Witness Name: Tracey Gillies
Statement No.: WITN6932061
Exhibits: WITN6932062-064
Dated: 06/09/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF TRACEY GILLIES

I provide this statement on behalf of NHS Lothian in response to the request under Rule 9 of the Inquiry Rules 2006 dated 27th July 2023.

I, Tracey Gillies, will say as follows: -

Section 1: Introduction

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

1. 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.

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

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

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)").

3. NHS Lothian is responsible for healthcare provision for the population of the Lothian area.

Section 2: Response to Criticisms by witness W7136

4. The criticisms the Board has been asked to respond to are set out at paragraph 44, paragraph 45 and paragraph 47 of the witness statement of witness W7136, which state:

   Paragraph 44

   My dad was admitted to Edinburgh Royal Hospital several times because he was in pain. Sometimes, the nurses would overdose him on painkillers because they thought it would help.

   Paragraph 45

   On one occasion, he was given five painkillers in one night, and he lost consciousness, even though it was already in his medical notes that one of the medications had been proven to be ineffective. On another occasion, they did not contact my mum before giving him a catheter. The information was only given to us after the event.

   Paragraph 47

   Before my dad was sent home, someone wrote down on my dad's medical notes that they had had a conversation with us (the family) and had agreed that my dad was not to be resuscitated. However, no one had spoken to us about this and the instruction was completely incorrect. In fact, we had been there in the same room and the doctor never once looked at us, let alone had a conversation with us.

5. In my role as UK IBI lead for the Board I received the aforementioned Rule 9 Request of 27th July 2023. I identified Dr Alan Christie, Consultant Medical Oncologist, as the most appropriate people to consider and respond to the criticisms made. He has now done so and his response is set out below, in his own words.

Response of Dr Alan Christie

6. The statement has been prepared on the basis of the contemporaneous electronic medical records as I was not directly involved at the time of the incidents in question.

7. At paragraph 44 of her statement, witness W7136 states that “My dad was admitted to Edinburgh Royal Hospital several times because he was in pain. Sometimes, the nurses would overdose him on painkillers because they thought it would help.” In paragraph 45 it is stated “On one occasion, he was given five painkillers in one night, and he lost consciousness, even though it was already in his medical notes that one of the medications had been proven to be ineffective.

8. These statements seem to cover one or two hospital admissions in 2021, I have summarised events below.

9. W7136’s stepfather had 2 hospital admissions to the Western General Hospital, one under general medicine from 27/6/2021 to 28/6/2021 (WITN6932062), and one under oncology from 21/10/2021 to 26/10/2021 (WITN6932063 and WITN6932064). There were no admission to the Royal Infirmary of Edinburgh.

10. I was not personally involved in his care during the first admission in June 2021 but have reviewed the electronic medical record. He was admitted at around 10pm with deteriorating pain control at home, and appears to have received 4 doses of 5mg of oramorph (oral liquid morphine) overnight. This enabled him to have small amounts of sleep, although it sounds like his sleep was still interrupted by his pain. He was reviewed by the palliative care team the following day, and the dose of his Fentanyl patch was increased from 50mcg/hour to 62mcg/hour, and the dose of his Oramorph increased from 5mg as required to 20mg as required.

11. W7136’s stepfather was subsequently admitted to the oncology ward on 21/10/2021 with deteriorating pain control, intermittent confusion and high calcium levels in his blood.

12. On the evening of 23/10/2021, he was increasingly distressed and agitated and receiving 1:1 nursing care. The nurses noted that he was in severe pain and was increasingly distressed, and he was given a further dose of morphine (10mg) as an injection under his skin, and a second drug midazolam (2mg) to help with his agitation. He became less responsive after this, but was still breathing at a normal rate with normal oxygen levels. His wife and W7136 were asked to come into the ward between 1am and 2am due to concerns that his health was deteriorating further, and the on-call ward doctor spent time explaining the situation with them. It was documented they

were happy with the outcomes of these discussions. The same doctor reviewed him again at 7am in the presence of his wife and W7136. He was now alert and comfortable, but fatigued and requesting to be left alone to rest.

13. Paragraph 45 also states “On another occasion, they did not contact my mum before giving him a catheter. The information was only given to us after the event.”

14. This statement is inconsistent with the contemporaneous medical notes.

15. On 23/10/2021 W7136’s stepfather was becoming increasingly confused, and the nurses looking after him were concerned that he hadn’t passed urine through the day. A scan of his bladder confirmed he was retaining urine which may have been contributing to his confusion in the context of his high calcium levels. As he was too confused to consent to treatment himself, the ward doctor on call spoke to his wife initially, then to W7136 over the phone at around 8pm to discuss catheterisation of his bladder. These discussions are clearly documented in the medical notes, including W7136’s consent for the nursing staff to proceed with bladder catheterisation for her stepfather. The catheter was inserted at 11.30pm, over 3 hours after this was discussed with W7136’s stepfather’s wife, and with W7136.

16. In paragraph 47 the witness states “Before my dad was sent home, someone wrote down on my dad's medical notes that they had had a conversation with us (the family) and had agreed that my dad was not to be resuscitated. However, no one had spoken to us about this and the instruction was completely incorrect. In fact, we had been there in the same room and the doctor never once looked at us, let alone had a conversation with us.”

17. This statement is inconsistent with the contemporaneous medical notes.

18. After W7136’s stepfather’s admission to the oncology ward on 21/10/2021, we were concerned about a general deterioration in his health, and that resuscitation would not be in his best interests if his heart was to stop, due to the lack of treatment options available for his underlying cancer. A temporary DNACPR (Do Not Attempt Cardio-Pulmonary Resuscitation) form was put in place overnight on 21/10/2021, with a view to discussing with W7136’s stepfather and his family the following day.

19. I was on annual leave on 22/10/2021, so he was seen by a consultant colleague on a ward round at 2.45pm. It was clearly documented that his wife and W7136 were present for these discussions, and that it was discussed that resuscitation or care in a high dependency unit or intensive care unit would be inappropriate in the event of a further deterioration in his health. A DNACPR form was agreed after these discussions.

20. At 6pm on 22/10/2021, W7136's stepfather's wife and W7136 requested a further meeting with medical staff to discuss why he needed to remain in the hospital as he now had a DNACPR form and his IV fluids were stopped, suggesting they were already aware of the presence of the DNACPR form. They expressed concerns about having insufficient time to discuss the DNACPR decision, and spent some time with the ward doctor discussing what the presence of a DNACPR form meant for his ongoing care. These discussions are clearly documented in his medical notes.

Section 3: Other Issues

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.

21. None.

Statement of Truth

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

Signed GRO-C

Dated 06/09/2023

Table of exhibits

Date	Notes/ Description	Exhibit number
June 2021	Electronic record	WITN6932062
October 2021	Electronic record	WITN6932063

October 2021	Electronic record	WITN6932064