Witness Name: Dr Pamela Johnston
Statement No.: WITN7142004
Exhibits: Nil
Dated: 18/04/2023

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR PAMELA JOHNSTON**

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I provide this statement on behalf of Tayside Health Board in response to the request under Rule 9 of the Inquiry Rules 2006 dated 17 May 2022.

I, Dr Pamela Johnston will say as follows: -

## Section 1: Introduction

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

   Name: Dr Pamela Johnston
   Address: NHS Tayside Headquarters, Ninewells Hospital, Dundee, DD1 9SY
   Date of birth: GRO-C 1964
   Professional qualifications: MBChB, FRCA

2. **Please set out your current role at the Board and your responsibilities in that role.**

   - Medical Director – NHS Tayside
   - UK IBI Lead for NHS Tayside

3. **Please set out the position of your organisation in relation to the hospital/other institution criticised by the witnesses (for example 'NHS ABC Health Board ("the Board") operates from Hospital X and Hospital Y (formerly Hospital Z)').**

NHS Tayside is responsible for healthcare provision for the population of the Tayside area.

## Section 2: Response to Criticism(s) by W0460

In my role as UK IBI lead for the Board I received the aforementioned Rule 9 Request of 17 May 2022. I identified Professor John Dillon and Sean McArtney, Operational Nurse Director as the most appropriate people to consider and respond to the criticisms made. They have now done so and their responses are below, in their own words.

The criticisms the Board has been asked to respond to are:

4. ***Paragraph 82 of WITN0640001***

***On one visit I saw that he was lying on a urine stained bed and I asked the nurses if they were not going to change it, that I would do it myself. He was put on oxycontin and was taken off morphine and was in and out of hallucinating.***

### Response of Sean McArtney, Operational Nurse Director

I write in respect of the Infected Blood Inquiry and specific to the 'significant criticism' contained within paragraph 82 of the witness statement by witness W0640 (Statement No WITN0640001) in relation to the nursing care that was provided to W0640's late husband.

I have reviewed W0640's late husband's nursing records from the point of admission to Ward 34 at Ninewells Hospital on the GRO-B 2018 to his date of

death on GRO-B 2018. I note that the statement from witness W0640 does not identify the specific date however the nursing records confirm W0640's late husband required a urinary catheter as part of his care during this hospital stay.

A review of the shift assessment 'traffic light' document (an assessment that determines the required level of care from green status being fully independent, amber status requiring a level of assistance and red status being fully dependent. Amber and Red risks require documentation of the care provided on the specific shift) and competed entries identify that from admission on the GRO-B 2018 until the overnight period between GRO-B and GRO-B 2018 W0640's late husband was independent and continent from a urinary perspective. The 'traffic light' shift assessment has been completed for the night shift commencing GRO-B 2018 and at 03:00 on GRO-B 2018 confirms that a short term catheter is in situ. The 'traffic light' shift assessment has been completed for the late shifts on both the GRO-B and GRO-B 2018 however not recorded on the early and night shift on the GRO-B and the early shift on the GRO-B 2018. The daily shift assessment must be completed on each shift, NHS Tayside apologises that there were three omissions in the documentation on the GRO-B and GRO-B 2018 specific to urinary elimination.

On the GRO-B 2018 nursing documentation states that 'urinary output unclear' and later in the day a bladder scan was performed and recorded 114 mls of urine in W0640's late husband's bladder. Nursing records describe a change in W0640's late husband's clinical condition and a plan for fluid resuscitation and a catheter was inserted at 01:25 on GRO-B 2018 to monitor fluid balance. The nursing entry after catheter insertion states 'minimal output from catheter.' W0640's late husband was then transferred to the surgical high dependency unit at approximately 03:30 on GRO-B 2018.

The nursing documentation between GRO-B 2018 and GRO-B 2018 state that urinary output was poor and concentrated. The nursing note on the GRO-B 2018 timed between 07:30 and 20:00 states 'poor dieresis, urine looks concentrated, discomfort at catheter site, slightly bypassed this afternoon.' At 19:20 there is a further entry in the nursing notes confirming that the catheter

was bypassing. The nursing notes on the GRO-B 2018 timed between 19:30 and 08:00 state that the catheter was flushed and there are no further entries regarding the catheter bypassing however documentation stating that W0640's late husband's urinary output remained poor. W0640's late husband was transferred to Ward 34 at 17:20 on GRO-B 2018 for palliative care.

The nursing documentation confirms that the catheter was bypassing and this is likely the cause of the urine stained bed sheets. Monitoring of urinary output via a catheter would be every hour and this is not evident in the nursing documentation. W0640's late husband had a 24 hour skin and care round bundle record sheet and during his stay in the surgical high dependency unit the agreed frequency of the care rounding has not been recorded. Given W0640's late husband's deteriorating clinical condition and requirement for high dependency care I would expect this to be as a minimum 1 hourly care rounding and hourly checking of urinary output and catheter site care.

On behalf of NHS Tayside I apologise that the frequency of care rounding and catheter care was not robust and the subsequent failure in timely changing of urinary stained bed sheets. This is not the standard of care that I expect.

**Response of Professor John Dillon**

5. ***Paragraph 3 of WITN0640005***

***I have not been through these files as I find the whole issue extremely distressing. I have requested the Inquiry team investigator's to look for answers pertaining to why we were not told GRO-B was so ill. I was informed on the Saturday before his death (on the Monday) that he would be coming home. Why his cancer to his liver was not diagnosed earlier, and importantly, why it was not explained to us how risky the TACE procedure was going to be.***

W0640's late husband had cirrhosis of the liver secondary to his previous hepatitis C infection which had been cured in the years prior to the development

of the hepatoma and also had non-alcoholic fatty liver disease. Although he had cirrhosis of the liver, this was compensated and stable and he was in a Child's A state which implies a cirrhotic liver is as healthy as it can be and still be cirrhotic. He was undergoing regular screening for complications that can develop in cirrhotic livers, one of which is the development of a hepatocellular carcinoma and he had an abdominal ultrasound scan in March of 2017 which was normal and an alpha fetoprotein which was normal on the 28th of June 2017. His hepatoma developed in the interval between screening and was not suitable for transplantation or resection because of its size and location. Transarterial chemoembolisation (TACE) was the next best approach to reduce the chances of the cancer progressing.

6. ***Paragraph 22 of WITN0640005***

***I note from the above entry that the medical profession talk of palliative care for*** GRO-B ***. This was only ever explained to me at 2 or 3pm the day he died. This is why his death was such a shock to the family and myself. We didn't have the chance to say goodbye, I feel I was robbed of that opportunity.***

Unfortunately W0640's late husband developed a rare complication of this technique, acute severe pancreatitis. W0640's late husband was managed for this complication of his TACE in a standard way. Unfortunately it progressed quite rapidly and when it became clear he was not responding to therapy this was communicated to the family but the gap between this becoming obvious and his death was very short. This was due to the aggressive nature of the pancreatic complication.

7. ***Paragraph 38 of WITN0640005 –***

***At the foot of the aforementioned letter, it states "I will see him back in clinic in 2 weeks time." I note that two months later almost to the day,*** GRO-B ***passed away. I question why his carcinoma was not identified earlier, which would have enabled possible hospital treatment.***

This refers to my letter of the GRO-B 2018 where I said I would see him back in clinic in 2 weeks' time after I had heard from Edinburgh. I would refer you to my letter of the GRO-B 2018 (WITN0640013) where I summarise the findings from Edinburgh that he was not suitable for transplantation or resection, I state that I had made arrangements for the TACE to happen and I had spoken to W0640's late husband by phone and made him aware of the diagnosis and the treatment plan. On the GRO-B the TACE was performed. Hepatomas were being actively screened for in W0640's late husband's case and he developed an interval tumour that was detected on a routine screening test in December of 2017. The first clue of its presence was in December 2017 with the elevated alpha fetoprotein. An urgent scan was arranged on the 9th of January 2018 and unfortunately W0640's late husband felt unable to get into the scanners to have this performed which delayed the diagnosis until the 22nd of January which was then confirmed on MRI on the 19th of February, the same test he had refused on the 9th of January. So the tumour was diagnosed within weeks of a routine screening test indicating that there might be a problem. All the prior screening tests with ultrasound and alpha fetoprotein had been normal so there was no opportunity for an earlier diagnosis of this tumour.

8. ***Paragraph 46 of WITN0640005*** –

***It is interesting to note that the consultants were concerned about the state of GRO-B 's liver as far back as 2009. I question why he was never offered a transplant sooner.***

W0640's late husband's liver had been under close observation by the Doctors in Haematology and Hepatology for many years and they were aware of his development of cirrhosis in 2008. He had been under surveillance for the complications of cirrhosis since that time and had been observed for any signs of decompensation of his liver that would have indicated the need for liver transplantation. There are nationally agreed criteria for the need for liver transplantation that identify a group of patients whose chance of one year

survival is lower with their native liver than with a transplanted liver. A liver transplant comes with a mortality of between 10-20% and so it is not routinely offered unless patients are in liver failure or have hepatocellular carcinomas that are within curative criteria. At no point did W0640's late husband have liver failure that would have required a liver transplant and therefore this was not offered to him, although he was being actively observed to see if he needed such intervention if his liver was to decompensate.

## Section 3: Other Issues

9. **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.**

## Statement of Truth

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

Signed GRO-C

Dated 18/04/2023