Witness Name: Chris Deighan
Statement No.: WITN7116033
Exhibits: NIL
Dated: 02/05/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF CHRIS DEIGHAN

I provide this statement on behalf of NHS Greater Glasgow and Clyde in response to the request under Rule 9 of the Inquiry Rules 2006 dated 16 August 2022.

I, Chris Deighan, will say as follows: -

Section 1: Introduction

1. **Introductory paragraph to include your date of birth, address, occupation and employment history.**

   Name: Dr Christopher J Deighan
   Date of birth: GRO-C 1966
   Address: Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

   Qualifications:
   - MB.ChB.: University of Glasgow, 1989
   - MRCP : Royal College of Physicians, U.K. 1992
   - M.D. : University of Glasgow, 2000
   - FRCP : Royal College of Physicians, Glasgow, 2004

   Employment:
   - Executive Medical Director: NHS Lanarkshire January 2023 to date

- Consultant Nephrologist: NHS Greater Glasgow and Clyde April 2000 to January 2023
- Deputy Medical Director: Corporate, NHS Greater Glasgow and Clyde May 2019 to January 2023
- Chief of Medicine, North Sector, NHS Greater Glasgow and Clyde – June 2015 to May 2019
- Clinical Director, Renal Services and Centre for Integrative Care, Regional Services Directorate, NHS Greater Glasgow and Clyde – October 2009 to June 2015

Section 2: Response to Criticisms by W4182

2. **Please insert your response to the criticisms made by witness W4182, as listed in the Rule 13 Notification sent to you on 4 July 2022.**

Before responding to the individual issues raised by W4182 regarding the death of his father, NHS Greater Glasgow and Clyde (NHSGGC) notes the lack of medical records available to allow a full response. Over the period of W4182's father's treatment, the Board managed its medical records in line with (SMH 58/60) *Scottish Hospital Service Destruction of Hospital Records* guidance of 1958, as previously confirmed in Statement No.: WITN6911007. Medical records were only required to be kept for a minimum period of three years after a patient's death. This means that many of W4182's father's medical records would have been destroyed from any point from 28th February 1993 onwards.

As a result, we have been unable to identify the majority of W4182's father's medical history, including records of his treatment at Glasgow Royal Infirmary (GRI) as well as virology and other laboratory test results. We have, however, been able to identity W4182's father's medical and nursing notes from Parkhead Hospital from admission on the 23rd February 1990 until his death on the 28th of February 1990. In addition, there is limited information available from the Renal Electronic patient records for W4182's father's name with a birth date of GRO-C 1915. This date of birth differs from the birth date provided by W4182 which is GRO-C 1915, but matches the birth date on the Death

Certificate. This plus other information from the renal electronic patient records indicates that this is the correct individual. The information from the renal electronic patient records is very limited and mostly laboratory data as this was very early in the development of electronic records. There is no identifiable narrative from his medical or nursing care around the time of his transfer to Parkhead Hospital.

Given the explanation above, I will endeavour to respond from the limited information available.

Paragraph 6

A few weeks before my Dad died, his condition deteriorated very rapidly and he was admitted to the Glasgow Royal Infirmary. The hospital staff were not completely honest with us at that time, they did not tell us that he had hepatitis. We only found out he had contracted non-A non-B hepatitis after he died. A few days after he was admitted to the Glasgow Royal Infirmary, we were contacted by the hospital to say that he had assaulted one of the nurses. We were told that he had grabbed a nurse in some way. I know my Dad, there was not a chance he would have ever done anything like that to anyone. He simply did not have that sort of thing in him, it was not in his nature. We were told that he was being moved to Parkhead Hospital, Glasgow, which was a mental health hospital, as a result of what they alleged had happened. He was taken there by ambulance that same day. My Mum and I went there straight away and managed to meet him at Parkhead Hospital. That was the point that his health deteriorated very quickly.

I can confirm that, within the nursing notes from Parkhead Hospital, comments were made that W4182's father was at times difficult to manage within the ward setting. It does appear that W4182's father was increasingly confused and agitated which was firstly attributed to depression. However, after admission to Parkhead Hospital, a history of 3 to 4 years of increasing confusion led the psychiatrists to come to the diagnosis of Alzheimer's dementia.

With respect to infection with Non A Non B Hepatitis, the documentation in the Parkhead Hospital notes is inconsistent and we are unable to identify a laboratory result confirming that W4182's father was positive for infection with Non A Non B Hepatitis. It is also not clear if and when any diagnosis was confirmed.

W4182's father recorded a rise in his liver function tests from mid-January of 1990 which is indicative of an inflamed liver - as would be seen in a recent infection with viral hepatitis. In his nursing notes, there is a comment from admission on 23rd February 1990 that he had been screened for Hepatitis and this showed Non A Non B Hepatitis, however documentation on 24th February 1990, the following day, notes that he is a 'possible carrier Hepatitis B and Non A non B' and is ''apparently being screened for Hepatitis B and non A non B Hepatitis''

His medical notes from the next day, 25th February 1990, record that he was identified as being antibody positive for Hepatitis B. The results suggesting evidence of previous exposure to Hepatitis B Virus but that he was not infectious. We are not able to identify any results for testing for Non A Non B Hepatitis although there is a comment in the notes that he might have Non A Non B Hepatitis. There is evidence in the notes that the Renal Consultant was unaware of the result of testing for Non A Non B Hepatitis. The testing for such conditions would take 1 to 2 weeks to turn round at the time and it is not possible to confirm if W4182's father was told that this testing had been undertaken given the absence of in-patient notes from the GRI.

A detailed review note from W4182's father's Psychiatrist following discussion with W4182's mother and W4182 on 27th February 1990 notes a list of diagnoses including: Transaminitis (Non A Non B Hepatitis) and the nursing notes from 28th February 1990 following his death note that he was a definite Non A Non B Hepatitis.

Therefore, in terms of the staff being honest about the testing, there is evidence that clinicians at Parkhead Hospital were aware that W4182's father had been

tested, but not aware of the test results themselves much before W4182's father's death. NHSGGC apologises that these results were not made known to the family, however, it does appear that the managing of W4182's father's progressive confusion and agitation over a period of weeks would have been the highest priority for the treating team.

Paragraph 7 and 8:

A meeting was arranged with my mother and I at Parkhead Hospital to discuss my Dad's health a few days later. I cannot remember the exact date of the meeting or who we spoke to but I remember the meeting itself was in a room with around half a dozen medical professionals. The exact words that were said to us were that "he's had a good innings, three score year and ten is what is normal and he is seventy four". In other words, they were telling us it was time to let him go. They asked us at that meeting for our permission to stop his treatment. From what we had seen of my Dad's health in the days prior to this meeting, I believe they had stopped his treatment sometime before that. He was extremely mentally wandered, I think his body was poisoned basically. He knew who we were but he couldn't speak. The last time I saw him, he still could not speak and there were just tears rolling down his face because he couldn't actually speak to us. I think he knew he was going to die but he just didn't have the power to speak to us and be heard.

I think they had let him reach a very bad state so that we basically had no option but to agree with what they were going to suggest. I firmly believe they ended my Dad's life. My Mum and I were sent to a private room, given a pot of tea and left to make that decision. We did decide to take their advice, we knew nothing about the hepatitis and we didn't know he had contracted it during treatment for his dialysis. We took their advice, because at that point Dad was at such a low point that he no longer had a good quality of life. Once we had agreed to stop his treatment, he died within twelve hours.

It is difficult to respond more fully to these events due to the lack of medical case notes from GRI, however, it can be evidenced from the case notes available that he was being actively treated in Parkhead Hospital, with blood tests being undertaken and acted upon on a daily basis. On 25th February 1990, the day before W4182's mother and W4182 met with the medical staff from the GRI and Parkhead Hospital, the blood results showed a high potassium level and this was treated, as was ongoing low protein diet and fluid restriction. The Renal Consultant had written that Continuous Ambulatory Peritoneal Dialysis (CAPD) could be stopped for a couple of days and there were discussions on the 25th February about the renal team coming to Parkhead to assist in delivering his CAPD.

Paragraph 13 & 14

I believe that my Dad's treatment was stopped without his consent. My belief is that the doctors in charge of his care at Parkhead Hospital stopped his treatment before consulting my mother and myself. There was information they had about him that they were not forthcoming with and I think that is why they pressured us into making that decision.

I believe that they stopped his treatment without his knowledge and without his family's knowledge. Neither my Dad nor his family were provided with full and adequate information. The speed with which his health deteriorated in those last few days of his life makes me strongly believe that they had stopped his treatment.

NHSGGC is very sorry to learn that W4182 believes this. As described in the response to paragraphs 7 and 8 above, it is difficult to respond more fully to these events due to the lack of medical case notes from the GRI. However, the Parkhead Hospital records note that the medical team continued to treat W4182's father up until the day before he died, and the same day his family met with the medical team. It is impossible to confirm what was said to him and how much of this information he may have been able to absorb or retain given the confusional state he appeared to be in at that time. As mentioned before, all treatments continued except CAPD which was discontinued at least the 48

hours before as it was causing distress and was difficult to deliver due to his confusion and agitation.

Paragraph 18

The hospitals attitude was that he had a good run so I don't think they ever considered treatment for his hepatitis, if they knew at the time. I do not think they were at all willing to help him.

The treatment for Non A Non B Hepatitis was first described in 1991 with the use of a drug called Interferon and so such treatment would not unfortunately have been available to Mr Jamieson.

NHSGGC regrets that it is only able to provide a partial response to Alan Jamieson's concerns due to the limited evidence it still holds. Living with kidney failure and dialysis is difficult for both the patient and his family and NHSGGC is sorry that this has affected the family so deeply. I hope this response answers at least some of your questions.

Section 3: Other Issues

3. **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

Dated 02/05/2023