Witness Name: Kathryn Thomson
Statement No.: WITN6940001
Exhibits: WITN6940002
Dated: 11.11.2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF KATHRYN THOMSON

I provide this statement on behalf of Liverpool Womens NHS Foundation Trust ('the Trust'), Crown Street, Liverpool, L8 7SS in response to the request under Rule 9 of the Inquiry Rules 2006 dated 1 July 2021.

I, Kathryn Thomson, will say as follows: -

Section 1: Introduction

1. I am the Chief Executive of Liverpool Womens NHS Foundation Trust, Crown Street, Liverpool, L8 7SS. I have been in post since September 2008. The Trust is the successor body with responsibility for the former Liverpool Maternity Hospital.

2. I confirm that I have had sight of the witness statement of witness W2631. I am very sorry to learn that she contracted hepatitis C following receipt of a blood transfusion at Liverpool Maternity Hospital in 1982. I am aware that the Trust is not required to provide a response at this stage but we wish to do so in order to provide as much assistance to the Inquiry and to witness W2631 as possible. I hope that our response assists her in some small way and I wish her well for the future.

Section 2: Response to Criticism of witness W2631

At paragraph 5 of her witness statement, witness W2631 states that in 1982, after she underwent a caesarean section at the former Liverpool Maternity Hospital, she experienced complications and required further surgery. The witness's first language is GRO-B *and a* GRO-B *speaking junior doctor was located to explain to the*

witness that she required a blood transfusion. The witness recalls the medical team "putting pressure on the junior doctor to hurry up in giving the information to [her]".

3. It is recorded in the medical records for witness W2631 that she attended the former Liverpool Maternity Hospital on 15 May 1982, whilst pregnant with her second son. On GRO-B 1982, witness W2631 underwent a caesarean section. Following this operation, witness W2631 suffered complications and began to bleed. At this point, witness W2631 was returned to the operating theatre to attempt to resolve those complications.

4. Witness W2631 explains that she is GRO-B by birth, with GRO-B being her fist language. Witness W2631 had arrived in the UK for the first time on 30 June 1980. As a result, there existed a language barrier between witness W2631 and treating clinicians. As a result of this language barrier witness W2631 reports that she felt very upset and scared as she did not understand what was happening. This was likely to have been exacerbated by the medical complications that she was experiencing.

5. Witness W2631 states that treating clinicians requested that a junior doctor, known to speak GRO-B enter the operating theatre to explain what was unfolding to witness W2631. At this point in time, it is reported that witness W2631 had lost four pints of blood. Witness W2631 was reportedly told that if she did not receive a blood transfusion she would die, such was the urgency of the situation. Witness W2631 states that the junior doctor also explained that she would require a general anaesthetic as she was distressed, and asked whether witness W2631 could consent to the transfusion, or if there were any religious reasons that she could not receive said transfusion. Witness W2631 reports that there were no reasons that would prevent the receipt of a blood transfusion.

6. Witness W2631 states specifically that she recalls *"the medical team putting pressure on the junior doctor to hurry up in giving the information to [her]".*

7. I am informed by clinical colleagues, that where a patient has suffered a medical emergency such as a haemorrhage, as was the case for witness W2631, clinicians are placed in a time-critical environment where they are required to act incredibly quickly in order to mitigate any serious adverse consequences to the patient, up to and including death.

8. In a bid to respond to this medical emergency with due haste, and thereby care appropriately for witness W2631, the amount of time that could be dedicated to patient-care and discussing the options available to witness W2631 was vastly reduced. This is true with all medical emergencies.

9. In the case of witness W2631, due to her haemorrhage, it is likely that it would have been explained to her that if she did not have a blood transfusion, she was at risk of death. Witness W2631 confirms at paragraph 5 of her statement that she was in fact told this. However, the Trust is unable to hypothesise as to what information, if any, would have been provided in relation to any potential risk of infection for any blood transfusion in 1982.

10. The Trust sympathises with witness W2631 as she felt rushed in an already alien environment whilst these discussions were taking place. However, considering the situation that witness W2631 was in at the time, it appears that the clinicians took appropriate actions in a time-critical environment to discharge their immediate duty for the preservation of life.

At paragraph 47 of her witness statement, the witness states that when her consultant sought her medical records from Liverpool Maternity Hospital at some time after 2005, it appeared "someone ha[d] physically removed the important evidence". She states that a page containing information about the blood transfusion she received following the caesarean section was removed.

11. I am aware that the Trust has previously conducted a search of W2631's medical records to attempt to assist W2631 in obtaining answers in relation to the receipt of infected blood.

12. During January and March 2007, the Trust received and responded to an enquiry from (who the Trust believes to be) the GP of witness W2631; this GP requested the medical records of witness W2631. It is thought that this correspondence is that which witness W2631 refers to in her witness statement at paragraph 47, looking for evidence of the blood transfusion that occurred in 1982. Internal correspondence confirms that a search was undertaken of these records, culminating in the response to W2631, to which she refers in her witness statement.

13. This search was undertaken on the Trust's electronic system 'Microfiche', searching the medical records held for witness W2631. In order to assist the Inquiry, I provide

some information relating to this system. This information has been obtained from individuals within the Trust with comprehensive knowledge of this system.

14. During 1998, all physical records that were held by the Trust were converted into an electronic format and uploaded onto the then-new system, 'Microfiche'. This is an electronic system by which each patient's medical history can easily be accessed and added to. Please note that it is not technologically possible to remove pages from records uploaded to Microfiche. This is by deliberate design of the system, to ensure that records are stored in their entirety for each patient.

15. As a result, if records are not present on Microfiche, this would mean that they were not converted nor uploaded to Microfiche in the first instance. Due to the amount of records that were required to be converted en masse when the conversion took place, the task of physically scanning in each record would have been performed by administrative staff; clinicians would not have been involved in this process. It is therefore considered highly unlikely that a clinician would have physically removed an existing record during this conversion process.

16. Witness W2631's clinical notes have been reviewed in advance of preparing this response to the Inquiry. These clinical notes are of the type held for every patient who access services of the Trust. Unfortunately, nothing relevant to the issue of a blood transfusion has been uncovered during this search.

17. Given the lack of information held by the Trust in medical records pertaining to witness W2631's blood transfusion, it is the Trust's view that a record of this transfusion was either not recorded in the first place on W2631's file, or was otherwise lost at or before the conversion to Microfiche took place in 1998.

18. Given the urgency of the situation that witness W2631 found herself in on GRO-B 1982, it is also entirely possible that clinicians did not complete the requisite paperwork, or that a record was created, but that this was not stored within W2631's records. Unfortunately, the Trust is simply unable to state with absolute certainty the position of the missing record that witness W2631 refers to.

19. Working practises in relation to recording patient data have evolved considerably since 1982. The Trust has a clear record keeping policy, guiding clinicians and administrative staff on the creation and storing of records. The Trust appreciates

wholeheartedly that this does not rectify the situation that witness W2631 has been placed in.

20. The Trust wishes to apologise unreservedly that these records are not held and for the distress that this has caused witness W2631.

21. Through making further enquiries, the Trust has been able to locate further information relating to witness W2631, albeit not in witness W2631's medical records file. The Trust has located a historic, physical ledger that details how many units of blood were removed from the blood bank on any given day.

22. Through reviewing this ledger, the Trust is able to confirm that there is an entry relating to witness W2631 on GRO-B 1982. The references to witness W2631 include reference to the 'nickname' that she went by at this point in time, which is detailed at paragraph 6 of her statement. The ledger states that on GRO-B 1982, six units of blood were ordered for witness W2631. Two units were removed from the blood bank at 15:15, with a further four units being removed at 16:20. One unit of blood was returned back to the blood bank at 18:30.

23. The ledger states that the reason for requiring this blood was as being 'post-operative' or 'bleed'. The blood group listed was blood group A positive. The Trust attaches a scan of this ledger, redacted so as to protect the identity of other patients, as an exhibit "WITN6940002" to this statement.

Section 3: Other Issues

24. At this time, the Trust has no further issues that it wishes to raise.

Statement of Truth

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

Signed GRO-C

Dated: 11.11.2021

Table of exhibits:

Date	Notes/ Description	Exhibit number
	Scanned copy of ledger held by blood bank	WITN6940002