Witness Name: Tracey Gillies
Statement No.: WITN6932058
Exhibits: Nil
Dated: 24/05/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF TRACEY GILLIES

I provide this statement on behalf of NHS Lothian Health Board in response to the request under Rule 9 of the Inquiry Rules 2006 dated 21 November 2022.

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.

Section 2: Response to Criticisms by W5576

4. **Please insert your response to the criticisms made by witness W5576, as laid down in the Rule 13 Notification sent to you on 20 October 2022.**

The criticisms I have been asked to address are:

Paragraph 9

Mum was never told about any risks associated with the transfusion they gave her, and I don't think she even fully understood that she was given blood. This was Mum's first time in hospital as she had given birth to all her children at home and was a very healthy woman. This experience must have been quite scary and confusing for her, and I don't think she would have asked many questions about what was happening. You didn't then; if the doctor said it was necessary you took that as gospel and Mum was of the generation that would never question the decision of a doctor.

The witness outlines that her mother was not given information related to risks associated with transfusion and did not feel empowered to ask questions. I am sorry if this was the case. It is difficult to comment on attitudes and understanding of risks relating to blood from 1979 but the witness is correct in referencing different attitudes between different generations.

Paragraph 32

I asked Dr Kumar why mum's condition had deteriorated so quickly, and he said that Mum now had cirrhosis of the liver. There was no explanation given as to how this had happened, we were just told it was something that eventually occurs with HCV. It all seemed like a big mystery. I don't even know if they were aware of infected blood at the time, but we tried very hard to get answers and it was like there was a closed door between us and the medical staff treating her.

I am sorry that an explanation about the nature of the progression of hepatitis C to cirrhosis and the consequences of this were not given to the witness.

Paragraph 38

Although the nurses knew we were taking care of Mum and dealing with her bodily fluids, we were never advised to take precautions like wearing gloves in order to prevent us becoming infected with HCV. We were just left to get on with it. I really don't think the hospital was even aware of how infectious Mum was, and she was never treated any differently to other patients or kept in an isolation ward.

Paragraph 39

Despite the close contact we were having with mum and our involvement in her care, it was also never suggested to my siblings or I that we should get tested for HCV. I have given blood on a number of occasions as has my brother James, so we would have been notified if we had been infected with HCV but what about the others? What about the potential risks to our children? We could have inadvertently passed anything on. I believe HCV testing should have been offered to us.

I am sorry that the discussion that should have occurred with family members, and possible risks for other members of the family in line with HCV testing did not take place.

Paragraph 49

What upset me the most was that it felt like there was no communication or updates from the doctors about what the next steps were in Mum's care. We tried hard to ask the doctor and nurses treating Mum for specifics about what was going, but we just did not get anywhere. In the end we just accepted how Mum was being treated and did not question what the doctors were doing. To an extent that's just the way it was and you can only push so hard.

I would like to apologise to the witness for the lack of communication and update from the doctors including the realistic and poor prognosis in the treatment of cirrhosis, and accept that this could have been improved on.

Paragraph 59

Mum's death had a massive impact on the entire family, and was very difficult to content with. As I've described above, the experiences we had during Mum's treatment and the lack of information and support we were offered was terrible. I'm glad that the NHS has improved since then because if the same thing happened now we could have hung them out to dry.

I am sorry for the poor experience of the witness and her wider family over such a difficult time and welcome the acknowledgement that NHS information and support have improved.

Section 3: Other Issues

5. **If you hold evidence you consider may be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference, please insert here**.

None.

Statement of Truth

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

Signed GRO-C: Tracey Gillies

Dated 24/05/2023