Witness Name: Joanne Segasby
Statement No.: WITN7482001
Exhibits: None
Dated: 27th October 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JOANNE SEGASBY

I provide this statement on behalf of James Paget University Hospital NHS Foundation Trust, in response to the request under Rule 9 of the Inquiry Rules 2006 22nd September 2022.

I, Joanne Segasby, will say as follows: -

Section 1: Introduction

1. I am the Chief Executive at James Paget University Hospital NHS Foundation Trust (the Trust), Lowestoft Road, Gorleston, Great Yarmouth, Norfolk, NR31 6LA. I took up the position of Chief Executive in April 2022. I joined the Trust in October 2018 as Associate Chief Operating Officer, becoming the Chief Operating Officer in May 2019 prior to securing the role of Chief Executive earlier this year. Prior to my time at the Trust I held managerial roles in Cancer Services, Women and Children's Services and was Operational Director for Surgery at the Norfolk & Norwich University Hospital from 2014. I am a registered nurse and have worked in the NHS for over 30 years carrying out clinical work in Accident and Emergency and Critical Care at Ipswich, Addenbrooke's and the Norfolk and Norwich University Hospitals. I am the Accountable Officer of the Trust. I have a BSc in Nursing Practice and an MBA in Business Administration Management, General both from the University of East Anglia.

2. I wish to make clear both my own and James Paget University Hospital NHS Foundation Trust's wish to assist in the Inquiry to meet its terms of reference. I would also wish to confirm our commitment to candour, openness and transparency and to assisting the Inquiry as far as possible.

3. The events which are the subject of the significant criticisms to which I am asked to respond, occurred sometime before I took up my post at the Trust and the response which follows is based on the outcome of enquiries within the Trust, a review of the patient notes held on our Patient Information System and consideration of the previous communications between the Trust and the Witness. Unfortunately I understand that there are very few people who have relevant experience or memory still working in the Trust and I am sorry that this response is therefore limited in its nature.

4. The information I provide in this statement is true and accurate to the best of my knowledge and belief and is based upon responses to the enquiries that have been made.

Section 2: Response to Criticism by W4069

5. I note the criticism that has been made by a witness with Inquiry reference number W4069 in relation to her late grandfather's treatment at James Paget University Hospital between 1982 and 2013 and was infected with Hepatitis C around 1990 as a result of receiving contaminated blood products.

6. At paragraphs 8 to 15 of the witness statement, witness W4069 states that her late grandfather, Mr W, found out, in 2011, he had contracted Hepatitis C (HPV), that this was mentioned casually as the doctors presumed that he already knew and that no information on how to manage the condition was provided to him.

7. Witness W4069 confirms that communications with the Trust were ongoing throughout 2012 with the intention to find out what went wrong and why Mr W was never informed that he was being tested for HCV in 2007 and why it was never ensured that he was aware of the outcome. Witness W4069 feels that lack of communication from the Trust placed family members at risk and that counselling was not offered to Mr W.

8. Witness W4069 expresses concern that there were no failsafe systems in place in relation to follow up appointments, that Mr W, who had Von Willebrand disease, was not called in for testing before 2007 and that the Trust were treating him as if he was terminally ill.

9. This was investigated when the witness raised concerns with the Trust in 2012. That investigation confirmed that the practice in place within the Haematology Department at the time was that following the clinic appointment the clinician would provide the patient with a slip of paper and direct them to the receptionist to book the next appointment. The system worked extremely well and on the rare occasion a patient may have walked out of the department without making an appointment the patient would, at a later stage, have phoned the department to enquire about their follow up. Unfortunately if a patient failed to present the slip of paper to the outpatient receptionist they would not have been given another appointment.

10. At the time Mr W attended the clinic the appointment system was paper based, as was the case with many medical records. However since then technology has developed and we now have a more sophisticated system in place. I can confirm that since the introduction of the Trust's Information Patient System there is an outcome for every patient which has to be completed, and as a result of this, the Trust now has a way of identifying any outcomes that have not been completed, which makes sure that patients are not lost to follow up.

11. Unfortunately in 2007 the Trust did not have its current hospital patient information management system in place and, therefore, it is not possible to identify the exact reason for the follow-up appointment not occurring. I can see from the investigation carried out previously that following the clinic appointment in 2007 Dr Braithwaite wrote to the GP to confirm that the Hepatitis C status was being checked and that a further appointment was due in six months. Unfortunately it is not possible to establish whether this information was relayed to Mr W during the appointment. In the event of a positive test result, the patient should be notified as soon as possible. Mr W should have been recalled to hospital when his positive test result was received. I sincerely apologise that this did not happen.

12. Mr W had a milder form of Von Willebrand's disease. Such patients are simply registered with the hospital and only need consultant and clinical input when they are due to have a clinical intervention i.e. dental extraction or surgery. In line with this, Mr W attended the Sandra Chapman Centre (the Trust's haematology and oncology day centre) in 2007, 2008 and 2010 for treatment in preparation for minor procedures. Any history of a coagulation disorder should form part of the clinicians overall assessment and would be a flag that a patient may have had blood products.

13. Dr Williams, Consultant Gastroenterologist, has confirmed that Mr W first came to the attention of the Gastroenterologists in 2006 when he was found to have iron deficiency anaemia. No causes were found on initial investigation and he was again admitted towards the end of 2006 with anaemia and further investigations were planned. He had recurrent anaemia due to small blood vessel abnormalities in the large bowel (vascular ectasia and angiodysplasia). These had been treated repeatedly by endoscopic therapy. A capsula endoscopy carried out in April 2008 suggested there was also small bowel angiodysplasia. Mr W became anaemic again in 2009 and Dr Williams was asked to review him on the ward. Dr Williams informs that Mr W had done well for quite some time up to that point but had obviously had further bleeding and two admissions in quick succession. Dr Williams feeling then was that Mr W had angiodysplasia and associated Von Willebrand's Disease as before but they had tried treating everything they could see endoscopically.

14. Dr Williams discussed several treatments with Mr W including surgery, hormonal treatment, Thalidomide and Octreotide treatment. It was agreed that he would try Octreotide and Dr Williams confirms he did very well on it. Mr W was discharged from clinic in March 2011 as he had gone some considerable time without requiring endoscopy or blood transfusion.

15. Dr Williams confirms that Mr W was not treated as a terminally ill patient, and symptomatic treatment would have just been simply giving him blood transfusions as and when he became anaemic. Instead he was appropriately investigated, actively treated and Dr Williams is of the opinion he benefited from that treatment.

16. I can also see from Mr W's notes that Dr Sheikh, Consultant Gastroenterologist, saw him in October 2011 and had a long chat with him about the diagnosis. The notes also confirm he considered the treatment options in conjunction with the patient's presentation including age, gender, advanced fibrosis and genotype. I am assured from the patient records that Dr Sheikh considered the pros and cons of treatment options and discussed this with Mr W.

17. Since this happened there have been significant changes in how NHS Blood Transfusion (NHSBT) carry out testing on donors and notify Trusts of problems, it forms part of Blood Safety and Quality Regulations.

18. The Trust has a Hospital Transfusion Team that convenes each month. Part of the work of this group is to monitor all notifications from NHSBT including recalls of donated blood. NHSBT will notify as soon as there is a potential issue with a donor, checks are carried out to determine whether any patients have received the units affected and gather all of the details to ensure that follow-up takes place.

19. There is a process in place for managing recalls of donated units, as follows:
    - If the unit has not been issued the laboratory complete an entry into the error log
    - If the unit has been issued then the Transfusion Practitioner will complete a patient safety incident on the Ulysses system (Trust incident reporting system), which is a permanent and a visible record that we have taken the correct action. Ulysses incidents are monitored by the risk and governance staff within each Division.

20. If a donor has developed an infection the Trust will speak to the patient (duty of candour) and do an initial test – the patient will then be retested as advised by an NHSBT Microbiology/Virology Consultant until we are happy they are clear. If the patient tests positive at any time this is disclosed and any treatment given. This testing is done under the Haematology umbrella with the consultant lead for transfusion and the Transfusion Practitioner performing the Duty of Candour discussion with the patient and carrying out any further monitoring required (including test results etc.).

21. The Hospital Transfusion Team are accountable to the Hospital Transfusion Committee, who are in-turn accountable to the Patient Safety and Executive Committee.

22. I would like to apologise sincerely on behalf of the Trust to witness W4069, and their family for the distress these events must have caused to them. This clearly fell below the high standard that we set ourselves in patient care at the Trust and I am very sorry that we let this patient and his family down in this way. I hope the family and the Inquiry are reassured that the systems and processes in place to manage appointments and blood transfusions have changed significantly since 2013 and that there are now more safeguards in place to protect and support patients.

Statement of Truth

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

Signed GRO-C

Dated 27/10/22.