Witness Name: Dr Roger Chinn
Statement No.: WITN7266011
Exhibits: Nil
Dated:

INFECTED BLOOD INQUIRY

THIRD **WRITTEN STATEMENT OF DR ROGER CHINN**

I provide this statement on behalf of Chelsea and Westminster Hospital NHS Foundation Trust in response to a request under Rule 9 of the Inquiry Rules 2006 dated 19 January 2022.

I, Dr Roger Chinn, will say as follows: -

Section 1: Introduction

1. My name is Dr Roger Chinn. My date of birth is GRO-C 1964. I hold the following professional qualifications: MB BS, MRCP, FRCR.

2. I am the Chief Medical Officer of the Chelsea and Westminster Hospital NHS Foundation Trust ("the Trust"). I am a full voting member of the Board of Directors. Amongst other duties, I am responsible for ensuring the high standards of patient safety and clinical effectiveness at the Trust and for providing professional leadership for all medical staff. I am the Responsible Officer at the Trust.

Section 2: Background to the Westminster Hospital

3. The Westminster Hospital ("the Hospital") was not run by the Trust in 1983. At that time, the Hospital was managed by Victoria District Health Authority. The Westminster Hospital at Horseferry Road closed in 1992. In 1993 the Chelsea and Westminster Hospital opened in new premises on Fulham Road.

4. The Chelsea and Westminster Healthcare NHS Trust was created in 1994 by virtue of the Chelsea and Westminster Healthcare NHS Trust (Establishment) Order 1994. In 2006 the Trust became a Foundation Trust.

5. As such, the Hospital was not run by the Trust at the time, and is not operated by the Trust currently as it no longer exists.

6. There have been several transfers of property and responsibility since the Westminster Hospital on Horseferry Road closed. By 1994, the Hospital resources

were moved to the new Chelsea and Westminster Hospital, which is operated by the Trust and I have been informed that the Trust inherited some of the records from the Westminster Hospital at Horseferry Road, whilst other records from that Hospital were sent to other hospitals in this area. The Trust has therefore tried to assist the Inquiry and Witness W0852 ("the Witness") by setting out as much information as possible below from the records available to the Trust.

7. The Chelsea and Westminster Hospital is operated by the Trust and was at the relevant time, 1994 to 2012.

Section 3: Response to Concerns of Witness W0852

8. Our sympathies go to the Witness and his family for the death of his late wife ("the Deceased").

9. The Witness has raised concerns at paragraph 22 of his statement that the liver biopsy in 1996 was poorly performed and at paragraphs 51, 52 and 57 of his statement regarding records management at the Trust. We also note concerns raised at paragraph 14. We want to do our best to address the Witness's concerns and share the information we have with the Witness and the Inquiry, in the interest of transparency. In order to do so, we have reviewed the Deceased's records available to the Trust and obtained input from Dr Michael Anderson, who was the Deceased's consultant gastroenterologist from November 2003. Dr Anderson also assisted in separately answering questions of the Witness following the Deceased death.

10. The Deceased had a number of surgical procedures during her life. She had an elective caesarean section on 8 June 1983 at the Hospital. We cannot locate evidence of a blood transfusion within the medical records, however many records are unfortunately illegible.

11. In terms of the Trust's involvement, on 16 February 1994, the Deceased was seen at the Trust Gastroenterology Department at South Westminster Clinic with clinical signs suggesting possible liver disease. In a month, she was reviewed in clinic again and a liver biopsy was advised. This biopsy was arranged but was cancelled because blood clotting was found to be abnormal. On 2 August 1995, after a review in clinic, a further attempt at liver biopsy was scheduled with plans to give fresh frozen plasma (FFP) in advance (a total of six units of FFP were given). The clotting tests did not improve sufficiently to allow a standard percutaneous liver biopsy which was again cancelled.

12. A transjugular liver biopsy is an alternative method of liver biopsy, usually only used to mitigate the increased risk of bleeding from the standard approach when there is deranged clotting function. It is performed by passing a device via a catheter inserted into a large vein in the neck. Transjugular liver biopsy was performed on 25 August 1995 in the Endoscopy Unit of Chelsea and Westminster Hospital. It was without complication and the Deceased was discharged the following day as was usual practice at the time.

13. When the Deceased was diagnosed with suspected liver disease it was appropriate to proceed to a liver biopsy. It was appropriate to plan that this would be by a standard percutaneous approach but this was not possible because of the abnormal blood clotting tests. If the biopsy had been performed with the clotting abnormalities that were present then there would have been a very high risk of a life threatening haemorrhage and it was therefore appropriate not to proceed with a standard approach. A further attempt after trying to correct the clotting abnormalities by giving FFP, which contains clotting factors, was reasonable practice at that time. By that time (1995), all blood products were screened for HCV infection, and it is known that the Deceased's cirrhosis was already present. It was entirely appropriate to then proceed to using the transjugular approach to a liver biopsy which remains usual practice in patients with significantly abnormal blood clotting tests today.

14. On 12 September 1995, the Deceased was reviewed in clinic. The biopsy was reported as showing active cirrhosis consistent with autoimmune hepatitis (AIH). This is a disorder in which the immune system is attacking the liver. It is not due to any viral infection such as hepatitis B or hepatitis C. Blood tests relating to autoantibodies are assessed and classically those with AIH will have anti-smooth muscle antibodies but some cases will have only anti-nuclear antibodies as was the case for the Deceased (ANA at high titre 1:2880 and a positive rheumatoid factor with a titre of 1:160). It would be usual to exclude a viral cause for liver disease prior to any liver biopsy. Whilst it is likely that this was done we cannot see relevant blood results in the records. This would usually only be done at the time of the initial assessment which was in February 1994 in this case. The usual treatment for AIH is by immune suppression medication which was commenced at this clinic visit with prednisolone. Azathioprine is also used and was commenced at a further clinic review.

15. Between November 1995 and August 1997, the Deceased was having regular reviews to monitor clinical status and blood tests in clinic approximately every three months. Further clinic reviews were undertaken thereafter.

16. On 7 January 1998, it was noted that the Deceased continued on low dose prednisolone with azathioprine. She had developed an underactive thyroid and was started on levothyroxine. AIH is associated with other autoimmune diseases such as hypothyroid disease. Regular reviews in clinic continued.

17. On 27 November 2003 the Deceased was seen in clinic. The history and prior investigations were noted, including the previous liver biopsy. Also noted were the elevated levels of IgG (immunoglobulin G) which are typically seen in AIH. The Deceased reported a very low intake of alcohol at only 2 or 3 units per week. The Deceased continued to attend the liver clinic at three monthly intervals and continued on immunosuppression.

18. On 6 May 2011, the Deceased had small varices seen at endoscopy and a low serum albumin which are both features of severe liver disease.

19. On 27 July 2012, the Deceased was seen in clinic as per her regular reviews and was noted to have recently been in hospital in Colchester and was found to have

abnormalities in the liver. It is understood that the Deceased moved away from London in 2010 and therefore Chelsea and Westminster Hospital was no longer her local hospital.

20. On 2 August 2012, a letter from Colchester Hospital advised that the biopsy of the lesions in the liver confirmed a finding of adenocarcinoma. It was not certain if this was due to metastatic disease for a primary carcinoma at another site or alternatively if the liver abnormalities were due to the development of primary hepatocellular carcinoma (HCC). Because of the known liver cirrhosis both of these diagnoses were likely. A histology review by the Chelsea and Westminster Hospital upper gastrointestinal multidisciplinary team on 6 August 2012 noted that the appearances were consistent with hepatic carcinoma, however the immunohistochemical profiles were not supporting of this. A review by the relevant multidisciplinary team at the Royal Marsden NHS Foundation Trust was advised as they have specialty expertise in this area There are no further entries in the Deceased's records after this date.

21. At the time, in 2012, a lot of effort was applied to try and establish whether the Deceased had been previously tested for hepatitis C virus (HCV) because of the known association between HCV infection and hepatocellular carcionoma. No confirmation was found of this from a review of the records available. Testing for HCV only became possible in the early 1990's. We therefore cannot definitively comment on whether the Deceased had HCV infection.

22. We also unfortunately cannot confirm whether the Deceased received a blood transfusion at the time of her caesarean section in 1983 at the Hospital, as these records are illegible.

23. We can however confirm that the Deceased was treated with for a diagnosis of autoimmune chronic liver disease leading to cirrhosis. Testing for HCV only became possible in the early 1990's. We cannot definitively say whether the Deceased had HCV infection. Standard practice at the time of her assessment for liver disease in 1994 would have included tests for viral hepatitis but these unfortunately are not present in the records available at the Trust. Further and in any event, if HCV was responsible for her cirrhosis then it would be expected that some commentary to this possibility would have been made by the reporting histopathologist at the time of the Deceased's liver biopsy in 1995. More importantly, if the Deceased had been infected with HCV at the time of a blood transfusion in 1983 then, in our experience, it would be extremely unlikely that cirrhosis would have developed by 1995. The process of progressive fibrosis and eventually cirrhosis typically will take several decades. Furthermore, cirrhosis develops much more slowly in women and especially in those consuming little alcohol.

24. We cannot be certain as to whether the Deceased had developed hepatocellular carcinoma (HCC) or metastatic carcinoma at the time of her final illness. Whilst HCV-associated cirrhosis disease is very well known to significantly increase the risks of developing HCC this would also be true of AIH-associated cirrhosis and does not therefore contribute to determining the likely cause of the cirrhosis.

25. In paragraph 51 of his statement, the Witness reports that the Deceased "went to Chelsea & Westminster Hospital in 1990 or 1991" and was treated as a new patient. The Chelsea and Westminster Hospital was not open at the time as it opened in 1993, thus it is not clear which hospital the Deceased attended, however it would appear that this was Westminster Hospital.

26. In respect of the Deceased's records, we can confirm the following. The Witness made a request to access the Deceased's medical records held by the Trust on 2 October 2017. E-notes were handed over to him on the same day. On 30 January 2018, the Witness contacted the Health Records Department requesting disclosure of the historic records from the 1980s when the Deceased was under the care of the Hospital. The Deceased's records from the Hospital were kept on microfilm and were moved to the Chelsea and Westminster Hospital. The Deceased's historic records kept on microfilm were disclosed to the Witness on 24 May 2018.

27. The Health Records employee speaking to the Witness, confirmed that the flood or the fire were not cited as excuses. However, it is correct that the room with microfilm records was affected by a flood in 2018, with the difficulties that followed as a result. Some of the Trust's archived records kept at a storage company called the Iron Mountain were also affected by a fire.

28. We hope that this clarification can be of assistance to the Witness and his family.

Statement of Truth

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

Signed GRO-C

Dated 26 April 2023