Witness Name:Louise Ashley
Statement No: WITN7692002
Exhibit: None
Date: 6 July 2023

INFECTED BLOOD INQUIRY

SECOND WITNESS STATEMENT OF LOUISE ASHLEY

I provide this statement on behalf of Homerton Healthcare NHS Foundation Trust in response to the request under Rule 9 of the Inquiry Rules 2006 dated 4 April 2023.

I, Louise Ashley, will say as follows: -

1 I, Louise Ashley am the Chief Executive of Homerton Healthcare NHS Foundation Trust, Homerton Hospital, Homerton Row, London E9 6SR. I have been employed at Homerton Healthcare since 3rd October 2022. Prior to that I was the Chief Executive of Dartford and Gravesham NHS Trust for four years.

2 I acknowledge witness W7463's complaint concerning his late father's treatment at Homerton Hospital between 2007 and 2017. I can confirm that to address some of the concerns raised by witness W7463, I have reviewed the documents provided by witness W7463, his father's medical records and consulted with clinicians at our Trust who were involved in his father's treatment and care. I also note that the Trust have previously provided witness W7463 with two detailed responses addressing his complaints, that are dated 21 January 2019 and 16 April 2021. The PHSO have also investigated witness W7463's complaint against the Trust and decided on 8 April 2021 that his complaint is not upheld.

3 I note that witness W7463 queries whether his father was transfused with infected blood at the Homerton Hospital when he received a blood transfusion

in April 2007. I am presuming the reference to April 2007 is an error by witness W7463 as his father received the blood transfusion at Homerton Hospital in May 2007. The suitability of checking all blood products sits with the NHS Blood and Transfusion Service who collect and supply blood and blood products. I can confirm to witness W7463 that all transfused blood within the UK is screened for hepatitis B using two separate sensitive tests that detect the virus. The risk of the virus entering the transfusion blood supply is less than 1 in 1.2 million blood donations. There is no further requirement for the Trust to make additional checks on blood received from NHS Blood and Transfusion Service.

4 The Trust's complaint response to witness W7463 dated 21 January 2019, explained that when his father was treated for oesophageal variceal haemorrhage in May 2007, he was transfused with blood. The presentation of such a bleed in May 2007 was the first sign that witness W7463's father had advanced liver disease with cirrhosis. Although his father's medical notes contained clear documentation outlining a history of alcohol misuse prior to this attendance in May 2007, it was important for the Trust's treating team to investigate whether there could have been any other contributing factors which may have led to his father's liver disease.

5 Hepatitis B was detected in witness W7463 father's blood on 11 May 2007. At this time, hepatitis B e antigen was negative and hepatitis B e antibody was positive. Further blood tests showed that the level of hepatitis B DNA in the blood was low. This serological pattern is not compatible with an acute infection but instead demonstrates chronic carriage of hepatitis B and confirms that hepatitis B was present prior to blood transfusion at Homerton. More than 95% of adults who carry hepatitis B in this way are infected in infancy. Conversely over 90% of individuals exposed to hepatitis B for the first time in adulthood naturally clear the virus without requiring treatment. This was not the pattern of hepatitis B infection observed in witness W7463's father. I would therefore like to reassure witness W7463 that his father did not contract the virus from the blood transfusions that he received in May 2007 at Homerton Hospital.

6 In response to paragraph 10 of witness W7463's statement I can confirm that the infection was not reported to the MHRA via the formal Serious Adverse Blood Reactions and Events (SABRE) reporting procedure as there was clear serological evidence that hepatitis B infection preceded blood transfusion and no clinical suspicion at all that hepatitis B was related to the blood transfusion that his father received in 2007.

7 At paragraphs 13 and 18, I note witness W7463 states that Homerton Hospital did not begin standard tablet-based hepatitis B treatment for his late father until 20 months later. I can confirm that his father was first diagnosed with hepatitis B on 29 June 2007. At the time of his diagnosis, the level of hepatitis B DNA in his blood was low and therefore a programme of planned clinic reviews to monitor him was put in place. In March 2008, the level of hepatitis B DNA was observed to have risen and repeat testing in June 2008 showed a subsequent rise again. A liver biopsy to demonstrate "active hepatitis B" was not required as witness W7463's father was already known to have cirrhosis of his liver. Therefore, based on the rises of hepatitis B DNA in his blood levels, a decision was made to commence his father on antiviral therapy. A letter was sent to his father's GP outlining the reason for the treatment and requesting a "shared care" prescribing agreement in advance of his father's planned liver clinic review for initiation of antiviral therapy on 17 November 2018. I would like to reassure witness W7643 that there was not a delay in commencing his father's treatment, as once hepatitis B DNA was seen to rise, a confirmatory sample was taken, and a plan of care put in place to initiate treatment at his father's next clinic appointment.

8 I note that at paragraph 15, witness W7463 states that during the formal complaints process, the Trust gave multiple replies which were weeks to months late. I note that the witness's complaint was lodged with the Trust on 26 September 2018, and this was acknowledged by the Trust on 28 September 2018. At the same time, the Trust confirmed that the witness should receive a response to the complaint within 30 working days, which would have been by

9 November 2018. It is also noted that on 28 September 2018, witness W7463 submitted a further four questions and asked for these to be added to his complaint. This was acknowledged by the Trust on 2 October 2018. The Trust then notified the witness on 8 November 2018 that investigations into the complaint were still ongoing and apologised for the delay. This was the day before the Trust response was due to be provided to the witness. The witness asked for a response date and chased again for the second time on 11 December 2018. The Trust then responded on 11 December 2018 to confirm that we would come back to him with further information as soon as possible. On 19 December 2018, the Trust updated witness W7463 to confirm that the investigation was now complete but due to the Christmas period, the Trust's formal response would be sent to him in early January 2019. The response was sent by the Trust on 21 January 2019. I am sorry for the delays by the Trust in providing the complaint response and that witness W7463's father sadly died before the Trust response was received. I fully appreciate that the delays by the Trust would have compounded the family's grief during what must have understandably been a very difficult period and I apologise for this.

9 I note that at paragraph 17, witness W7463 confirms that the Trust's complaint response dated 21 January 2019 stated that his father had been transfused with 3 units of blood, when in fact it was 5 units. On behalf of the Trust, I sincerely apologise for this error as having reviewed a discharge summary for his father, it states that 3 units of red cells were transfused prior to the emergency endoscopy and then a further 2 units on the ward, giving a total transfusion of 5 units of red cells during the admission of 5 May 2007 to 14 May 2007. I note that the Trust's response dated 16 April 2021 clarified that 5 units of blood were transfused in total with 3 red cell units on 5 May 2007, one cell unit on 11 May 2007 and one further red cell unit on 13 May 2007. I am very sorry that the complaint response dated 21 January 2019, contained this error.

10 I note that at paragraph 22, witness W7463 states that Homerton Hospital declared that it would refuse to reply to any further correspondence from him. I can confirm that in our further complaint response dated 16 April 2021, we did

confirm that this would be our final response on this matter following the outcome of the PHSO investigation and that we will not be providing any further responses to the issues that he has raised. This was because all the issues had been addressed in the PHSO final decision letter dated 8 April 2021 where witness W7463's complaint was not upheld.

11 In relation to paragraphs 24 to 26 of witness W7463's statement, as reflected in the Trust complaint response dated 21 January 2019, Dr O'Sullivan would like to offer his apologies to the witness that it was felt there was a commitment made by the medical team to complete a referral to GRO-B hospice at that time. Dr O'Sullivan has explained that reference was made to the hospice in light of his father's gradual decline and that in the future a potential admission to the hospice could be considered. Dr O'Sullivan also spoke with his father's GP regarding this plan prior to his discharge and his GP was in agreement with the plan set. The GP had also confirmed to Dr O'Sullivan that he would consider involving the palliative care team at GRO-B in witness W7463's father's care once he was discharged. The medical note that witness W7463 has attached as Exhibit WITN743012 confirms this plan. It is clear that there was some misunderstanding between the medical team and witness W7463 in regard to a referral to GRO-B and this was completely unintentional. I am extremely sorry that the Trust did not provide clear information to witness W7463 and his family concerning his father's referral to GRO-B hospice and apologise for any additional distress this caused witness W7463 and his family at an already difficult time for them.

12 In response to paragraphs 36 and 37 of witness W7643's statement, I note that he would like an explanation regarding the difference between the CQC's remit versus the PSHO's remit. The PHSO has a statutory responsibility under the Health Service Commissioners Act 1993 to consider a complaint that someone has sustained injustice or hardship as a consequence of: failure in services provided by a health service body in England; failure to provide a service which it was a function of the body to provide; and/or maladministration connected with any other action taken by or on behalf of such a body. The CQC is the

regulator of health and adult social care in England. The CQC's purpose is to make sure health and social services provide people with safe, effective, compassionate, high quality are and encourage care services to improve. The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

13 I would like to say sorry to witness W7463 for any distress that the Trust has caused the witness and his family, and I do hope that I have been able to reassure witness W7463 that his concerns have been taken seriously and that action has been taken where necessary to review and avoid any such occurrences happening again. I would also like to reassure witness W7463 that the Trust will also do its best to implement any relevant recommendations made by the Inquiry, which I hope will have a positive impact on anyone using our service in the future.

Statement of Truth

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

Signed GRO-C

Date 19/07/2023