Witness Name; Tracey Gillies
Statement No.: WITN6932025
Exhibits WITN6932026-31
Dated: 17 June 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF TRACEY GILLIES

I provide this statement on behalf of NHS Lothian in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 August 2020.

I, Tracey Gillies, will say as follows: -

Section 1: Introduction

1. **Please set out your name, address, date of birth and professional qualifications**

   My name is Tracey Gillies, my date of birth is GRO-C 1966, and my professional qualifications are MBChB FRCS. My address is NHS Lothian, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

2. **Please set out your current role at the Lothian Health Board and your responsibilities in that role.**

   My current role is as Executive Medical Director with consequent responsibilities and as Responsible Officer for NHS Lothian.

3. **Please set out the position of your organisation in relation to the hospital/other institution criticised by the witnesses (for example "NHS Foundation Trust ('the Trust') operates from Hospital X and Hospital Y (formerly Hospital Z)").**

NHS Lothian is responsible for healthcare provision for the population of the Lothian area. It is responsible for the Royal Infirmary of Edinburgh and the Western General Hospital.

Section 2: Response to Criticism of witness W2633

Criticism of W2633

The Board has been asked to respond to the following criticisms:-

4. **At paragraph 6 of her statement, witness W2633 states that her late father, who suffered from haemophilia, knew that if he attended the Royal Infirmary of Edinburgh (RIE) on a busy weekend in the 1970s and 1980s, there was a risk he could receive imported blood products, and consequently he avoided having treatment. Please comment on this.**

5. **At paragraph 8, witness W2633 states that it was clear to her father that people at RIE had lied to him about the blood products he received. She states that her father would mention his concerns about the safety of blood products to Professor Ludlam and RIE staff, and they would tell him not to worry as they only used local product (paragraph 10); that her father was as not told of the risks of local products, only that they were not imported (paragraph 20); and that he believed the RIE staff may have used cheap imported product (paragraph 14). Please comment on this.**

6. **At paragraph 16, witness W2633 states that her family's concern was that RIE staff may have known that the blood products her father received carried a risk of infection and yet chose to administer them, whereas they should have used an alternative. Please comment on this.**

7. **At paragraph 12, witness W2633 states after he was diagnosed with hepatitis C in late 1993/early 1994, her father wrote to RIE to attempt to identify the occasions on which he may have been infected with hepatitis C, but did not receive a response. Witness W2633 goes on to state that she believes her father could have been informed about his hepatitis C diagnosis sooner than he was (paragraphs 16-17), and that her father was not told about his diagnosis earlier**

so staff could see how the hepatitis would develop (paragraph 21). Please comment on this.

8. At paragraph 15, witness W2633 states that the information her father was given about his hepatitis C diagnosis was inadequate. She states he was not told of the risk of cancer or deteriorating health, and was not given enough information about the risk of infecting others. Please comment on this.

9. At paragraphs 19-20, witness W2633 states that her father was tested for hepatitis C and other viruses without his knowledge or consent. Please comment on this.

10. At paragraph 11, witness W2633 states that after haemophilia inpatient care was moved from the RIE to the Western General Hospital, haemophilia patients were treated alongside leukemia and other blood disorder patients. The haemophilia patients complained because of the emotional impact of being treated alongside terminally ill patients. Please comment on this.

11. At paragraph 32-33, witness W2633 states that two of her father's oncology appointments at RIE in 2017 were incorrectly scheduled on the same day, as the second appointment was intended to discuss the results of the first appointment. Witness W2633 goes on to state that at a follow up appointment, her father was told that he could not have surgery because he was too high a risk as a haemophiliac, and the family felt let down by the NHS. Witness W2633 also states that from this point there was no follow up palliative care. Please comment on this.

12. At paragraph 44, witness W2633 states that her father experienced a poor standard of care when he was admitted to Western General Hospital with a urinary infection in 2018, shortly before his death. Witness W2663 states that the poor treatment included being left in bed with the bedrails up; delayed referral to speech and language therapy and physiotherapy; being left without clothes because staff had not advised the family that he required more clothes; not being given appropriate care because staff were too busy; and not being given test results until after he had been discharged, delaying his treatment with antibiotics. Witness W2633 states she believes the admission hastened her father's death. Please comment on this.

The Board identified Professor Christopher Ludlam as the most appropriate person to respond to the criticisms made. Professor Ludlam is now retired but was the Haemophilia Director at the Royal Infirmary of Edinburgh. He was one of the patient's treating clinicians and is the clinician towards whom the criticisms narrated at paragraphs 4 to 10 above are directed. His response is attached (WITN6932026).

The Board identified Dr Colette Reid as the most appropriate person to respond to the criticisms narrated at paragraph 11 above. Dr Reid is the Associate Medical Director for Cancer Services at NHS Lothian. Dr Reid did not have involvement in the patient's care and treatment at the relevant time but has been asked to review the criticisms and medical records and provide a response on behalf of the Board, which is attached (WITN6932029).

In relation to paragraph 12, I would respond as follows:-
The issues raised have been investigated and responded to under NHS Lothian's complaint policy (DATIX number 49950). This involved a meeting with two family members in September 2018, and this was followed up with a note of the meeting. I acknowledge that this should have been managed formally as a complaint but was in fact logged as a concern. This aspect was raised by the family with their MSP, Tommy Sheppard, and subsequent correspondence acknowledged this.

The SPSO were then approached by the family in 2019 (April) and investigated the following four points:

1. The Board failed to provide reasonable nursing care to Mr Gordon-Smith during his admission of July 2018

2. The Board failed to provide reasonable medical treatment to Mr Gordon-Smith during his admission of July 2018.

3. The Board failed to make appropriate arrangements for Mr Gordon-Smith's dentist appointment.

4. The Board failed to handle your complaint in a reasonable manner.

The SPSO upheld all four aspects of this and the report is provided here (WITN6932031). The SPSO acknowledged in May 2020 that the actions had been met and the file was closed. All documentation can be provided.

I would also like to respond to the criticism at paragraph 10 above.
It is always difficult to arrange optimum configuration of services when considering whether these should be delivered from a single site or with a team split across two or more sites. The intention of delivering all haematology in-patient services from the Western General Hospital was to avoid a single haematology team working across multiple sites to deliver in-patient care. It was a decision made with good intention but clearly did· not work well, and the emotional impact on haematology patients is regrettable and is acknowledged. The criticisms were taken on board and the service reconfigured to return the in-patient care of haemophilia patients to the Royal Infirmary.

Section 3: Other Issues

13. **If there are any other issues in relation to which you consider that you have evidence which will be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference, please insert them here.**

None.

Statement of Truth

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

Signed GRO-C

Dated 17 June 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number

February 2022	Comments from Professor Christopher Ludlam	WITN6932026
April 1993	Haemophilia Society booklet	WITN6932027
1993	Hepatitis Information sheet entitled “Hepatitis C Liver Disease and its Treatment”	WITN6932028
March 2022	Comments from Dr Colette Reid	WITN6932029
	Clinic Letters referred to by Dr Colette Reid	WITN6932030
May 2020	The Scottish Public Service Ombudsman Report	WITN6932031