Witness Name: Matthew Coats
Statement No.: WITN7732001
Exhibits: Nil
Dated: 18 September 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MATTHEW COATS

I provide this statement on behalf of West Hertfordshire Teaching Hospitals NHS Trust (the "Trust") in response to the request under Rule 9 of the Inquiry Rules 2006 dated 31st July 2023.

I, Matthew Coats, will say as follows: -

Section 1: Introduction

1. My name is Matthew Coats, Chief Executive of West Hertfordshire Teaching Hospitals NHS Trust based at Watford General Hospital, Vicarage Road, Watford, Hertfordshire, WD18 0HB.

2. I am providing this statement on behalf of the Trust, in my capacity as the Chief Executive responsible for the Trust.

Section 2: Response to Criticism by WITN2634001 of criticising witness

3. I write in response to the Rule 13 notification to West Hertfordshire Teaching Hospital NHS Trust on 26 June 2023, notifying the Trust of significant criticism by a witness to the Inquiry (Inquiry reference W2634) in relation to her being infected with Hepatitis C (HCV) around 1979 as a result of receiving infected blood.

4. I am sorry to learn of the treatment described by the witness and am grateful to the inquiry for providing the Trust with the opportunity to respond.

5. In order to respond to the concerns raised within the inquiry, I asked Martin Keble, Division Director for Clinical Support Services and Dr Justin Harrison, Clinical Director of Pathology to review the information provide by your witness WITN2634001.

6. Consideration was given to the guidelines in place at the time and a review was undertaken of all available medical notes and documents reflecting the care given.

7. The remainder of this statement is written as if I am responding to the patient herself. I hope this response is helpful to her and I am sorry for the distress that she experienced during her care at St Albans and Hemel Hempstead Hospitals.

8. I understand from the information you provided, that you received a blood transfusion at Hillingdon Hospital following a caesarean section in 1979 and that you were not informed of the potential risk of blood borne viruses.

9. You also advised that in 1990 following an altercation with your ex-husband, you received a further blood transfusion in St Albans Hospital whilst you were unconscious and that you were not advised of the risks. Having reviewed your medical notes dated 11 July 1989, you were treated for an arterial bleed which was sutured under general anaesthetic. Post operatively you expressed a wish to go home however due to your pale appearance, a further blood test revealed that you were anaemic, which resulted in you being transfused with two units of blood. I am advised that at the time it was not common practice to obtain written consent for blood transfusions. The Trust now has a much more robust process in place before carrying out blood transfusions. This requires obtaining consent from the patient and providing them with information on the risks, benefits and alternatives including an opportunity to discuss any further questions that the patient may wish to raise. In circumstance where the patient is unable to give consent, for example, in emergency situations, the clinician will consent on behalf of the patient, where it is in their best interest.

10. You advised that you had a further admission to St Albans Hospital before being transferred to Hemel Hempstead Hospital in December 2002. During this episode of care, you described your negative experience about being discharged without any diagnosis, except a swollen liver and not being informed of why your blood samples were being taken. You further explained that it was not until you attended Hemel Hospital to see the neurologist for the results of your brain scan, that you were informed that you had HCV.

11. Having reviewed your medical notes, you were admitted on the 7 December 2002 following a large Upper GI Bleed. An endoscopy showed that that you had oesophageal varices, which was due to a previously unknown cirrhosis of the liver (swollen liver) with portal hypertension. Further investigations were then undertaken to identify the cause of the cirrhosis. As part of this investigation a blood sample was taken on 10 December 2002 for HCV testing, which was sent to the Public Health Laboratory (PHL) in Luton. This was reported by PHL on 3 January 2003, and received by the Trust on 6 January 2003, which was after your discharge on 24 December 2002. At this time, results were paper based and relied on this reaching the appropriate clinician in order for these to be shared with the patient. Unfortunately, this did not happen leading to your results not being communicated to you. I am very sorry for the distress and anxiety that the delay caused you.

12. Changes in clinical practice and more robust and efficient reporting of clinical results has led to significant investments to improve patient experience. The Trust now uses an electronic reporting system which provides clinicians with instant access to laboratory results as soon as they are reported. I appreciate that this will not change your experience, but I hope you take some comfort in knowing that the process for reporting results has improved significantly, including the turnaround time for clinical information being provided to patients.

13. I am sorry to learn that you were unhappy about the advice provided to you post diagnosis about the treatment options available to you. The current process is for the Hepatitis and Gastroenterology teams to inform patients of the results and to provide advice, including literature and patient leaflets and counselling, before discussing treatment option. Referrals can also be made to the Royal Free Hospital, which is the specialist UK centre for Hepatitis, for patients with complicated histories.

14. I am pleased to say that advancements in technology, processes, applied knowledge and training around HCV, has positively influenced the standard of care, including information and support, leading to improvements in patient experience.

15. I would like to take this opportunity to thank you for sharing your experience regarding the care provided by West Hertfordshire Teaching Hospitals NHS Trust. It is our vision to provide the very best service for every patient, every day and I will ensure that we share your statement with the wider teams for shared learning in order to continuously improve our services to achieve this.

Section 3: Other Issues

16. I have had access to the patient's records for the purpose of preparing this statement. These records are not attached to this statement as they are confidential to the patient.

Statement of Truth

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

Signed _ GRO-C

Dated 18 September 2023