is not available, leucodepleted units should be transfused; and
b. Intra-uterine transfusions (IUT) and neonates up to 28 days post expected date of delivery.

In this case the blood appears to have been given in a clinical emergency situation (Antepartum haemorrhage with placenta praevia) and was not an elective, planned transfusion. The incident was reported and the blood sent for sampling, which identified that the blood was CMV positive. Treating and other clinicians, including a Consultant Haematologist, Consultant Paediatrician, and Infection Control Consultant, advised that there was minimal risk to both the patient and the baby. The patient and the baby were tested, with negative results. A review took place following this incident and a number of new procedures were put in place by the Trust, including guidance placed at relevant points of the ward and a change in one of the systems to automatically ask key questions. Additionally, meetings and training presentations were provided to staff.

13. Following the Trust's search using the search terms contained in the spreadsheet enclosed with the Inquiry's Request for Information dated 16 October 2020, there were an additional couple of incidents identified where patients had adverse transfusion reactions. However as these incidents did not relate to infection, we have not included the detail of these incidents here or in the exhibited schedule

Request 2. Schedule of any other referrals to the complaint, claims and incidents team of the Trust

14. The Trust has carried out a detailed search of its records and systems in relation to this request, using the search terms contained in the spreadsheet enclosed with the Inquiry's Request for Information dated 16 October 2020. The Trust can confirm, based on its searches, that there have been no complaints, claims or incidents to the Trust with potential relevance, wholly or in part, to the Infected

Blood Inquiry's Terms of Reference with particular reference to the specific issues set out above.

15. However, we refer the Inquiry to paragraphs 5 to 7 above, in relation to the written statement of witness W1950, received from the Inquiry on 26 November 2020.

16. As previously set out at paragraphs 2 and 6 above, the Trust notes that it has previously provided a statement to the Inquiry, dated 24 April 2019, in relation to some anomalous patient records that were identified beyond their relevant retention date, but that this was a one-off incident insofar as the Trust is aware.

Request 3. Schedule of material sent to the Surrey History Centre

17. The Surrey History Centre (the "Centre") has confirmed that it does not hold any records in relation to the Camberley (Frimley Park) Haemophilia Centre.

18. The Centre did confirm that it holds the following records:

    (i) Agenda and minutes of South West Surrey Community Health Council and its sub-committees (Patients' Services and Policy & Planning), 1974-1985;

    (ii) Records of West Surrey and North East Hampshire Health Authority, 1963-1993; and

    (iii) Admission and discharge registers (1943-1962) and maternity register (1973-1974) for Frimley and Camberley Hospital.

19. The Trust has reviewed the catalogues set out above, and is of the view that there does not appear to be anything of relevance to the Inquiry's Terms of Reference contained in the catalogues. Please note however, that the Trust has not had sight of, and so has not reviewed, the actual minutes, records and registers set out above.

Statement of Truth

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

GRO-C

Signed

TIMOTHY BOON LEONG HO

Dated 21st December 2020