Witness Name: Alison Davis
Statement No.: WITN7304001
Exhibits: None
Dated: 15 August 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ALISON DAVIS

I provide this statement on behalf of Medway NHS Foundation Trust ("the Trust") in response to the request under Rule 9 of the Inquiry Rules 2006 dated 19 July 2022.

I, Alison Davis, will say as follows: -

Section 1: Introduction

1. My full name is Alison Davis. My date of birth is GRO-C 1965. My professional address is Medway NHS Foundation Trust, Medway Maritime Hospital, Gundulph Trust HQ, Windmill Road, Gillingham, Kent, ME7 5NY. I am the Trust's Chief Medical Officer and was appointed to this role on 10 January 2022. I am a member of the Trust Board, accountable to the Chief Executive for developing and delivering the direction and management of the Trust's medical services, including the delivery of national, regional and local objectives for the services. I am also the named role for the Caldicott Guardian. I am Ophthalmology National Co-Lead and a GIRFT (Getting It Right First Time) clinical ambassador for all specialities across London and am committed to clinical quality improvement.

Section 2: Response to Criticism(s) by Witness W3968 ("the Witness")

2. This statement is the Trust's response to the criticisms made by Witness W3968, as laid down in the Rule 9 Request dated 19 July 2022 and as referenced in the Rule 13 Notification of Criticism to the Trust dated 6 May 2022.

3. Criticism was made by the Witness with Inquiry Reference W3968 in relation to treatment provided to his father by Medway Maritime Hospital in 2011. The Witness's father ("the Deceased") was infected with HIV sometime before 1987 and Hepatitis C sometime before 1993 as a result of receiving contaminated blood products.

4. The Trust has reviewed the Deceased's medical records held by it which are limited to the care it provided to the Deceased. Medical records held by other NHS Trusts, organisations and GP notes have not been obtained for the purposes of responding to this Rule 9 Request.

5. It is confirmed from Trust medical records that there are no clinical notes which pre-date 2011 and the Trust was not involved in any way with the transmission of infected blood to the Deceased in the 1980s and 1990s. The Witness's statement suggests that this occurred at Lewisham Hospital but remains unverified by this Trust.

6. The Deceased's notes confirm that he attended the Trust in November 2011 and January 2018, and it is particularly the experiences in 2011 which the Trust believes are the basis for the Witness's criticisms detailed in their statement. The Witness's statement raises a number of criticisms at paragraphs 14, 21 and 26 which can be summarised as follows:

    14. failure by the Trust to respect the confidentiality of the Deceased's medical notes which were left open in plain sight;

    21. delays in the admission of the Deceased both in getting to hospital and the nature of care and treatment they received whilst there; and

    26. when the Deceased was admitted to St George's Hospital to have further treatment, their decision to attend a less conveniently located hospital was informed by their past experience with the Trust.

7. In response to the criticism raised at **paragraph 14**, the Trust is aware that the Deceased attended its Maritime Hospital in November 2011. The Trust is deeply concerned that the Witness's observations and recollections from this time were that the Deceased's confidentiality was not maintained in respect of his patient records. Without further details about where and when the medical notes were left open, it is difficult for further investigations to be made into these concerns. At all times, the Trust endeavours to respect the confidentiality of patient records and we are very sorry if this

was not observed on this occasion. Over the last 10 years, all Trusts and NHS organisations in the UK have undergone significant changes involving a review of their policies and considerable improvements to their practices. This has been with the support and oversight from NHS England, NHS Improvement and NHS Digital to ensure that robust governance measures are implemented to protect the confidentiality of patient data.

8. These changes have also been supported by the implementation of new data protection legislation in the UK GDPR and the Data Protection Act 2018. The Trust continuously strives to achieve best practice in its operations with ongoing governance and data protection programmes supported by training to best protect client confidentiality. An example of this is where the Trust's Information Governance team conduct unscheduled spot checks to assess whether there are any patient records that are visible to the general public. Where this is observed, the Information Governance team implement a continuous auditing and improvement programme.

9. In response to the criticism raised at **paragraph 21**, the Trust is dismayed to note that there were apparent failures in its care of the Deceased when he attended Medway Maritime Hospital in November 2011. The clinical notes at the time state that the Deceased succumbed to a UTI on 14.11.11 and was taken by ambulance to the Trust where he arrived at 17:02. The clinical notes show entries in ED approximately every 30 mins, commencing at 17:35 where the Deceased was seen by nursing staff at regular intervals, and by doctors on at least 3 separate occasions. Subsequent entries suggest that the Deceased was comfortable and remained in ED and at 18:35 the patient notes record "*Needs Side Rm*". It appears that there was a delay in transferring him and he remained on a trolley where it was recorded at 22:10 that medics were aware that he was waiting to be moved to the Will Adams Ward (B3), but this did not occur until 23.36. Prior to discharge, a clinical note on 15.11.11 at 12:20 states "*mobile and independent around side room. No need for side room but no available beds on the ward*" which suggests that a delay of 6+ hours before the Deceased was transferred to ward was due predominantly to the unavailability of beds on Trust wards.

10. The Discharge Summary confirms that the Deceased was discharged at approximately 12:53 on 15.11.11.

11. The Trust regrets that there is nothing in the medical notes to address the Witness's criticism about ancillary staff not assisting his father while he changed clothes, only

that the Deceased was attended upon at regular intervals. The medical notes do state that the family was present at the hospital when the Deceased was admitted and consequently the Trust acknowledges that the Witness has his own direct observations and experiences to draw upon in making this account. The Trust is very sorry that the Witness and his family felt that they, and the Deceased was unsupported at this time.

12. In response to the criticism raised at **paragraph 26**, and more generally in relation to comments by the Witness in his statement, I, on behalf of the Trust, would like to say how sorry I am for any failings in the care received by the Deceased and as an extension of this, any upset suffered by the Witness and his family. I also wish to extend my personal condolences for their loss. I can only imagine the distress that they have all suffered together as a family since their father was infected with contaminated blood and am deeply saddened that the experiences the Deceased and his family received at the Trust contributed to this. I, and the Trust take this opportunity to wish the Witness and his family all the very best for the future.

13. As a final point, the Trust continuously strives to improve its standards of care so that the experience shared by this family are a thing of the past. The Trust's Patient Experience Strategy is embedded within our overarching Patient First Trust Strategy.

Section 3: Other Issues

14. The Trust would be happy to meet directly with the Witness and his family to learn more about their, and the Deceased's experiences with the Trust, if the family feels that this would be helpful. However, the Trust understands and acknowledges that the family may not wish to do so given the passage of time.

Statement of Truth

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

Signed GRO-C

ALISON DAVIS

Dated 23/05/22