Witness Name: Dr John Logan
Statement No.: WITN7451014
Exhibits: WITN7451007-012, 015-016
Dated: 19/01/2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR JOHN LOGAN

I provide this statement on behalf of NHS Lanarkshire in response to a request under Rule 9 of the Inquiry Rules 2006 dated 14 June 2019.

I, John Logan, will say as follows: -

Section 1: Introduction

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

   My name is John Logan. My address is NHS Lanarkshire Headquarters, Kirklands, Fallside Road, Bothwell, G71 8BB. My date of birth is GRO-C 1962. I am a medical doctor and my professional qualifications are MB, ChB; DRCOG; MRCGP; MPH; MFPHM. My General Medical Council registration number is GRO-C.

2. **Please set out your current role at NHS Lanarkshire and your responsibilities in that role.**

   I am a consultant in public health medicine in the NHS Lanarkshire Directorate of Public Health and I am the NHS Lanarkshire lead public health consultant for blood borne viruses. I have been employed by NHS Lanarkshire in this role since 1999.

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

Lanarkshire Health Board is responsible for healthcare provision for the population of the Lanarkshire area.

Section 2: Response to Criticism of witness W2130

4. **In paragraph 4 of her statement, Mrs Dyson states that she required an emergency Caesarean section during the birth of her son and was given several units of blood following the surgery. After the transfusion, Mrs Dyson became very sick and was transferred to the Monklands Hospital Infectious Diseases Unit, where she was put into an isolation room, away from her new-born child. She states she was provided no explanation as to why this was the case and that the doctors and nurses were deliberately evasive towards her and she was given no information about what infection she had. Please comment on this.**

Unfortunately, medical notes from Bellshill Maternity Hospital and from Monklands Hospital for the 1980s and most of the 1990s no longer exist as they were destroyed in keeping with the NHS Scotland records retention and destruction policy at the time.

With regards to Mrs Dyson being admitted to an isolation room it is likely that Mrs Dyson had been found to have, or was suspected to have, an infectious disease. For example, she may have developed a post-partum septicaemia due to streptococcal infection. Isolation rooms protect patients who may already have one infection and who may have weakened immunity from acquiring other infections and also affords protection to other people from acquiring and transferring to others the infection that the patient in an isolation room may have.

New-born babies are vulnerable to infection especially if they are not able to be breast-fed which was likely the case in the first few weeks at least for Mrs Dyson's baby due to Mrs Dyson being very unwell and in isolation.

It is likely that the main reason that Mrs Dyson and her baby were kept apart from each other was in order to protect each of them from acquiring infection, however, particularly to protect the baby from acquiring infection from Mrs Dyson.

It may be that Mrs Dyson was provided with no explanation of the situation and how it was being managed, that the doctors and nurses were deliberately evasive towards her and that she was given no information about what infection she had. However, this would not have been usual practice in 1988. When patients are very ill, especially when they are ill with infection, their ability to understand and retain information provided to them can be impaired and their perception of their situation and others who are caring for them can be altered by their illness. Whatever may or may not have happened it is very much regretted that Mrs Dyson's memory of her experience is as she has detailed in her witness statement.

5. **In Paragraph 6, Mrs Dyson states that she returned to Monklands Hospital in February 1986 as an outpatient to have a Barium Meal test. Following a procedure she states her hepatic portal vein was punctured and emergency surgery was performed. Whilst in intensive care she was told that she was pregnant. Please comment on this.**

(I note that the date narrated in the Rule 9 Request is February 1986, but in the statement of the witness it is narrated as February 1989.)
A referral letter dated 12 November 2007 (WITN7451015) contains the following paragraph:

EILEEN DYSON (GRO-C 58)

GRO-C

I would be very grateful for any advice you may have in the further management of Mrs Dyson. You may remember we discussed her briefly on the 'phone a few weeks ago. I wondered whether she might be a candidate for TIPPS.

She has a rather long and complex history. When she was pregnant around 1980 she required blood transfusion. Following this she became jaundiced. It subsequently transpired that she had acquired hepatitis C infection. In 1998 she underwent liver biopsy in the Royal Infirmary in Glasgow. This showed only minimal active hepatitis. Her first problems started in 1989 when she was admitted as an emergency to Monklands Hospital with a massive haematemesis and subsequently underwent laparotomy. She was found to be bleeding from gastric varices. Subsequent investigations showed cavernous transformation at the portal vein and portal vein thrombosis. Doppler scan at that time suggested the blood flow was into the liver. Shortly after this she developed abdominal pain and abnormal LFT's. An ultrasound showed gall stones/.....

(It is noted in the letter that Mrs Dyson was pregnant in 1980. This would appear to be an error as her first pregnancy would appear to have been in 1988.)

It would appear from Mrs Dyson's witness statement that a biopsy was being carried out to aid the assessment of an irregularity in her oesophagus following the barium meal examination. It may be that the intention was to biopsy the oesophagus and that in doing this the oesophagus was weakened, or the oesophagus was perforated, or the oesophagus and portal vein were perforated. As detailed in the above referral letter "subsequent investigations showed cavernous transformation at the portal vein". Had this been known about at the time of the barium meal test result a decision to carry out a biopsy of the oesophagus may not have been made.

Emergency surgery was required to prevent death due to blood loss. (Haematemesis mentioned in the referral letter means vomiting of blood.)
For various clinical reasons it is important for doctors and nurses caring for gravely ill patients in intensive care units to know if a patient is pregnant. A

pregnancy test would have been undertaken and Mrs Dyson was informed of the result.

Good communication and provision of compassionate care are two of the key areas that are focused on in the NHS Lanarkshire quality strategy and implementation plan.

NHS Lanarkshire seeks to provide the best available care to patients and carers using available resources. The approach to providing patient and carer centred care has developed significantly in recent years with all members of staff being involved in contributing to assuring the quality of care provided and taking a continuous quality improvement approach. In NHS Lanarkshire the approach to quality assurance and quality improvement is managed by a programme that is embedded across the organisation which is called the Lanarkshire Quality Approach.

Copies of the following documents are appended to this response:

- NHS Lanarkshire Quality Strategy 2018-2023 (WITN7451007)
- NHS Lanarkshire Quality Strategy Implementation Plan 2022/23 (WITN7451008)
- Annual report (2021-2022) on feedback, comments, concerns and complaints (WITN7451009)
- The Healthcare Quality Assurance and Improvement Committee (HQAIC) toolkit (WITN7451010) – this includes details of the terms of reference of this committee and the committee structure
- Care opinion (What's your story?): Annual Review of stories told about NHS Scotland Services in 2021-2022 (WITN7451011). NHS Lanarkshire promotes Care Opinion, monitors the stories, shares these with members of staff, monitors feedback and reports on this work to the corporate management team. The Annual Review includes details of each NHS Board.
- An SBAR report on the development of the NHS Lanarkshire Quality Strategy 2023-2028 (WITN7451012). This includes an updated info-graphic which summarises the aims of the quality strategy and is being

used to promote engagement with the development of the new strategy. The new strategy will involve greater provision of information about the quality strategy on the NHS Lanarkshire public website.

Further information is available from the Quality Directorate by emailing: lqa@ GRO-C

It is recognised that as well as having high level strategies and plans the delivery of a high quality service depends on the quality of relationships, interactions, communication and other aspects of treatment and care with every patient and their family and carers. Implementation of the quality strategy is closely monitored and reported to the executive directors of the corporate management team and to NHS Lanarkshire Board members.

It is acknowledged that the quality of care provided to patients and carers in the past may not have been satisfactory and if that has been the case regarding care provided to and received by Mrs Dyson and her carers, this is very much regretted.

As part of seeking to learn from the information witnesses have provided to the UK Infected Blood Inquiry a member of the NHS Lanarkshire Quality Directorate has reviewed Mrs Dyson's witness statement to identify the theme's raised by Mrs Dyson (WITN7451016) which the NHS Lanarkshire Quality Strategy (WITN7451007) seeks to address.

Section 3: Other Issues

6. **If there are any other issues in relation to which you consider that you have evidence which will be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference, please insert them here.**

Should Mrs Dyson wish to meet with me and a member of the NHS Lanarkshire Quality Directorate to talk about her witness statement, the Quality Directorate's review of her witness statement to identify themes and the current approach to

health care quality assurance and quality improvement, I would welcome the opportunity to arrange a meeting at a place, date and time that is convenient for her.

Statement of Truth

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

Signed GRO-C

Dated 19/01/2023

Table of exhibits:

Date	Notes/ Description	Exhibit number
12/11/2007	Referral letter to Professor Hayes	WITN7451015
	Theme's raised by Mrs Dyson's witness statement.	WITN7451016
May 2018	NHS Lanarkshire Quality Strategy 2018-2023	WITN7451007
07/10/2022	NHS Lanarkshire Quality Strategy Implementation Plan 2022/23	WITN7451008
27/06/2022	Annual report (2021-2022) on feedback, comments, concerns and complaints	WITN7451009
Feb 2022	The Healthcare Quality Assurance and Improvement Committee (HQAIC) toolkit	WITN7451010

2021/2022	Care opinion (What's your story?): Annual Review of stories told about NHS Scotland Services in 2021-2022.	WITN7451011
September 2022	An SBAR report on the development of the NHS Lanarkshire Quality Strategy 2023-2028.	WITN7451012