Witness Name: Dr Graham Foster
Statement No.: WITN7003002
Exhibits: Nil
Dated: 15/06/2022

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF Dr Graham Foster**

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I provide this statement on behalf of Forth Valley Health Board in response to the request under Rule 9 of the Inquiry Rules 2006 dated 26 January 2022.

I, Graham Foster will say as follows: -

## Section 1: Introduction

Dr Graham Foster
Director of Public Health and Strategic Planning
NHS Forth Valley
Date of Birth: GRO-C 1966

Employment Details:
I am a GMC registered Medical Practitioner with specialist registration in General Practice and Public Health.
Senior Medical Officer, Scottish Government Health Department, 1997-2001.
Consultant in Public Health Medicine, NHS Forth Valley 2001-2012.
Director of Public Health 2013 – present.

## Section 2: Response to Criticism of witness W0904

1. NHS Forth Valley recognises the very sad death of this witness's spouse at the young age of 45 due to a haematological malignancy (blood cancer) first

diagnosed in summer 1988 and extends its deepest sympathy for this tragic and untimely loss.

2. The witness describes a sequence of events and has made complaints about Stirling Royal infirmary. Whilst there are no medical records or other evidence beyond this witness statement, there are some comments we would wish to make on the criticisms in the witness statement.

3. The criticisms the Board has been asked to respond to are contained in paragraph 16, page 4 and paragraph 43 i), page 9.

4. **Paragraph 43 (i) page 9.** The witness has stated they wish to complain that Stirling Royal Infirmary (SRI) "Initially gave (the patient) a wrong diagnosis that could have been the end of her straight away." In the detail of the statement the witness states that the patient was "misdiagnosed" "with myeloma". In 1988 Stirling Royal Infirmary was a District General Hospital served by four General Physicians including Dr Sheila Reith whom the witness names in other evidence. The hospital did not have a specialist haematology unit and normal practice was to transfer all patients requiring specialist haematological investigation, diagnosis, and treatment to a specialist regional haematology service in Glasgow or Edinburgh. There are a number of common haematological malignancies with symptoms similar to Myeloma and in 1988 it would not have been possible for Stirling Royal Infirmary to confirm an exact diagnosis or to start treatment without referring the patient to the specialist unit. From the witness statement there is no reason to infer that this patient received anything less than satisfactory care at SRI. This included assessment by a General Physician who correctly and timeously diagnosed the patient as having a haematological malignancy with symptoms consistent with myeloma and correctly transferred the patient to the regional specialist unit for specialist tests and to recommend a treatment plan. In this case the Western Infirmary identified the precise condition as the relatively unusual, Waldenstrom's Macroglobular Anaemia and recommended the treatment plan. I would ask the enquiry to accept that it is not appropriate for the witness to complain about the hospital or the staff based on what might have happened had they not acted as

they did. The patient did not receive the wrong chemotherapy and there is no evidence to support the suggestion that the patient's life was put at risk by a "misdiagnosis" at SRI.

5. Paragraph 16, Page 4. The witness states that "They later informed us that they had traced the infected blood back to a male donor". Whilst there is no evidence to confirm or deny this specific recollection of events the patient had received multiple blood transfusions in Glasgow and Stirling during this time and local staff in Stirling would not have been responsible for tracing the source of a specific blood donation.

6. Paragraph 16, Page 4. The witness states "We were never given any indication that there was a risk from the transfusion". Whilst the witness may not have been personally aware of transfusion risks, we would respectfully suggest that the witness cannot testify as to what the patient was told during multiple periods of in-patient treatment. Hospital visiting hours at this time were limited and the witness would not always have been present during ward rounds or when the consent for transfusion was signed. Medical confidentiality prevents doctors from discussing medical matters with anyone other than the patient. Normal practice would be for each patient to be cross matched and to sign a consent form prior to every blood transfusion. Patient consent is a required step before giving blood or blood products due to the specific risks of blood transfusion including transfusion reactions and infections.

**Section 3: Other Issues**

7. NHS hospital records are not held in perpetuity or routinely shared between hospitals. There are national guidelines relating to data protection and the routine destruction of medical records. This patient's hospital records were destroyed by medical records staff in good faith and in accordance with the extant local and national medical records retention policies at the time.

8. The Board has nothing further to add.

**Statement of Truth**

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

Signed GRO-C

Dated 15/06/2022