Thursday, 10 March 2011

THE CHAIRMAN: Good morning.

MS DUNLOP: Good morning. Today we continue our investigation of the deaths of four individuals and today's proceedings are devoted to looking at the circumstances of Mrs Eileen O'Hara.

My first witness today is Mrs O'Hara's daughter, Mrs Roseleen Kennedy.

MRS ROSELEEN KENNEDY (sworn)

Questions by MS DUNLOP

THE CHAIRMAN: If you find the proceedings distressing, just have a word with Margaret and we will accommodate you.

You might not think they are going to be but sometimes it works that way, but we will try and look after you as best we can.

A. Thank you.

THE CHAIRMAN: Ms Dunlop?

MS DUNLOP: Mrs Kennedy, you have provided a statement to the Inquiry.

A. Yes.

Q. And it would be a good idea if we had that in front of us. Mrs Kennedy's statement has appeared very quickly on the screen. Can we see that's your statement?

A. Yes.

THE CHAIRMAN: What is its number?

MS DUNLOP: [WIT0030420]. Mrs Kennedy, back to your statement. I just want to go through it and I'm not going to ask you to read it out or anything like that but I'm just going to ask you one or two questions as we go along. Is that all right?

A. That's fine.

Q. So we see from the first paragraph that you are the daughter of Eileen O'Hara, who was born on 9 October 1938 and she died on 7 May 2003. You say you have three siblings. Are you the oldest in the family?

A. Yes, I'm the oldest.

Q. I think you have two sisters and a brother. Is that right?

A. Two sisters and a brother.

Q. You say in paragraph 2 that the first surgery you remember your mother having was a hysterectomy at Stobhill in 1980?

A. Yes.

Q. I think we will see from the records it was November 1979.

A. I knew I was 14. I knew it was either side of that.

Q. You don't know about any blood transfusion then?

A. No.

Q. But we will come on to that.

THE PENROSE INQUIRY

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You then say that your mum worked as an orderly at Stobhill. Of course she had a lot of medical treatment at Stobhill too?

A. We actually lived quite close to Stobhill.

Q. And in the north of Glasgow there is a lot of loyalty to Stobhill. Is that fair comment?

A. Yes.

Q. So your mum probably enjoyed her work there as well, didn't she?

A. Yes.

Q. Then you tell us in paragraph 4 that your mum had heart surgery in 1985 at Glasgow Royal Infirmary. You say that she had a heart valve replacement and your mother was given a mitral valve from a pig. In fact, she had had rheumatic fever as a child and that had caused some problems with her heart in later life. Is that correct?

A. Yes, I knew all about that and she had already had the valve widened in the 60s.

Q. And again, you say you don't know if she was given blood or blood products during or after this surgery and we will be come on to this too. On the following page you say:

"Soon after my mother gave up work she became unwell. I don't think she gave up work due to poor health."

So in terms of the impression people had, I don't think there is any question of conveying the wrong impression on that. Then she went back to the Royal Infirmary and saw the heart surgeon who had performed the mitral valve operation in 1995; I think it would have been 1990 or 1991, and in fact we know it was 1991 she had the valve replaced again. This time I think it was a metal valve rather than a pig valve.

A. Yes.

Q. You say that yourself at paragraph 7; the mitral valve was replaced by a metal one and there was blood transfusion at that time. Then your mum was able to look after your daughter until June 1995 but by that time she wasn't really well enough to carry on.

A. No.
<table>
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<tr>
<th>Q.</th>
<th>Doing the childcare for her granddaughter and then she went back to hospital and had some more tests. I should have said that you actually remember that one of the issues they wanted to check was lymphoma? A. Yes, I think because that's something that we had heard of and it was something totally new. It was always just hearted related things my mum went to hospital for. It seemed quite a departure. Q. If I can say so, Mrs Kennedy, you have a very clear recollection of things which it is easy to spot in the medical records. A good tie-up there. Then you remember that she was referred to a gastroenterologist. You say his name was possibly Dr Fraser. Might it have been Dr Forest? A. Probably, I can't remember. Q. She was admitted to Stobhill in July 1995 for liver biopsy and a bone marrow test for lymphoma. Your sister, Annette, who I think is here today, was working in Stobhill at the time as a nurse and found out from your mum's doctor that your mum had cirrhosis of the liver and she had Hepatitis C, and even then the doctor was indicating that she had probably got the Hepatitis C from a blood transfusion. A. Yes. Q. You remember all of that, I expect? A. Yes.</th>
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<td><strong>Just so that you understand, Mrs Kennedy, that this actually comes from the medical records of a different patient but you will see that it is headed up</strong></td>
<td><strong>initially to interferon with normalisation of transaminase values ...</strong></td>
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<td><strong>&quot;Transfusion transmitted Hepatitis C guidelines for counselling patients.&quot; It is dated April 1995.</strong></td>
<td><strong>I gather that people's liver enzymes can return to normal:</strong></td>
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<td>**I just wanted to let you have a little look at this. The introduction that sets the background for this is which is that: **</td>
<td><strong>... only 50 per cent of the responders, that is 20 to 40 per cent of those treated, have a sustained response. Response rates depend on the particular genotype of Hepatitis C.&quot;</strong></td>
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<td><strong>&quot;Recipients of blood or blood components from donors now known to be carriers of Hepatitis C virus are being traced with a view to providing counselling, testing and specialist referral as appropriate.&quot;</strong></td>
<td><strong>Then: &quot;Other treatment approaches are under development, including the combination of interferon with other antiviral agents.&quot;</strong></td>
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<td><strong>So to express it in other words, really, what's going on is that when testing of donated blood was introduced to find Hepatitis C virus in 1991, blood donors were found who were carriers of the virus and it was then possible to look back at donations that those blood donors had begun and trace the recipients of the blood, and contact them and test them to see if they had been given Hepatitis C. Does that make sense to you?</strong></td>
<td><strong>I take it that you are not aware of your mother ever being counselled along these lines?</strong></td>
</tr>
<tr>
<td><strong>A. Yes.</strong></td>
<td><strong>A. No.</strong></td>
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<td><strong>Q. So this is the background to these guidelines and it is pretty self-explanatory in paragraph 2 that what the guidelines are for is for use in counselling patients identified through the look-back exercise as</strong></td>
<td><strong>Q. And she didn't receive information along the lines that we see described in these guidelines?</strong></td>
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<td><strong>Hepatitis C-positive. They give some background to the exercise, explain the implications of being found to be anti-HCV positive, provide information on ways of avoiding infecting others, give advice as to the appropriate steps to be taken and notes about the likely management at specialist centres, about which patients are likely to ask.</strong></td>
<td><strong>Q. Right. Of course, we understand that your mother was never traced as part of a look-back exercise. So it wasn't that someone was able to identify the donor and then find your mother and follow those guidelines, but nonetheless, as a person who was thought to have</strong></td>
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<td><strong>Can we just perhaps move slowly through this document. If we go a little bit further down the page, you will see the point I have made about the screening -- this is paragraph 6 -- for antibodies to Hepatitis C from 1 September 1991. Move to the next page:</strong></td>
<td><strong>Page 12</strong></td>
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<td><strong>&quot;Estimated up to 3,000 recipients will be traced as part of the look-back exercise. Chronic hepatitis is often asymptomatic. The diagnosis of chronic Hepatitis C is likely to be an unwelcome surprise for most patients.&quot;</strong></td>
<td><strong>Page 11</strong></td>
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<td><strong>Then it says, paragraph 8:</strong></td>
<td><strong>&quot;Although 40 to 80 per cent of patients respond initially to interferon with normalisation of transaminase values ...&quot;</strong></td>
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<td><strong>&quot;Patients should be counselled on the implications of the test result and referred for a specialist opinion.&quot;</strong></td>
<td><strong>I gather that people's liver enzymes can return to normal:</strong></td>
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<td><strong>Then, &quot;Implications of a positive test&quot;, &quot;Modes of transmission&quot;. Then can we go to the next page. You see there is a section headed &quot;Avoiding infecting others&quot;?</strong></td>
<td><strong>... only 50 per cent of the responders, that is 20 to 40 per cent of those treated, have a sustained response. Response rates depend on the particular genotype of Hepatitis C.&quot;</strong></td>
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<td><strong>A. Hm-mm.</strong></td>
<td><strong>Then: &quot;Other treatment approaches are under development, including the combination of interferon with other antiviral agents.&quot;</strong></td>
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<td><strong>Q. So the person who is carrying out the counselling is able to cover that as a topic in case people are concerned that they might infect their family members. So we see advice, for example, such as that in paragraph 14:</strong></td>
<td><strong>I take it that you are not aware of your mother ever being counselled along these lines?</strong></td>
</tr>
<tr>
<td><strong>&quot;Tooth brushes and razors must not be shared. Cuts or skin lesions should be covered with waterproof dressings.&quot;</strong></td>
<td><strong>A. No.</strong></td>
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<td><strong>And so on:</strong></td>
<td><strong>Q. And she didn't receive information along the lines that we see described in these guidelines?</strong></td>
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<td><strong>&quot;Further assessment and follow-up: All anti-HCV positive patients should be referred to a specialist with an interest in the condition for further assessments. This will usually involve a period of observation and, in most cases, a liver biopsy. Patients ... may be offered treatment with interferon.&quot;</strong></td>
<td><strong>Q. And she didn't receive information along the lines that we see described in these guidelines?</strong></td>
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<td><strong>Then the next page. Then notes about management at specialist centres: &quot;Further counselling will be given at specialist centres. Treatment options can be discussed in more detail.&quot;</strong></td>
<td><strong>Q. Right. Of course, we understand that your mother was never traced as part of a look-back exercise. So it wasn't that someone was able to identify the donor and then find your mother and follow those guidelines, but nonetheless, as a person who was thought to have</strong></td>
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<td><strong>Then there are some statistics about the prospects of successful treatment in paragraph 23:</strong></td>
<td><strong>Page 12</strong></td>
</tr>
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<td><strong>&quot;Although 40 to 80 per cent of patients respond initially to interferon with normalisation of transaminase values ...&quot;</strong></td>
<td><strong>Page 12</strong></td>
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A. Yes.
Q. So as it turned out, because of the way the investigation was carried out, it really didn’t reach people like your mother, who were not formally as part of a look-back exercise. Does that give you a bit of background to what did or didn’t happen?

A. Yes.
Q. Right. To go back to your statement, we go back to page 4, paragraph 12. You say that your mother always coped well with ill-health and always did as doctors said and advised:

"But she found Hepatitis C very difficult and she hated having "Hep C risk" stamped on the front of her medical notes. She found that embarrassing."

A. I think she would rather it was inside because if you are seeing that every day, I think that she did just find it embarrassing, yes.

Q. Then you tell us in paragraph 13 that your mum went to the warfarin clinic. Basically she saw a cardiologist around 1990?

A. Yes.
Q. Is that Dr Dunn?

A. Yes, Dr Dunn.
Q. And she went to the diabetic clinic as well?

A. Yes.
Q. And she went to the diabetic clinic as well?

A. Yes.
Q. Do you remember that she was diagnosed with diabetes around 1990?

A. First she just took tablets but later on she became insulin dependent.
Q. Do you remember that it was Dr McLaren she saw?

A. I couldn’t say the name of the doctor.
Q. You say:

"She was never referred to any specialist in relation to her Hepatitis C and was not referred to a liver consultant."

Again, if you are able to stay you will hear some more evidence about what happened. Then she also went to her GP, and you say that some information and warnings were able to be given to the family as a result of the efforts of you and your sister?

A. I think my sister was working in Stobhill at the time and then she moved on and she found what you should be doing and what you shouldn’t be doing through her work.
Q. Then you say that in your view she asked every medical person she saw about treatment for Hepatitis C and she was always told she wasn't suitable?

A. Yes.
Q. Do you think it was explained to her more than that?

A. Yes.
Q. Was there some explanation as to why she wasn’t suitable?

A. I think the explanation is that she already had cirrhosis of the liver, and if you already have cirrhosis of the liver, then there is -- you can't really do anything. That’s the way she presented it to me. That was the reason why. There was nothing could be done.

Q. Did you know, either from your own knowledge or from something your sister told you, about the low success rates of treatment that we saw from the guidelines?

A. Yes, I think we did. I think we did think if you have got cirrhosis of the liver, then it really maybe -- it possibly is too late.
Q. You say that from 1995 your mum's symptoms worsened. She was tired and weak and looked pale with a thin face, but you say she was never depressed and she still managed to walk around the town.

A. Yes.
Q. She looks to have been a pretty stoical individual. Is that correct?
A. Yes.
Q. Do those names sort of ring a bell?
THE CHAIRMAN: Mr Di Rollo, do you have any questions that you want to put to Mrs Kennedy?
MR DI ROLLO: No, thank you.

THE CHAIRMAN: Mr Anderson?
MR ANDERSON: No, thank you, sir.
THE CHAIRMAN: The original one?
MS DUNLOP: Yes. Can we then look at 0899. This is obviously a piece of paper. It is information from an obstetric unit and it is dated 1 November 1971, and if we look on the right-hand side at the bottom, there is a question on the form: "Previous blood transfusion."

And someone has deleted "No", so obviously by November 1971, Mrs O'Hara has had a blood transfusion and it would suggest that that must have been the valvotomy. I think Dr Mutimer will obviously come on to this, but Dr Mutimer says it is possible that there was a blood transfusion but I suggest that this makes it look really quite likely that there was a blood transfusion in association with the valvotomy.

Then we move to 1985, insofar as cardiac surgery is concerned, and look at 1303. This is a blood bank prescription sheet because we can see it is headed up "Blood bank", and then not quite half way down the form it says: "Blood transfusion prescription."

And it is dated 5 June 1985. You see that Mrs O'Hara's blood group is shown there, B negative, and that someone has prescribed five packs of concentrated red cells and batch numbers are given. In fact, all...
five of these batches are signed as having been given, given and checked. The only other thing to note about it perhaps is the date of 5 June. It seems to suggest that the prescription is work that was carried out in advance because the operation wasn't until 7 June, but perhaps that wasn't unusual to organise the blood in advance, and I accept this is speculation but particularly where perhaps the blood group is more unusual, B negative, one might take that step in advance.

THE CHAIRMAN: Professor James suggests that this is for the bypass machine to be primed.

MS DUNLOP: I see, thank you.

If we then look at 1426, this looks, although the description of it is cut off at the top, to be a chart and it looks to be the beginning of an IV fluid chart. It is dated 7 June 1985. We can see that it seems to start at 2.45 in the afternoon. If we then move to 1425, this seems to be a continuation of 1426 and if we look, we can identify, not always in the same columns, but in the concentrated red cell column there are three batch numbers and then in the bottle or pack number column, there are two batch numbers. But in fact, although the writing is not 100 per cent easy to make out, it does look broadly as though those five numbers tally up with the batch numbers that were shown on the original prescription sheet.

So that seems to be the use of all five of the packs and that would be supported by the fact that the administration column was signed in relation to each batch on the previous page we looked at. So in summary, it looks as though there were five packs of red cells given to Mrs O'Hara in association with, if I can just call it, the pig valve operation in 1985. If we look at 1428, we can see that there was also plasma shown there. That's item D. That's actually 6 June, with some plasma given intravenously. There is also something called "Hartman's" but I gather that's fluids", and in handwriting it says: "B negative blood."

And someone has copied down one of the batch numbers. So it looks as though in fact only one of the two batch numbers that we saw on the previous sheet may have been used, but a transfusion nonetheless.

Then if we go to 1979, 0076.

MS DUNLOP: I think we were looking at 0076, which follow it if you think it is appropriate.

THE CHAIRMAN: Has anyone been able to decipher what the other IV fluids are? Dextrose, that's straightforward; it's the other two.

MS DUNLOP: Dextrose, yes. I don't know what A and C are.

THE CHAIRMAN: The IV fluids.

MS DUNLOP: 0881.

THE CHAIRMAN: The anaesthetic record or the one before?

MS DUNLOP: The anaesthetic record or the one before?

THE CHAIRMAN: The IV fluids.

MS DUNLOP: 0881.

THE CHAIRMAN: Has anyone been able to decipher what the other IV fluids are? Dextrose, that's straightforward; it's the other two.

MS DUNLOP: Dextrose, yes. I don't know what A and C are.

THE CHAIRMAN: Yes. It is the "R" that has attracted my attention, needless to say, and the fact that they add up to 500 millilitres, but no one knows.

MS DUNLOP: I think if anyone could guess as what it might be it would be Professor James.

THE CHAIRMAN: He can't.

MS DUNLOP: But maybe he can think about it and see if anything comes to mind.

PROFESSOR JAMES: Do you have the nursing records of that operation because if you do, then they would perhaps give the same information in a different way and the nurses usually --

MS DUNLOP: They will be there somewhere but I don't have it today.

PROFESSOR JAMES: In that case, conceivably afterwards then we can find and shown to Lord Penrose.

MS DUNLOP: The exercise that has been carried out is to attempt to look at the haematology records and see what can be ascertained by way of blood. I freely accept we didn't chart every type of fluid that Mrs O'Hara received.

THE CHAIRMAN: The contrast perhaps makes it unlikely that this is blood related.

MS DUNLOP: I think a view was taken that it wouldn't be blood. I think once we saw the entry relating to blood, that was the trail we followed.

THE CHAIRMAN: Yes. Gentlemen, if anyone has got any concern about it, it has been flagged up and you can follow it if you think it is appropriate.

MS DUNLOP: I think we were looking at 0076, which...
because I don't actually have the court book number of
enquiries were made through SNBTS, and I must apologise
Equipped with all that information, further
MS DUNLOP: Oh, yes, so it is. Concentrated cells.
Still in November 1979, if we look at 0738, we can
see that, again in handwriting, someone has filled in
the blood pack numbers. That's towards the right of the
form about in the middle from top to bottom. Blood pack
numbers, and there are two numbers there and what looks
like "C/C" which presumably means concentrated cells.
THE CHAIRMAN: Concentrated cells is circled down below.
MS DUNLOP: Thank you. But underneath that is written:
"One unit whole blood, one unit pack cells."
Still in November 1979, if we look at 0738, we can
see that, again in handwriting, someone has filled in
the blood pack numbers. That's towards the right of the
form about in the middle from top to bottom. Blood pack
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like "C/C" which presumably means concentrated cells.
THE CHAIRMAN: Concentrated cells is circled down below.
MS DUNLOP: Oh, yes, so it is. Concentrated cells.
Enquiries were made through SNBTS, and I must apologise
because I don't actually have the court book number of
Page 25

the letter giving the response. Actually, I think, on
reflection, sir, it would be a bit difficult to do it
without the numbers. It would be a bit slower without
the numbers. I need to get the numbers and it might be
more convenient to have a short break at the moment to
let Dr Mutimer's connection be established and then we
can return and speak to Dr Mutimer and I will resume the
story in relation to these blood transfusions at a later
point today if that's convenient.
THE CHAIRMAN: Yes, I don't think there is any problem about
that.
(10.17 am)
(Short break)
(10.30 am)
DR DAVID MUTIMER (continued)
THE CHAIRMAN: Good morning, Dr Mutimer.
A. Good morning.
Questions by MS DUNLOP
MS DUNLOP: Good morning, Dr Mutimer. This is the third day
in a row that we have taken evidence from you. So you
are obviously now known to the Inquiry team but for
anybody who is with us, who has not been here yesterday
or the day before, I should establish that you are
a liver specialist, a consultant liver specialist in
Birmingham. Is that correct?
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1. is November 1979. As Mrs Kennedy said, that was the
time when Mrs O'Hara underwent a hysterectomy and we can
see that the operation performed there is vaginal
hysterectomy. And there, IV fluids during operation,
still towards the top of the form on the right-hand
side, maybe it is the same "R". It does seem to say:
"RL 500 mls."

8. PROFESSOR JAMES: It is "right line". It means she probably
had drips in both arms. Probably it is "right line", so
the "mils" there will be of dextrose or normal saline;
12. they won't be of blood, they would have been recorded as
blood.

12. MS DUNLOP: Thank you. But underneath that is written:
"One unit whole blood, one unit pack cells."

16. THAT SUFFICE TO THE TERMS OF THE CHECKUP.
THE CHAIRMAN: Good morning, Dr Mutimer.
A. Good morning.

19. MS DUNLOP: Good morning, Dr Mutimer. This is the third day
in a row that we have taken evidence from you. So you
are obviously now known to the Inquiry team but for
anybody who is with us, who has not been here yesterday
or the day before, I should establish that you are
the general practitioner of the patient.

20. A. That's correct.

21. Q. And you work in one of the seven transplant units in
Britain?
A. Yes.

22. Q. -- I have now forgotten which queen it is; the
Queen Elizabeth Hospital?
A. It is Queen Elizabeth, the Queen Mother.

23. Q. Thank you. Now, you have been asked to prepare a report
on Mrs Eileen O'Hara. Is that correct?
A. That's correct.

24. Q. And do you have that report in front of you?
A. Yes, I do.

25. Q. The reference for that report is actually [BLA0012298].
It should be 0HA and I think that will be changed but it
has gone in as a BLA report. And we have it on our
screens too.

26. Dr Mutimer, we have already looked at the subject
matter which you cover on your first page, which is
Mrs O'Hara's medical history, more in relation to her
other problems. So we have already looked at cardiac
surgery and obstetric and gynaecological surgery, and we
have identified a blood transfusion at some point before
1971, which would appear, probably, to be associated
with the valvotomy. Transfusions in June 1985, and
indeed there is also a transfusion in 1991 but I think
perhaps by the end of your evidence, we will see that
that may not be so important. We have also identified
transfusions in 1972 with the Cesarian section and 1979,
the hysterectomy, probably much as you suspected but
I think you maybe didn't have all the older notes that
are available to us.

27. So if we could turn to page 2 of your report, and
perhaps before we go any further, just to look at a page
from the records, which is 2543.

28. THE CHAIRMAN: The prefixes please?
MS DUNLOP: Sorry, all of these, sir, are OHA.

29. Q. The reference for that report is actually [BLA0012298].
Simply that there has been mention of
diabetes and to locate that historically, we can see
that that's a GP referral dated 7 March 1990. So the GP
is referring Mrs O'Hara to Stobhill and she has recently
been found to be suffering from diabetes. Just so that
we know when that happened.

30. Go next to 1178. I should explain, sir that,
that's a GP referral dated 7 March 1990. So the GP
is referring Mrs O'Hara to Stobhill and she has recently
been found to be suffering from diabetes. Just so that
we know when that happened.

31. Q. -- I have now forgotten which queen it is; the
Queen Elizabeth Hospital?
A. It is Queen Elizabeth, the Queen Mother.

32. Q. Thank you. Now, you have been asked to prepare a report
on Mrs Eileen O'Hara. Is that correct?
A. That's correct.

33. Q. And do you have that report in front of you?
A. Yes, I do.

34. Q. The reference for that report is actually [BLA0012298].
It should be 0HA and I think that will be changed but it
has gone in as a BLA report. And we have it on our
screens too.

35. Dr Mutimer, we have already looked at the subject
matter which you cover on your first page, which is
Mrs O'Hara's medical history, more in relation to her
other problems. So we have already looked at cardiac
surgery and obstetric and gynaecological surgery, and we
have identified a blood transfusion at some point before
1971, which would appear, probably, to be associated
with the valvotomy. Transfusions in June 1985, and
indeed there is also a transfusion in 1991 but I think
perhaps by the end of your evidence, we will see that
that may not be so important. We have also identified
transfusions in 1972 with the Cesarian section and 1979,
the hysterectomy, probably much as you suspected but
I think you maybe didn't have all the older notes that
are available to us.

36. So if we could turn to page 2 of your report, and
perhaps before we go any further, just to look at a page
from the records, which is 2543.

37. THE CHAIRMAN: The prefixes please?
MS DUNLOP: Sorry, all of these, sir, are OHA.

38. Q. The reference for that report is actually [BLA0012298].
Simply that there has been mention of
diabetes and to locate that historically, we can see
that that's a GP referral dated 7 March 1990. So the GP
is referring Mrs O'Hara to Stobhill and she has recently
been found to be suffering from diabetes. Just so that
we know when that happened.
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function tests". The GP tells the other doctor that Mrs O'Hara was taking a moderate degree of alcohol only to begin with, however, it is on abstaining completely from alcohol, the liver function tests are still deranged. If we look at 2535, if we go to the page before, November 1990, the report is going back to the GP from the gastroenterologist, and in a nutshell this letter seems to be saying that the gastroenterologist doesn't think that the liver function tests can be explained by cardiac problems. Is that correct? I think you really get that from the beginning of the third paragraph.

A. Yes, that's what is stated.

Q. In fact, we can see the way Dr Morris's mind was working when we read that because we can see that he or she has organised testing for Hepatitis C. Do you see this in the third paragraph:

"I was unsure whether she had received blood transfusion with her various operations but I suppose this remains a possibility, I have therefore checked hepatitis screens."

Can you interpret for us, please, the end of the preceding paragraph. He or she says:

"Abdominal examination, one finger breadth palpable hepar with possible spleen of tip palpable."

A. Slightly delphic?

A. I think the important observation there is that the doctor feels that the spleen may be palpable. In the setting of liver disease that would suggest there was significant liver damage; the spleen being palpable in a patient with liver disease often implies the presence of cirrhosis.

Q. What's the "one finger breadth palpable hepar"?

A. I think he has said that he can just feel the edge of the liver but that's not very useful. That's not clearly abnormal. The abnormality is the palpable tip of the spleen.

Q. Yes, I can see that.

Q. That obviously had a effect on the approach that was taken at that time and if we go back to 1168, we can see

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that in December 1990, the gastroenterologists really sent Mrs O'Hara back to the cardiologists. You say in your report that:

"The negative Hepatitis C antibody test is a surprising result."

A. Yes.

Q. Can you just explain for us, please, why you find that surprising?

A. Well, in retrospect we know that Hepatitis C infection was present, but we don't know the exact date of the infection. I suspect that the infection was already established and caused cirrhosis already at this stage. This was a very early blood test, November 1990 was very soon after discovery of the virus and this would probably have been the very first commercial assay available. The assays that were developed at that stage were quite sensitive and that was important because they were principally used in transfusion medicine and the purpose was not to miss any cases of Hepatitis C in the blood donor pool. So the problem was not so much sensitivity of those assays, it was specificity. We would see frequently false positive results, but false negative results were not that common. I think in this case, it is almost certainly a false negative result.

Q. Dr Mutimer, we are actually going to hear some evidence

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8 (Pages 29 to 32)
A. If you have got an expert coming tomorrow, you should wait for that.

Q. Perhaps we can hold ourselves in suspense and hear how the different genotypes fared when subjected to the early tests, but in general terms if I say to you that there was a difference between the genotypes in terms of how likely the early tests were to pick them up, that doesn't surprise you, I take it, does it?

A. No, no, I recall that.

Q. Of course, Mrs O'Hara's hepatitis was actually never genotyped, at least not that we have been able to ascertain. So that, I am afraid, is a bit of a loose end but that may be an explanation. But your considered view --

A. Everything is telling us that Hepatitis C was present, it is just her particular blood result which is hard to reconcile with all of the other clinical laboratory data.

Q. Yes, but perhaps no surprise that at the time the gastroenterologist took it at face value and sent Mrs O'Hara back to the cardiologists. Is that reasonable?

---

A. I think she was needing cardiology anyway because in late 1990 her heart valve was starting to give problems.

Q. I'm not sure that she was sent back to them to try and sort out the abnormal liver function but it certainly would have bluffed the gastroenterologists. They probably thought that the Hep C test would come back positive. They still had a patient with abnormal liver function and a patient who probably had significant liver disease. So it should probably have remained in their domain.

---

A. Okay, I don't have that page.

Q. All right. What do you have, if I can ask?

A. I was looking at the previous -- I have got now a letter to Dr Lorimer.

Q. Yes, a cardiologist at Glasgow Royal Infirmary?

A. Dated 18 January.

Q. Yes. I was just suggesting to you that the important part is the last sentence.

A. Yes, she had come to need another replacement.

Q. And we can ask the cardiologist about that but presumably that's urgent?

A. You will have to ask the cardiologist.

Q. 1144.

A. I'll tell you when it comes up.

Q. Right.

A. Glasgow Royal Infirmary letterhead?

Q. Yes.

A. Yes. Operation notes.

Q. Yes. We see Professor Lorimer is shown at the top --

A. Yes.

Q. -- and it tells us in fact that this has been, I think, an investigation; it has been cardiac catheterisation.

Q. So not the full valve replacement but an investigation prior to that. Is that correct?

A. Yes.

Q. And we can see that there is a mention in this of liver enlargement. Yes, there we are:

"On examination ..."

The last sentence in that section says:

"... she had 3 centimetres ...

I'm not sure I get the emphasis correct when I say this but hepatomegaly. How would you say it, doctor?

A. Hepatomegaly.

Q. Can you interpret that for us, please?

A. I'm just trying to locate it, I'm sorry. I have page 1 of that document, a cardiac catheterisation.

Q. Yes, it is the section headed "On examination ..."?

A. Yes.

Q. The last sentence. I just wondered if you could explain that, please.

A. Yes, so again this 3 centimetres hepatomegaly usually means that the edge of the liver is palpable

3 centimetres below the ribs on that right-hand side. So a normal liver would be not palpable or just palpable and the greater the measurement of hepatomegaly, the more likely it is that this is an abnormal liver, and
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the abnormality here could be congestion of the liver
because of the cardiac problem or it could represent
intrinsic liver disease due to the inflammation, the
Hepatitis C.

Q. What's the meaning of the 3 centimetres bit?
A. That's just trying to provide an objective measurement
as to how enlarged the liver is. So the greater that
figure, the more likely it is that you really have got
an abnormal liver. It doesn't tell you what the cause
of the abnormality is. You recall the previous
description from Dr Morris, I think it was, the gastro
registrar said 1 centimetre. So it may be that this is
a liver which has gone from being palpable 1 centimetre
below the ribs to 3 centimetres. In other words, there
appears to be a progressive process with progressive
enlargement of the liver.

Q. Right. So the 3 centimetres is really a rough estimate
of the abnormal increase in size of the liver. Is that
right?
A. Yes, it is; it is rough, though.

Q. Do doctors use finger breadth as a surrogate for
a centimetre? Is that how it is done?
A. Sometimes they do, so "3 finger breadths hepatomegaly"
would be a common description. Most fingers are about 1
centimetre in diameter.

---

1 Q. Next can we look at 2502? We can see that this is
2 Dr McLaren at the diabetic clinic in Stobhill in 1994,
3 and you cover this in your report, but Dr McLaren is
4 writing firstly about her diabetes but also he says --
5 and this is the end of the second paragraph:
6 "I was rather surprised to find that she has
7 hepatosplenomegaly."
8 So an enlarged liver and an enlarged spleen?
9 A. Yes.
10 Q. I think we get the plan if we turn the page, please.
11 This is the last paragraph. His preliminary view is
12 that this is secondary to the mitral valve replacement.
13 He has written to the cardiac surgeon at the Royal about
14 this saying:
15 "If it has previously been noted it is unlikely to
16 be of any significance. If it is new I think she would
17 require at least an ultrasound."
18 Is this a reasonable plan, Dr Mutimer?
19 A. Yes, I think in 1994 it is two or three years after she
20 had a successful valve replacement? So I would be
21 surprised if the cardiologist would accept
22 responsibility for the enlargement of the liver and
23 spleen. And I think it is much more likely that this is
24 showing disease of the liver and then the enlargement of
25 the spleen is almost certainly due to that. So it all
points to the likely presence of cirrhosis at this
stage, with portal hypertension, in other words pressure
building up behind the liver, and that includes
enlargement of the spleen.

Q. I suppose, as a matter of logic, the plan may be
slightly flawed because he is only going to investigate
if this is a new finding, whereas it could be a finding
of some standing that has never been explored. Is that
unfair?

A. Well, there had been a number of specialists involved in
the care and then in the middle of it all she has had
valvular heart disease of sufficient severity to warrant
replacement. So I think lines are possibly getting
crossed and perhaps investigations that have been
performed previously have been slightly lost, have gone
out of focus. So now that the heart is in good
condition, people are about to pay more attention to the
enlargement of the liver and spleen, I think.

Q. I see. And then if we follow what happened next, if we
look at 2501, please. Dr McLaren is reporting to the GP
that he has had rather a delphic communication,
preumably from the Royal Infirmary, from the
cardiothoracic surgeons, the burden of which I think is
that they have not noted hepatosplenomegaly before. So
he is saying that that requires to be investigated
further. He is consistent. So he is saying, "We need
Mrs O'Hara to have an ultrasound of her abdomen".
Can we just look at 2500 briefly, before we go to
2494. I have missed one.

Yes. Dr McLaren is a bit puzzled and he is saying
ultrasound has confirmed the presence of splenomegaly
but it has suggested there is also a degree of portal
hypertension. So maybe this is all secondary to
cirrhosis, marginally disturbed liver function tests.
So he is thinking along the right lines here, is he?

A. Yes, he is.

Q. And then if you look at 2494 it actually looks as though
he is a bit cross because he received, as we saw, rather
a delphic letter from the Royal Infirmary, and he says
in the middle paragraph that when he had written to
them, he asked if this had been noted previously.
That's the liver problems:

"I got a completely unhelpful letter back from the
surgeon there who obviously had not bothered to review
her notes, since Mrs O'Hara herself tells me she had
been told there was something wrong with her liver due
to her heart disease."

So, Dr Mutimer, I haven't actually been able to find
the delphic communication but I think we know enough
from this letter of its terms, and actually you
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1 A. Yes, I have got it. I'm sorry, it is a very small font.
2 Q. All right.
3 A. Yes, the fat infiltration is probably not surprising and
4 is possibly as much related to the diabetes as to the
5 Hepatitis C. It is very common for diabetics to have
6 excessive fat in the liver, which on ultrasound has
7 a characteristic appearance. Some cases of Hepatitis C
8 without diabetes will also have excess fat in the liver.
9 So this finding is not surprising and it doesn't
10 contribute anything new or surprising.
11 Q. Does it interfere with the functioning of the liver?
12 A. The fat infiltration can interfere with the functioning
13 of the liver but in most cases the liver function is
14 excellent, despite having excessive fat in the liver, in
15 the majority of cases.
16 Q. Can we look at the second page of that letter, 2487. We
17 can see that Dr Tait, who seems to be working in
18 association with Dr Dunn, Mrs O'Hara's cardiologist, has
19 initiated a number of investigations. Importantly, one
20 of the investigations he has arranged is a further
21 hepatitis screen, and that's no doubt the right thing to
22 do in your opinion?
23 A. Yes, I can't recall whether this is the same hospital as
24 the hospital that Dr Morris was working in.
25 Q. I think he was at the Royal Infirmary.

A. Yes, it is difficult for the patient. She has got
a number of specialists in more than one hospital. So
unfortunately it is a frequent cause of confusion and
does delay and impede achieving the correct diagnosis.
Q. But if we look at 2486, what certainly seems to be
happening is that Dr McLaren from the diabetes clinic is
trying to get to the bottom of things, and in fact also,
looking at this letter, the cardiologists are trying to
find out a bit more about the possible liver problems
too or the actual liver problems. If we read this
letter, the cardiologists are writing to Dr McLaren, the
diabetes physician, and it looks like an accurate
summary in the first paragraph of the history of this
particular complaint.

The other thing I wanted to ask you about, which is
mentioned in this letter, is that there was possible fat
infiltration of the liver. Is that a significant
finding?

A. I'm looking for that.
Q. Sorry. That's about line 3 of the second paragraph.

A. At the Royal, wasn't he?
Q. Yes.
A. So that would be fairly typical to go through a whole
liver screen I think, if you had not had one done in the
hospital before and if there is a puzzle like this
persisting.
Q. What about his comment:
"The present degree of right heart failure ..."
This is the beginning of the first full paragraph:
"The present degree of right heart failure would
suggest an alternative cause for the
hepatosplenomegaly."

What about that? Can you explain that, please?
A. Yes, I think we discussed this briefly five or ten
minutes ago. I think the cardiologist would be
reluctant to accept responsibility for the problem once
the mitral valve had been replaced and the heart problem
resolved. So they would be saying that any congestion
of the liver which might have caused enlargement should
no longer be an issue because the cardiac problem was
resolved. They are getting back to making the point
that enlargement of the liver and spleen, we should be
looking for things that affect the liver directly, like
Hepatitis C, for instance.
Q. Right. Can we look at 0834. This is the result of the

A. Yes, I think we discussed this briefly five or ten
minutes ago. I think the cardiologist would be
reluctant to accept responsibility for the problem once
the mitral valve had been replaced and the heart problem
resolved. So they would be saying that any congestion
of the liver which might have caused enlargement should
no longer be an issue because the cardiac problem was
resolved. They are getting back to making the point
that enlargement of the liver and spleen, we should be
looking for things that affect the liver directly, like
Hepatitis C, for instance.
Q. Right. Can we look at 0834. This is the result of the

Hepatitis C screen from February 1995 and this time we
can see that it's positive.
A. It is not on my screen yet. Here it is. February 1995,
confirmed positive for Hepatitis C antibody.
Q. Yes. You asked, Dr Mutimer, in your report whether
there had ever been a PCR test. Perhaps you should just
explain to us so that we all understand, what might have
been the limitations of that test that we are looking at
compared to a PCR test?
A. Well, the antibody test simply tells us that the patient
has been exposed to Hepatitis C at some stage in the
past. It doesn't tell you whether or not the virus is
still present. And we know that about 20 per cent of
people who acquire Hepatitis C will eliminate the virus
with their own immune responses and that usually occurs,
if it is going to occur, within the first six months
after infection. So this result does not tell us that
there is persistent infection. It tells us that the
patient has been exposed to Hepatitis C, and we need to
do an additional test to confirm that the virus is still
present. Of course, in a lady who appears to have quite
significant liver damage, the probability now is
starting to become very high that the virus is still
present.
Q. But just to put it beyond doubt, can you look at 2710.

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<td>I hope you can see that at a reasonable size font. That is a result from April 2003 and you see that that is a PCR test.</td>
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<td>A. I'm still waiting.</td>
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<td>April 2003, HCV PCR positive. So the PCR test is a test which will detect the virus particles specifically. So that says infection is still present.</td>
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<td>Q. Can we go back in time, please, to March 1995. We are taking that out of order but just to confirm that there was a PCR test some years later, go back to March 1995, to 2476. This is back to the cardiology clinic and Mrs O'Hara has been undergoing investigations for the liver problem but she has also developed herpes zoster. That's shingles, isn't it?</td>
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<td>A. Yes.</td>
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<td>Q. But in fact that seems to have been the most acute problem at the time of writing this letter. Is that fair? If you look in particular at the bottom of that page.</td>
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<td>A. She has got a lot of pain following an episode of shingles, so postherpetic neuralgia usually means after the rash has resolved, there is still irritation of the nerves and that can be very painful.</td>
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<td>Q. And in fact she has been admitted to hospital because of that. That looks to have put the investigations into a new light.</td>
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<td>A. Yes, I think that plan of management was entirely acceptable.</td>
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<td>Q. Right. 2474, the page before. Dr McLaren is also still involved. He is saying:</td>
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<td>&quot;The hepatic investigations have been deferred. I see from her notes she does have antibodies against Hepatitis C, presumably from her blood transfusions.&quot; And he says:</td>
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<td>&quot;Perhaps this would explain why she has developed cirrhosis.&quot; Which is presumably the diagnosis. If we follow the correspondence through; look at page.</td>
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<td>A. I have just got 2474.</td>
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<td>Q. Sorry.</td>
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<td>A. Yes.</td>
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<td>Q. Okay. Yes, Dr McLaren is really presuming that there is clinical details. If I saw that report, I would probably dismiss it and think that this was simply a case of cirrhosis due to Hepatitis C.</td>
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<td>A. Lymphoma is a possibility but not likely.</td>
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<td>Q. One of the things which is striking, Dr Mutimer, when one reads through Mrs O'Hara's records, is that all of this effort to get to the bottom of her liver problems in the first half of the 1990s appears to be at the initiative of the diabetic physician and the cardiologist. That is unusual, is it not?</td>
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<td>A. She has got a good diabetic specialist and a good cardiologist, I think. They are probably very well trained physicians in the early 90s. They probably have very good background training in general medicine, including gastroenterologist. So I don't have any reason to criticise any of the doctors who have been involved with her care so far. You are right that it has taken a long time to get to the right diagnosis and to say what the stage of the disease is.</td>
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<td>I think people's familiarity with Hepatitis C in the early 90s was really quite poor. Remember, the virus was only discovered in 89. The first tests available in clinics in 1990. So a lot of our knowledge about Hepatitis C at that stage was fairly superficial. But</td>
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12 (Pages 45 to 48)
you are right, there has been a number of doctors at a number of hospitals who have been involved and eventually they have got there. Perhaps it is that first test in 1990 which has really thrown them off track, I think, and that was unfortunate because, you know, it was a very clever thing for the doctor to do in 1990, to say there has been transfusion. There is liver disease, is it Hepatitis C? And then unfortunately an erroneous result has thrown him off track, I think.

Q. Perhaps we should clarify -- and we are going backwards just briefly -- that in 1990, it was possible to test patients to see if they had Hepatitis C but there wasn't screening of donated blood. Just because people may be puzzled as to the difference in the purposes for which tests were used in the United Kingdom in 1990. So just to clarify that screening of donated blood wasn't introduced until the autumn of 1991 but in 1990 it was certainly possible to test patients to see if they had Hepatitis C, to see if they had antibodies to Hepatitis C. Is that right?

A. Yes, that's true.

Q. So you said it was a very clever thing to do, to think of doing that test in 1990 but would you say overall, is it your view that there is somebody missing from the team at this point, and that somebody would be a gastroenterologist or a liver specialist?

A. I think it is difficult. You have flashed up a number of documents of different hospitals over a period of time and I can't recall from that how selective you have been and what the involvement of gastroenterology has been. So I think Dr Morris was the registrar in gastroenterologist if I recall correctly. I can't remember whether there was a consultant involved at the infirmary or not, I'm sorry.

Q. Could you just take it from me that certainly there was gastroenterological involvement in 1990 and that was when the general practitioner took up the suggestion of seeking gastroenterological advice, but when the negative result from the test came through at the end of 1909, she was referred back to the cardiologists and we agreed earlier, or you explained to us earlier that that was a sensible thing to do because of the mitral valve problem.

There doesn't, from the records -- it is not that I have missed out gastroenterological involvement. There is not gastroenterological involvement in the background between 1990. And we are actually going to come to it; there was some but at the point at which we are examining matters, which is May 1995, it has been since 1990 that she last saw a gastroenterologist. Just so that you are clear about the factual situation.

A. That's okay. I think again, if there had been no background cardiac problems this probably would have come to a correct diagnosis much more quickly but this lady has been distracted by the need for, really quite major cardiac surgery, and it has also muddied the thinking about the cause of her abnormal liver function tests. So I can understand the delays that we see in establishing the correct diagnosis. It could have been diagnosed more quickly but I can understand why it took as long as it did.

Q. So you understand how it happened?

A. Yes.

Q. Right. 2469 is the liver biopsy. And this is still under the aegis of the cardiologist department. She was admitted on 20 June 1995 as an arranged admission for liver biopsy.

Then can you tell us about the bone marrow trephine and aspirate. Is that part of the lymphoma theory?

A. Yes, I think they took advantage of the same inpatient stay, I think, to look at the liver histology to confirm cirrhosis. But in addition, perhaps it was the appearances of the CT scan and also the fact that the patient had, I think, a low platelet count and so on, that made them concerned that perhaps there was an underlying blood condition like a lymphoma. So I have seen a number of patients who have been investigated along these lines and usually you conclude that it is just a cirrhosis that's the problem.

Q. Right. Indeed, if we look at the second paragraph, we can see that the liver biopsy has showed cirrhosis with lymphocytic infiltrate. So not a surprise, I take it?

A. No, expected.

Q. Indeed, it would have been a surprise if it hadn't perhaps.

A. Yes.

Q. What about the lymphocytic infiltrate. What's that?

A. That's typical of Hepatitis C. That's just the body's immune cells reacting to the presence of the virus in the liver.

Q. Then 2468, so the page before. The cardiologists are reporting to Mrs O'Hara's GP about the liver biopsy and saying that they think gastroenterologists should be asked to review her and further assess the need for additional treatment such as interferon. He is going to see her. This registrar is going to see Mrs O'Hara in four months' time but he will wait until Dr Forest's review. Dr Forest is a gastroenterologist, I understand, or was a gastroenterologist. If we look at 1011, something has gone awry with the dating of this
letter, Dr Mutimer, because the typist appears to have been able --

A. I am still not --

Q. You don't have it?

The typist appears to have been able to type it four months before it was dictated. So I don't think that can be right.

But do you have 1011?

A. Yes, this is a very good letter.

Q. Right. That has gone to Dr Forest. We should just note that I think the correct date is probably 12 September, if it was dictated on the 11th and then was typed on the 12th. If we with then look at 1003, here we have Dr Forest. You mention this at the top of page 3 of your report. Can we have Dr Mutimer's report beside --

A. I have got a hard copy as well.

Q. Yes, you have a hard copy but I think for the rest of us if we could have that, [BLA002298], except it will be 2300, I think. Have you got the letter in front of you, Dr Mutimer? The letter from Dr Forest? Have you got that?

A. Yes.

Q. Right. When you have a minute, if you could go to the third page of the report, please. The first paragraph in your report on page 3 seems to be referring to this

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letter. It looks as though, from Dr Forest's letter, what he has done is look at her notes, including the biopsy report, but it doesn't look as though he has seen Mrs O'Hara. For our purposes, this is an important letter from Dr Forest. I'll just give you a moment to refresh your memory. (Pause)

Right? Sorry, doctor, you have looked again at the letter, right?

A. I have looked at the letter from Dr Forest to Dr Dunn, yes.

Q. Right.

A. You are right, it looks like he has responded but not yet having seen the patient.

Q. Right. Just almost as an incidental matter, you see that he says in the second paragraph that:

"The cirrhosis could be idiopathic."

Then again makes the same point in the third paragraph but says that it could be cryptogenic. These are both terms, I understand it, to describe an ailment that one can't really explain in casual terms, but what's the difference between idiopathic and cryptogenic?

A. Asking an Australian about Greek and Latin is a real challenge, I think. I think one of them's Latin and one is Greek, I think. Cryptogenic, I think, is Greek which

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means that the cause is not known. Idiopathic is probably Latin and means the cause is not known, they mean the same thing.

Q. We certainly have our own inhouse expertise on the etymology of those two words.

A. Was I correct.

MS DUNLOP: I am afraid the chairman is shaking his head.

THE CHAIRMAN: They are both Greek.

MS DUNLOP: The chairman is going to tell us the difference.

Q. They are both Greek and they both roughly mean, "We don't know".

THE CHAIRMAN: "Cryptos" means you can't find out, it is hidden. "Idio" means it is singular in some specific way.

MS DUNLOP: I suppose we can at least see that Dr Forest has some classical education, that he is freely able to use both. Does it surprise you that he is raising the possibility that the cause is unknown?

A. There is an elephant in the room, isn't there? So I would have thought it is all due to Hepatitis C, really. I'm not sure why he is suggesting that Hepatitis C is present but not responsible for the damage. That's not likely.

Q. Right. Although you have commented on this in your report, I think we should take today in evidence your comments on the fourth paragraph about interferon.

Before doing that, I'm sorry, Dr Mutimer, this is a tiny point but in your report you say:

"He suggests the chance of successful treatment was in the order of 20 per cent."

But actually he says 25 per cent. Can we just note that, perhaps, before you give your comments on his --

A. Yes, I'm not sure why I wrote 20 per cent, if that's the only estimate that Dr Forest ever gave, then my statement can be corrected, if you like.

Q. Right. But could you give us some comment on what he is saying about interferon?

A. Say that again, please.

Q. Sorry, I just wondered if you could give us your comments on what is in the letter about interferon. You do comment on this in your report and I think you are broadly supportive of the line he is taking. Is that correct?

A. Yes. At that time, 1995, the only treatment being used generally for Hepatitis C was interferon. It was a type of interferon that was given by injection three times a week, and the results of treatment were fairly poor. The results of treatment in patients who had more advanced liver disease are inferior to poor. So I think the estimate of 25 per cent was optimistic. I think you
suggested we still don't know the genotype but even with
a favourable genotype and with our present treatment,
a response rate of 25 per cent would be acceptable. So
it was very optimistic back in those days.
Q. And Mrs O'Hara is in the category of patients who have
established liver disease, so she would be, as it were,
poorer than poor, her prospects would be lower than
poor?
A. Yes, I think so, and I don't think that the data would
have existed in 1995 for Dr Forest to be able to give
a more accurate estimate. The studies were not
informative really when it comes to treating patients
with advanced liver damage, we just knew that the
results were inferior, we didn't know how bad they were.
Q. Actually he refers also to there being money for a trial
at the Royal and the Western, so obviously not Stobhill.
So almost as a sort of added consideration, she would
have to be referred to one of those hospitals.
A. It is an expensive drug and there was very little
experience in treating Hepatitis C at that time. So it
was probably policy in many larger cities to try and
focus the expertise in one or two centres rather than to
have every hospital trying to provide the service. So
I'm not surprised that that was the situation in 1995.
Q. I don't need to take you to it but pages 1045 and 1049
show that Mrs O'Hara had ultrasound examination after
this and there were two varices. I think actually in
the two previous patients on whom you have commented,
viruses were a finding and our understanding is that
these are almost like a sort of internal varicose
vein --
A. Yes.
Q. -- in the liver.
A. Yes, the varices would indicate that the patient -- when
taken with all the other evidence that we have seen,
would indicate that the patient has cirrhosis due to
Hepatitis C, that she has high pressure behind the liver
as a consequence and that these varicose veins, which
are potentially in all of us, have now, because of the
pressure, swollen up and are visible.
Q. Just before we leave the letter, it looks like he has
read the biopsy report but from the end of the letter he
hasn't looked at the actual biopsy, and he is saying
that's what he is going to do:
"I will arrange to review her liver biopsy."
It is October 1995.
A. Yes, that would be an acceptable practice, to review the
biopsy in your own meetings with your own pathologist so
that you could come to a conclusion about the severity
of the inflammation and convince yourself that you agree
with the diagnosis that was made at the other hospital.
So it is not essential but that's actually very good
practice, I think.
Q. Yes. I think everybody is in Stobhill actually at this
point, Dr Mutimer. Can we look at 1008. This
is March 1996 and this is Dr Bong writing from Dr Dunn's
team saying that Mrs O'Hara has been seen
in February 1996:
"The cardiologists are under the impression that she
may be called back for further biopsy to see if there is
any evidence of ongoing hepatitis. We would be most
grateful for your advice."
So he or she is alluding to Dr Forest's review
in October and asking, in March of the next year, if
there is going to be a further biopsy. I should say that
someone has written "Review liver biopsy" on it and then
"Notes". Then 1012. This is May 1996. Dr McLaren is
writing from the diabetes side of things saying:
"You may remember Dr Bong wrote to you in March
about whether this patient required a repeat liver
biopsy. I saw her at my clinic, she said she had not
heard anything from you. I'm enclosing her case notes
in case she could have got lost in the system."
Then 1017, July 1996. This is from Dr Forest and it
looks as though the handwriting that we saw on the
previous letter saying "review liver biopsy" and "notes"
is the same handwriting as the signatory of this letter,
but this is Dr Forest replying to Dr McLaren.
A. I don't have that page yet.
Q. Sorry, I'll wait.
THE CHAIRMAN: Ms Dunlop, if you are contemplating a break
at any point.
MS DUNLOP: If we look at this one, and in a nutshell,
Dr Mutimer, this letter is really saying the same as
Dr Forest had said in the previous year, isn't it?
A. I think where my figure of 20 per cent came from.
Q. Right.
A. It is interesting that the paragraph starting:
"The other problem is that the trust will not pay
for this treatment ..."
In retrospect I think the patient was probably lucky
that she didn't receive the treatment. I suspect that
she would have had a lot of side effects and no success
from the treatment.
Q. Right. So it is not as though there would be any
difficulty with her being, as it were, a Stobhill
patient, in inverted commas, because Dr Forest has
spoken to the gastroenterologist. I think this probably
means the gastroenterologist at the Western Infirmary,
and he has indicated his willingness to see any patients
from Stobhill. We don't really learn quite why it is
that the trust wouldn't pay. Do you think that might be
something to do with how --

A. From the previous letter, I think this was a new
treatment and it looked to me as if there was an
investment in funds but focused on a couple of
specialist centres. So if this patient was not going to
receive interferon, then it looks like the
gastroenterologists at Stobhill would be quite able to
continue her entire management at that hospital.

Q. Can we just flip over and look at the end of the letter,
just to see. Dr Forest is saying that he doubts very
much if she is a candidate for interferon. I think we
can detect from everything you have said that you would
agree that that's a reasonable view.

A. Yes, it is and I suspect that the product sheets for
interferon back then also had, as a caution, patients
with cardiac disease. That may also have influenced his
thinking about her suitability.

Q. Right. It does still look as though Dr Forest hasn't
seen Mrs O'Hara, doesn't it?

A. Yes, it does.

Q. It looks like more of a desktop review, if you can say
that in medicine.

A. Yes, I think he has looked at the file, he has given it
thought, his planning management is appropriate but he
has not seen the patient.

Q. Perhaps all that might be missing is the chance for the
patient herself to discuss the illness and the reasons
why treatment isn't suitable with the expert. Is that
fair?

A. Exactly, yes, I think so. I think Dr Forest had the
local expertise and I suspect that the patient and
family were mining for more information about what the
implications were. So that would be good practice, to
see them and discuss that.

Q. If we look at 1020, that is just the end of this little
chapter. Having received that letter from Dr Forest,
Dr McLaren wrote to Mrs O'Hara and told her that she
didn't need a repeat biopsy, so that seems to be the end
of that little chain of events, Dr Mutimer, except to
say that -- I should explain, sir, that we are unable to
have Dr Forest's version of this little chapter.

Q. Can we just flip over and look at the end of the letter,
the hepatitis infection and the enlarged spleen and that
she is also a bit anaemic, and then there is going to be
an endoscopy. Are they looking for the varices here or
could there have been other bleeding, other than
varices?

A. They would be looking for a cause of blood loss. Just
looking at the second page of the letter, the
haematologist thinks that the patient is iron-deficient,
which means there is likely some chronic blood loss.
That can be due to the portal hypertension, it can be
due to the cirrhosis. It is appropriate that she has an
endoscopy for two reasons. One is to see whether the
varices are present and if they are small or large, and
at the same time the endoscopus? can look around the
stomach to make sure that there is no additional cause
of blood loss, like a stomach ulcer or a stomach cancer.

Q. If we go to 2249, this is just perhaps worthy of note
because it is another example, or it is an example of

MS DUNLOP: Just another small batch of correspondence to
look at. Can we look at 2439, please? This is
Mrs O'Hara. She has actually been referred to the
haematologist at Stobhill and she has been referred
because of neutropenia and thrombocytopenia. Can you
just explain those, please?

A. I don't have the letter in front of me but leukopenia
means that the white blood cells in the blood are at a
reduced number, thrombocytopenia means the platelets in
the blood are at a reduced number. Both of those are
observed in patients with cirrhosis.

THE CHAIRMAN: I think Dr Mutimer may have defined
leukopenia and not neutropenia.

MS DUNLOP: Sorry, doctor, it was neutropenia. Is that
a subset of --

A. Yes, it is, that's right.

Q. Yes.

A. It has the same significance, so patients with cirrhosis
frequently have leukopenia, including neutropenia, and
they suffer with thrombocytopenia.

Q. Right. Neutrophils are one type of white cells. Is

A. That's correct.

Q. And we see a recital of the symptoms she has:
Hepatosplenomegaly, presumably secondary to Hepatitis C?

A. Yes.

Q. And then 2440, just over the page, and indeed this is
a haematologist saying that these symptoms are due to
the hepatitis infection and the enlarged spleen and that
she is also a bit anaemic, and then there is going to be
an endoscopy. Are they looking for the varices here or
could there have been other bleeding, other than
varices?

A. They would be looking for a cause of blood loss. Just
looking at the second page of the letter, the
haematologist thinks that the patient is iron-deficient,
which means there is likely some chronic blood loss.
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varices are present and if they are small or large, and
at the same time the endoscopus? can look around the
stomach to make sure that there is no additional cause
of blood loss, like a stomach ulcer or a stomach cancer.

Q. If we go to 2249, this is just perhaps worthy of note
because it is another example, or it is an example of

THE CHAIRMAN: And we don't have a statement from him of any
kind?

A. No.

Q. Is that an appropriate moment to have a break?

THE CHAIRMAN: Yes.

MS DUNLOP: Dr Mutimer, we are going to have a short break

(Short break)
Mrs O'Hara asking for information. Do you see that in the middle of the letter, doctor? She has attended the gastroenterologists in the past, she was once again enquiring about the possibility of interferon therapy for her Hepatitis C. She had read a recent article in the newspapers about this.

The haematologist has seen, from the notes presumably, that she was considered for this but is perhaps deferring to the gastroenterologists and saying to the GP, "Well, if you want gastroenterological input, you can refer her."

A. Yes.

Q. And there isn't actually any trace of that having happened around that time. Now, can we move to 2156, please? We have moved quite a bit further forward, to March 2003, and this is a letter from a Dr Millburn, general practitioner, and this is something you refer to in your report, that Dr Millburn is sending Mrs O'Hara to Stobhill, and there is a list of her difficulties, but at the moment the problem is that she has right hypochondrial pain. So where was she sore?

A. She is sore under the ribs on the right-hand side.

Q. And the other thing perhaps to note from this letter is that the GP is saying her liver function tests were normal for her. In absolute terms, are these, what, only mildly abnormal?

A. Yes, they are only mildly abnormal.

Q. And then can we just look at the second page, 2157? The GP is asking for an urgent appointment and thinking about an abdominal ultrasound. We then go to 0844. This is 31 March. There has been a CT scan and there is severe pancreatitis, so inflammation of the pancreas.

Is that correct?

A. Yes, that's right.

Q. Is this showing quite a significant degree of abnormality, doctor?

A. We are looking at the CT scan --

Q. Yes.

A. -- dated 31 March, and the scan shows what we already knew, that the liver and spleen were enlarged. We already knew that the patient had varices. Some of those would be visible with the endoscopy, some of them would not be visible but would show up on the CT scan. So that's not surprising.

There is no evidence of a pancreatic mass. Moderate amount of ascites. No other abnormality. And that's about all. So it doesn't really tell us what the cause of her abdominal pain is.

Q. The reference to the varices entwining around the underside of the liver, and the dilated veins, the varices which can form, frequently form extensively in that area. So they don't cause pain, they don't cause pancreatitis. So it is not a surprising appearance and I don't think we have a diagnosis of pancreatitis from that scan.

Q. Right.

A. This could all just be cirrhosis and the patient may have developed ascites due to that.

Q. But clinically we can see that there is said to be severe pancreatitis. That's just in the clinical history part.

A. Yes.

Q. And that is the explanation for the pain under the ribs on the right-hand side, is it?

A. That would be sufficient explanation.

Q. And we know that there was an attempt made to treat gallstones but we have Mr Robertson coming this afternoon, and since it was Mr Robertson who tried to do this, we will ask him about that.

But perhaps we can just take this reasonably briefly. We should go back to your report here, [BLA0012300], and you deal with this period in the middle of that page.

A. Yes. It is a fairly brief summary of what was a very difficult and complicated admission.

Q. Yes. You see that there was the pancreatitis and the attempt to clear the stones -- the stones were causing the pancreatitis, or at least that was the theory, was it?

A. Yes, that's right. Probably the most common cause of pancreatitis in a patient of this age would be gallstones and I think that the scans had shown that the patient suffered with gallstones. If it is a very severe and prolonged episode of pancreatitis, then it is the frequent practice to try and clear some of those stones away from the bile duct.

Q. We can ask Dr Robertson about this this afternoon but it does look as though the treatment of the pancreatitis was successful to some extent, but then Mrs O'Hara developed cellulitis. In short, can you explain what cellulitis is?

A. Yes, cellulitis is an infection of the soft tissues and, according to my letter, the cellulitis was mainly affecting her lower limbs. I think that in the course of this illness Mrs O'Hara had a lot of problems with
fluid retention and that would be manifest in a couple of ways. One would be that she would develop ascites or fluid in her abdomen, which we saw on the CT scan, but in addition to that, the fluid retention is likely to be more generalised and particularly affecting her lower limbs and bottom, and under those circumstances there is a susceptibility to infection because of that swelling of the tissue with fluid. So it looks as if there is the susceptibility and then indeed, unfortunately, she developed infection in those tissues.

Q. Just really for the record, can we keep the report, Dr Mutimer's report, but look at 1853, please, and this section of Mrs O'Hara's records relates to her final illness and she was transferred to the coronary care unit and you say that -- do you say that?

A. I don't mention the coronary care.

Q. No, you do not but she was transferred to the care of the cardiologists at the beginning of May 2003, and I think actually Mrs Kennedy mentioned that. Just to pick up a couple of points you make in that same paragraph, you say that she had a white cell count -- and this is, I think, really very close to the time of paragraph, you say that she had a white cell count -- pick up a couple of points you make in that same paragraph, you say that she had a white cell count -- and this is, I think, really very close to the time of her death -- that her white cell count was 40. We can see that on 1862. Yes, it is about seven lines down on 1862. Someone has written:

"White cell count 40.4."
That would seem to be the entry that you are referring to, doctor.

A. I'm not sure. Perhaps there was a laboratory record as well.

Q. Yes, it's probably that as well. But how is that in absolute terms?

A. That's very high. So that would only be seen in someone with very severe infection. In this context that tells you that there is a very severe infection requiring aggressive and prompt treatment.

Q. Right. If she didn't have the neutropenia that you referred to earlier, would her white cell count be higher than 40 or is it not a factor?

A. It is probably not a factor. 40 is extremely high. We probably wouldn't distinguish between the benefits of having a count of 40 or a count of 45 or 50. I think it is just telling you that there is a very, very serious infection.

Q. What should it be? What's normal?

A. This was a total white cell count, I think, so the normal value would be about 5.

Q. Something else you say is that her liver function tests remained remarkably good, and I think we should just have a look at some of those results from May. 1546, 1543, and the date of this one?

A. Yes, 1546 still.

Q. All right. It's coming. There we go.

A. 1543, and the date of this one?

Q. 5 May.

A. Is it the following day?

Q. Yes. 

A. So the pattern of abnormality is similar. The alkaline phosphatase is a little bit higher, I think, than yesterday's but that doesn't really contribute anything.

Q. What should it be? What's normal?

A. I have got 1546 still.

Q. All right. It's coming. There we go.

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A. CRP is what we call C Reactive Protein. It is a chemical that is liberated into the blood in patients who have got serious infections. A value of 126 is not surprising. We know that Mrs O'Hara was suffering with infection and difficulty managing that.

Q. Right. And 1540 is the following day. Do you have that, Dr Mutimer?

A. I have got 1543.

Q. You will get 1540 in a moment.

A. Yes.

Q. Yes. It looks as though the AST and ALT have gone up a bit, doesn't it?

A. I can't recall the previous day's. It is a test which will fluctuate a little bit from day to day but it is not the way that you would monitor whether the liver was failing or not. The CRP, you can see, is still high, and in fact higher than yesterday, I think, and from memory I think that it has probably risen, despite the fact that the patient most likely was on antibiotics already at that stage.

Q. I was just interested, doctor, because you had said in your report that the liver function tests remained remarkably good. I mean, is there any measurement, or your report that the liver function tests remained remarkably good. I mean, is there any measurement, or are there my measurements, in particular that we can see on these strips that tell us that?

A. It looks as though the AST and ALT have gone up at the very end that the bilirubin started to go up and, similarly, the prothrombin time, or the INR, is affected by the warfarin. They had to stop the warfarin but when they did that, the prothrombin time returned almost to normal values.

So liver was coping remarkably well during the first weeks of this really very serious illness, which indicated to me that if she had not developed this serious illness, the liver still had significant mileage left in it.

Q. I thought I had found the prothrombin time, Dr Mutimer, but in view of what you have said, I may be looking at it too late. There is a value for 1 May on 1586.

A. I haven't recorded the exact date of stopping the warfarin in that record. That's important to know if we are going to interpret the prothrombin time.

Q. Yes, that's 1 May.

A. It says 85 seconds. I think that that was taken while the patient was on warfarin.

Q. Perhaps we can then look at 1590?

A. It would be subsequent measurements, I think, that --

Q. We have that. 1590. This is, I suspect, the last measurement. This is up at 99.

A. That's on 7 May.

Q. Yes.

A. I think that -- that's a agonal result really. That's with the patient almost passed away. So it would be the sequence of values that I have looked at during the entire course of the admission and then looked at those with reference to the patient taking warfarin or not.

So my impression of those results was that the liver managed really remarkably well in the early phases, despite the severity of the pancreatitis.

Q. Can we just look at the page before that, please, 1589?

A. Yes, I was thinking more of this set of blood tests that was done in the few days leading up to the patient's death, but if you have got a patient with cirrhosis of the liver who develops a serious problem elsewhere, like a pancreatitis or any other serious non-liver illness, then probably the best way to see whether the liver has sufficient strength to cope with the stress is to look at the serum bilirubin, which we discussed, and also the INR, which is a reflection of the blood clotting. The point that I make in my report is that it is really only at the very end that the bilirubin started to go up and, similarly, the prothrombin time, or the INR, is affected by the warfarin. They had to stop the warfarin but when they did that, the prothrombin time returned almost to normal values.

So liver was coping remarkably well during the first weeks of this really very serious illness, which indicated to me that if she had not developed this serious illness, the liver still had significant mileage left in it.

Q. I thought I had found the prothrombin time, Dr Mutimer, but in view of what you have said, I may be looking at it too late. There is a value for 1 May on 1586.

A. I haven't recorded the exact date of stopping the warfarin in that record. That's important to know if we

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Page 76

19 (Pages 73 to 76)
hasn't even got it. Do you have the diabetes booklet?

A. Not yet.

Q. Right. I'm being advised, Dr Mutimer, that you should flick through this booklet yourself at your end. A good page to look at is the contents page, which is 2115.

A. All right. What page do I want?

Q. I was looking at the contents page, which is 2115.

THE CHAIRMAN: 28 of 316.

MS DUNLOP: Oh, yes, 28 of 316. Does that help?

A. It will help. Contents? I have got that, yes.

Q. People with diabetes get this booklet and it gives them dietary advice, a treatment record, annual review, notes, questions and answers, and actually I think, if you study this booklet, there is some contribution from a pharmaceutical company.

Now, of course, diabetes is a completely different illness but are there comparable documents about Hepatitis C; in other words, good patient information booklets/leaflets?

A. There are good information booklets and leaflets, and probably a million websites as well, which are of variable quality. So there is plenty of information there. Most outpatient departments these days in gastroenterology or hepatology would have some useful booklets, perhaps from the British Liver Trust on Hepatitis C, or useful booklets that are actually manufactured with the help of the pharmaceutical industry as well. So there are a lot of resources there.

Q. Was that true in the mid 1990s or to a lesser extent?

A. No.

Q. No?

A. A much lesser extent.

Q. Right. So was the patient then more dependent just on getting information from the doctor?

A. Yes, and I think most GPs would have very little knowledge of hepatitis. So it would be specialist knowledge that they would be looking for.

Q. Right. Now, Dr Mutimer, just finally can we go back to your report, please? Thank you, I can see it appearing. You were asked to consider, and you have considered, the cause of death. At this point I think I would like you to look at the death certificate. Keep your report but look at the death certificate as well, which is [OHA0012641].

Now, under, "Cause of death" -- do you have the death certificate in front of you?

A. Not yet.

Q. Not yet, right.

A. Yes, I do.
Q. Is that fair? Right. And you say:
"Blood transfusion may have been the source of Hepatitis C. It is also possible that the infection, though nosocomial was not a direct result of transfusion."
You had better explain nosocomial, doctor, or is that another classically-derived term?
A. Yes, I have used it so I can explain it. I think I made the point with one of the other patients as well that infections can be acquired in hospital, it is not just from blood transfusion, and that includes Hepatitis C.
So we see people who have acquired Hepatitis C without ever having received a transfusion but who have had complex and difficult medical problems over a long period of time. With them it is likely that they somehow come into contact with it in the hospital setting. So "nosocomial" refers to that.
So the blood may have been the source of Hepatitis C infection, we can't be certain. It is most likely but, with so many and such complex past illnesses, the hospital setting, including the blood transfusion, is likely to have been the source of her infection.

Q. Thank you, doctor. I appreciate that it's never going to be possible to know.
Just finally, you say, before listing the documents you have seen, that it seems unlikely that Hepatitis C infection made a major contribution to shortening this lady's life. Having looked at things again and looked at the medical records and the whole history again, is that still your view?
A. Yes, it was certainly my view after going through all of the records. What we didn't discuss was the segment in my report that just tries to come to grips with what sort of health she had in the years between 1999 and 2003, and I can only have an impression. I never saw the patient, of course, but it was my impression that her health was not very good at that stage and that there was diabetes, there was possibly additional cardiac problems, possibly angina. So it is difficult in that setting to say what her prognosis would be if she did not have cirrhosis of the liver.

On balance, I think that her life expectancy was not long because of those issues. The Hepatitis C and the cirrhosis may have shortened her life.

Q. Yes. I'm sorry, Dr Mutimer, I was actually saving some of that material for the cardiologist to look at but there certainly is some reference in the records to cardiac problems.
A. But it does explain how I came to that conclusion, though.
Q. Right. Thank you. Thank you, doctor. I have no further questions.
THE CHAIRMAN: Mr Di Rollo?
MR DI ROLLO: Sir, there is just one matter I wanted to ask in relation to the death certificate.
Dr Mutimer, it is Simon Di Rollo on behalf of the family. I just want to ask you one question in relation to your evidence about the death certificate. You indicated that Hepatitis C should have been recorded as a cause of death.
A. Yes. You just need to remind me of the organisation of the certificate, please. What should be 1A and what should be in 2? 2 is contributing causes, I think. Is that correct?
Q. I think that's correct, yes.
A. So I think the cause of death then, to be clear, was the -- the immediate cause of death was sepsis, the sepsis was due to the pancreatitis, I think, and the contributory causes, I think, to her death include the cirrhosis, which was due to the Hepatitis C.
Q. And that should have been recorded on the death certificate, you have explained.
A. That's my understanding. The cirrhosis was relevant and the cirrhosis was due to the Hepatitis C.

THE CHAIRMAN: You have said, "That's my understanding."

I'm slightly concerned, Mr Di Rollo, that Dr Mutimer may not in fact be necessarily the best person to talk about what should go in a Scottish death certificate.

A. That's it.

THE CHAIRMAN: I think that's what he may have been telling us. Is that the position?

A. Yes, I think I would accept that if I had been filling it out, I would have put cause of death as sepsis due to pancreatitis, and the contributing causes here were the cirrhosis, which was due to the Hepatitis C -- and probably diabetes as well.

THE CHAIRMAN: So, looking at your professional opinion, those are the factors that caused or contributed to death, irrespective of how you fill out forms in Scotland?

A. Yes, that's a fair way of saying it.

THE CHAIRMAN: You are concerned?

MS DUNLOP: Sorry, sir, I don't want to interrupt but I am holding in my hand notes on how to fill in death certificates, which do we have. They date from January 1999. I don't think we put this into the court book. Not everything is in court book. But we would help.

MR DI ROLLO: The question that he was asked before was -- and he agreed with the proposition -- that the Hepatitis C should have been entered on the death certificate, but perhaps we can just see that in its place when we come to that later.

THE CHAIRMAN: Another letter to come, which touches on this. We will come to it later. It is a letter from Dr Petrie, a consultant cardiologist, but who was a registrar in the unit at the time, and he has contributed a paragraph on the cause of death and what he would have put on the death certificate, but perhaps we can just see that in its place when we come to that later.

THE CHAIRMAN: Yes, we can do that.

MS DUNLOP: The next, witness, sir, is Dr Kevin Robertson.

THE CHAIRMAN: After lunch.

(12.50 pm)

PROFESSOR JAMES: Thank you very much, David.

THE CHAIRMAN: Then, Dr Mutimer, I can thank you very much indeed and I'm sure that Oliver James would want to acknowledge your departure also.

MS DUNLOP: In fact that is the end of Dr Mutimer's involvement. So after three bites of having to give evidence by videolink, he is free now. He's a free man.

THE CHAIRMAN: Then, Dr Mutimer, I can thank you very much indeed and I'm sure that Oliver James would want to acknowledge your departure also.

PROFESSOR JAMES: Thank you very much, David.

A. Okay, it's a pleasure. Thank you.

THE CHAIRMAN: After lunch.

(2.00 pm)

THE CHAIRMAN: Ms Dunlop, before we start, Mr Di Rollo and Mr Sheldon.

MR SHELDON: No, thank you, sir.

MR ANDERSON: I have no questions, thank you, sir.

THE CHAIRMAN: Mr Sheldon?

MR SHELDON: No, thank you, sir.

THE CHAIRMAN: Dr Mutimer, I don't know whether you are being brought back after lunch or not.

MS DUNLOP: No.

THE CHAIRMAN: No? Thank you very much indeed.

MS DUNLOP: I hadn't planned to, sir.

THE CHAIRMAN: You hadn't planned to? Thank you very much indeed.

MS DUNLOP: In fact that is the end of Dr Mutimer's involvement. So after three bites of having to give evidence by videolink, he is free now. He's a free man.

THE CHAIRMAN: Dr Mutimer, I don't know whether you are indeed. Mr Sheldon?

MR SHELDON: No, thank you, sir.

MR ANDERSON: I have no questions, thank you, sir.

THE CHAIRMAN: In fact that is the end of Dr Mutimer's involvement. So after three bites of having to give evidence by videolink, he is free now. He's a free man.

THE CHAIRMAN: Thank you very much indeed.

PROFESSOR JAMES: Thank you very much, David.

THE CHAIRMAN: You hadn't planned to? Thank you very much indeed.

MS DUNLOP: I hadn't planned to, sir.

THE CHAIRMAN: No? Thank you very much indeed.

MS DUNLOP: No.
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<th>A.  I studied at Glasgow University and trained chiefly in the West of Scotland and latterly in Sydney, Australia.</th>
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<td>The Chairman: Sit down if you would like.</td>
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<td>A.  Thank you.</td>
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<td>The Chairman: Ms Dunlop?</td>
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<td>Ms Dunlop: Good afternoon, Dr Robertson.</td>
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<td>A.  Hello.</td>
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<td>8</td>
<td>Q.  Hello. Your full name is Kevin Robertson. Is that correct?</td>
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<td>A.  Kevin William Robertson, yes.</td>
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<td>Q.  Thank you. And you are a consultant surgeon. You are now at Crosshouse Hospital. Is that right?</td>
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<td>A.  I was a consultant surgeon while working in Stobhill in 2003. I’m working as a speciality doctor at present at Crosshouse.</td>
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<td>Q.  Sorry, what are you doing in Crosshouse?</td>
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<td>A.  General surgery.</td>
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<td>Q.  Right. With what particular specialism?</td>
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<td>A.  I guess I would still be considered upper GI and pancreatico-biliary surgery.</td>
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<td>Q.  I’m not sure everybody can hear you.</td>
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<td>A.  Shall I say that again?</td>
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<td>Q.  Perhaps you had better.</td>
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<td>A.  Sorry. General surgery is my major remit but I would have an interest in upper GI and pancreatico-biliary surgery.</td>
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Day 3 The Penrose Inquiry 10 March 2011

1. limit of normal.
2. Q. So is that actually specific for pancreatitis?
3. A. It is not absolutely specific and that’s why I say that
4. it must include an appropriate symptom complex. For
5. instance, amylase is also produced in the salivary
6. glands. So mumps can cause it to be elevated.
7. Q. And she had --
8. A. Cholelithiasis.
9. Q. I think I need to practise that a bit. Is that
10. gallstone disease?
11. A. I’m not quite sure where we are in the letter. She had
12. gallstones present in her gall bladder. She has
13. cholelithiasis. Which is gallstones in the gall
14. bladder.
15. Q. It was cholelithiasis that I was trying it look at in
16. line 5. You say she became pyrexial and Mr McMahon had
17. asked if you would become involved in looking after her,
18. and you say you initially tried to manage her
19. conservatively and reduce her INR. What's her INR?
20. A. It stands for international normalised ratio. It is
21. essentially an indication of how easily the blood clots.
22. INR is normally measured for patients who are taking
23. warfarin medication.
24. Q. What was the thinking here?
25. A. Her INR, I believe, was elevated when I first saw her.

My intention was that she proceed towards the ERCP, an
endoscopic sphincterotomy I mentioned at the end of that
paragraph. That’s a procedure that can be associated
with bleeding and I wanted her INR to be addressed
before that was performed.

Q. We know actually, Dr Robertson, for having looked at her
medical records, that she was on warfarin. I take it
that that would be because of having had heart valve
replacement?

A. Yes, that would be a good indication to take the
medication.

Q. Right. You managed to stabilise Mrs O'Hara's condition
and then you tell us in the following paragraph that:
"Anaesthetic advice was that general anesthesia was
not indicated."

So how did you do it instead?

A. Sorry --

Q. The ERCP.

A. Yes, because we felt that general anaesthetic was
inappropriate, we felt that one of the options for
treating her presumed gallstone, pancreatitis, namely
cholecystectomy, was inappropriate because that would
require a general anaesthetic. ERCP, an alternative
approach with sphincterotomy, can be performed under
sedation and it was sedation that was used.

Q. I didn't quite understand what the thinking was behind
the comment that she would be difficult or impossible to
wean from the ventilator?

A. I think, in fact, one of my anaesthetic colleagues has
documented that at one point in our notes. I can find
a reference to that if you wish, but essentially what it
means is that having induced a situation of artificial
respiration to allow the surgery to be performed, part
of that would include muscle relaxation, so the function
of breathing is actually taken over by the ventilator
machine. Sometimes it can be difficult to reverse that
process for patients.

Q. What is it that can cause that difficulty in reversing
the process?

A. Erm.

Q. To make the question a little more focused, with
somebody like Mrs O’Hara, what would it be that might
cause the problem?

A. For this lady -- again, if you would wish a particularly
accurate answer to that I think you would need to speak
to an anaesthetist, but from a general surgical
perspective it would be the combination of medical
problems that she had. We certainly knew that she had
heart valve replacements and significant problems with
cardiac function.

Q. I didn't quite understand what the thinking was behind
the gallstones that she had on her gall bladder, one of
those or maybe more had migrated into the bile duct.
The bile duct is a structure that connects the liver,
essentially, to the gut, and at its lower end it is
joined by the pancreatic duct at the ampulla of vater,
an anatomical structure that is a narrowing. And at
that narrowing a stone can become impacted and when that
happens, it can upset the pancreatic gland, which cannot
drain properly causing the pancreatitis. The aim of an
ERCP and sphincterotomy was to cut the muscle that
causes that narrowing at the ampulla of vater, and
thereby hopefully prevent further Stones from causing
a similar problem, allowing the stones to drop out into
the gut rather than getting stuck at the ampulla.

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| Q. | And in the sequence -- this is the first -- |
| 1 | THE CHAIRMAN: I'm trying to get a little explanation that |
| 2 | Professor James can give a short explanation that |
| 3 | would cover all of this, if it be of any help. I'm not |
| 4 | sure it is necessary. As I understand it, what you have |
| 5 | indicated is that a stone can escape from the gall |
| 6 | bladder, go down to the junction with the pancreas. At |
| 7 | the site it can cause swelling of the mucosa, the |
| 8 | lining of the piece of gut that houses the ampulla of |
| 9 | vater, the structure that I'm trying to operate on it. |
| 10 | It itself is probably about 5 millimetres across and the |
| 11 | opening is about a millimetre or a millimetre and a |
| 12 | half. |
| 13 | You are approaching that with a metre long scope, so |
| 14 | the degree of access is quite difficult. So all in all, |
| 15 | it is fairly difficult; made much more difficult in this |
| 16 | situation because of the acute pancreatitis. |
| 17 | Q. Is this what we would call keyhole surgery? |
| 18 | A. No. |
| 19 | Q. Can we then go, please, to 1454. That's 7 April. 1454 |
| 20 | is 10 April. Same team. This wasn't entirely |
| 21 | successful either, was it? |
| 22 | A. No. Again partly for the same reasons, and more |
| 23 | importantly here really because we had managed to make |
| 24 | a cut into this muscular ring that I'm describing, the |
| 25 | sphincter at the bottom of the bile duct or at the |
| 26 | junction of the bile duct and the pancreatic duct. But |
| 27 | in doing so we had caused what we had feared might be |
| 28 | the case, and that's bleeding. That has been treated |
| 29 | endoscopically, the 12 millimetres of 1 in 10,000 |
| 30 | adrenaline is used to partly compress and partly to |
| 31 | cause vasoconstriction and hopefully control the |
| 32 | bleeding at that site. Because of that bleeding, and |
| 33 | I think I have also noted there, because of some |
| 34 | respiratory issues as well, the procedure was cut short. |
| 35 | Q. And you record that you had an anaesthetist standing by? |
| 36 | A. Yes. I mean, ideally it would have been done with one |
| 37 | procedure. |
| 38 | Q. Right. Can we go back to where we were with the letter, |
| 39 | please? So we would now be on 1452. And we find you |
| 40 | reporting all of this at the top of the page, page 2: |
| 41 | "At the last of these we were able to confirm clear |
| 42 | duct system. It was a difficult time but Mrs O'Hara |
| 43 | seemed to be making slow progress."

You'd asked for cardiological input and also input from the gastroenterologist in light of her
decompensated cardiac and hepatic failure. I just
wanted to ask you, doctor, we have seen the word
"decompensation" a lot. It might be helpful if you
could give us a little bit of an explanation of what
doctors mean when they use that term.

A. Yes, in this instance we were aware that this lady had
underlying liver pathology, namely that she had had
Hepatitis C, and also that there was a degree of
parenchymal change, probably cirrhosis, related to that
that is identified on the ultrasound scan that she had

---

| A. | That's correct. |
| 1 | THE CHAIRMAN: So what you are trying to do here is not just |
| 2 | attack the stone and break it up, but actually to relax |
| 3 | the muscular tension around that point so that further |
| 4 | blockages won't happen. |
| 5 | A. That's correct. |
| 6 | THE CHAIRMAN: Is that ...? |
| 7 | MS DUNLOP: Dr Robertson, I was asking you to look at what |
| 8 | I think is the note of the first attempt you made, and |
| 9 | will you have composed this note or will it have been |
| 10 | a junior member of staff? |
| 11 | A. I suspect it is me that has written it. |
| 12 | Q. And you have recorded that it was ERCP but it had |
| 13 | failed? |
| 14 | A. That's correct, yes. |
| 15 | Q. Can you just, again in terms that we could perhaps try |
| 16 | it, rather than one being completely unsuccessful and |
| 17 | the last being completely successful. I'm not sure -- |
| 18 | Q. I'm obliged. So it would be fairer to say that number |
| 19 | 1, as you have recorded, was a failure, whereas numbers |
| 20 | 2 and number 3 together achieved the desired result? |
| 21 | A. Yes. I mean, ideally it would have been done with one |
| 22 | procedure. |
| 23 | Q. Right. Then finally, if we look at 1453, we have you, |
| 24 | on 7 and 10 April, making an attempt and then this one, |
| 25 | 1453, is 18 April, but I think on this occasion you were |
| 26 | successful. Is that right? |

---

25 (Pages 97 to 100)
on her admission. Also we were aware that she had
cardiac disease and that her heart function was not what
might be expected in a similarly aged person who hadn't
had the kind of heart problems that she had had.
What I mean by decompensation is that these
conditions were normally medically controlled;
particularly the cardiac disease would be medically
controlled with medications. That control was impaired
by her illness and decompensation, to my mind there,
means that the hepatic and cardiac failure were less
well controlled and therefore the symptoms that they
might cause were more manifest.
Q. In the next paragraph you say that the good news was
that the pancreatitis seemed to resolve but there were
numerous other medical problems. You say she developed
a tense abdomen. Should the word after "marked" be
"ascites"?
A. Yes, that's correct.

Q. A-S-C-I-T-E-S?
A. That's right, yes.
Q. And you think that was a combination of decompensated
hepatic and cardiac failure and a degree of
hypoalbuminemia. So a deficiency of albumin. Is that
correct?
A. That's correct. I didn't receive the initial letter,
which I think was sent to Stobhill.
Q. I think perhaps, doctor, we lost you. We didn't realise
that you were at Crosshouse and not at Stobhill. But in
any event really, the question that the Inquiry was
anxious to put to you was your view about whether you
think Mrs O'Hara might have died when she did without
having Hepatitis C at the time?
A. Right. Okay. I mean, I have formally responded to that
in that report, saying that I'm not an expert on
Hepatitis C, either the diagnosis, management or its
complications. So I think anything I would say about
that, that statement, needs to be borne in mind.
I think this lady had a rather complicated past
medical history and if I'm honest to the Inquiry, even
having looked at the notes in retrospect, I'm not
entirely sure what the cause of death was and that makes
it very difficult for me to make an authoritative and
useful comment on that to the Inquiry.
Q. Yes. I think all that we were trying to put to you,
doctor, was that knowing that you are not an expert in
hepatitis, if one took hepatitis out of the picture and
looked at the remaining difficulties that Mrs O'Hara had
in April and May 2003, what do you think the position
might have been?
A. Okay. I think, you see, to my mind that's impossible to
do because the Hepatitis C maybe caused cirrhosis, the
cirrhosis is partly involved with the portal
hypertension. Those problems would probably have had an
effect on her cardiac function in the metabolism of
cardiac drugs. It all becomes very complicated.
I don't think you can easily take one element of illness
away and consider the situation with only the others
because they are all interrelated.

Q. I understand. Perhaps I can just suggest to you that the way it has been put is that the hepatitis -- and its effect on Mrs O'Hara's liver -- will have compromised her ability to respond to the infective illnesses that she had. Would you agree with that?

A. Right. I couldn't make a comment on that. I'm not aware of how that would affect her immune functions. So I'm sorry but I couldn't make an authoritative comment.

Q. It is quite all right, thank you, doctor.

I think you have charted the last period of Mrs O'Hara's illness very thoroughly. Perhaps the only thing I see that I did mean to check with you -- and this is looking at the third page of this report, so if we could go on there, it will be 172. Do you have a hard copy in front of you?

A. I do have a hard copy.

Q. Perhaps I can just read it out, and I hope not disadvantage anyone. You say about two thirds of the way down the third page that: "On 3 May Mrs O'Hara did deteriorate with increasing confusion and shortness of breath."

It was just: "ITU admission was thought inappropriate."

I just wondered, can you remember why that was?

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ask, doctor -- and this is with the benefit of
a document in front of you. If you could look at
[OHA0012608]. This is a letter from Stobhill, in fact
from a Dr Fraser in the cardiology clinic, to what
I take to have been a general practitioner, about
Mrs O’Hara. At the time she was pregnant but I noticed
in it the sentence:
"She has rheumatic heart disease."
I think this may relate to having had rheumatic
fever as a child.
A. That’s right.
Q. I just wondered if you could give us a little bit of an
explanation of that, please?
A. Yes, Dr Fraser was my predecessor at Stobhill and
rheumatic fever was a fairly common disorder in Scotland
in the 1940s and 50s in particular, and it usually
occurred between the ages of five and fifteen, and it
was about five times more common in women than in men,
and the origin was the streptococcus infection.
Quite a significant number of patients who had
rheumatic fever, that diagnosis was not made at the time
because they were often diagnosed as having growing
pains or other disorders effecting their joints. So
many of these patients first presented, in fact, with
the heart manifestations of rheumatic fever. Rheumatic fever could effect the joints but specifically affected
the heart valves, and in Mrs O’Hara’s case as in many
other cases, it was the mitral valve, the valve between
the two sides of the chambers on the left side of the
heart.
Q. I take it that the illness weakened the valve, did it?
A. Yes, in those days, in the early days it would make the
valve quite thickened and narrowed, so that the blood
would not be able to flow through that valve adequately.
Q. Is that described as “stenosis”?
A. That’s exactly how it is described, yes.
Q. I think we are learning a bit as we journey through
this, doctor.
A. Could you look at 0899, please. This is another
obstetric document, or a document relating to
obstetrics, but someone has asterisked quite carefully
there that Mrs O’Hara has mitral valve disease and
that’s the same as what we have just been discussing, is
it?
A. Yes, it is.
Q. Next I wanted to ask you to look at a page 2520. I’m
doing this, Dr Dunn, because in your letter, which
perhaps we could have as well -- if we could have that
side by side, [OHA0012637]. There it is.
I should say, doctor, that this letter dates
from September 2005 and it is a letter you provided in
fact to Crown Office about Mrs O’Hara. Is that right?
Q. You had been asked by Crown Office to answer some
questions?
A. That’s correct.
Q. And you wrote back. It is just that I noticed you had
said that you didn’t have information about the
operation in 1991. You say at line 4 of your letter:
"There is no information between 1999 and 1993 in
regard to the second valve operation the patient had."
Just to say that this is a letter concerning the
operation. It was to redo the mitral valve replacement,
a St Jude bileaflet mechanical valve. Where does
St Jude come into it? Is that the manufacturer or is
that the design?
A. That’s the manufacturer.
Q. Right. So she had had that operation in October 1991.
I think perhaps when you were commenting that you didn’t
have any information about that, you were meaning that
you were trying to establish what blood transfusions
Mrs O’Hara might have had over the years. Is that
right?
A. Basically, just imagine this; she had her first valve
operation in 1962, I think it was, a valvotomy, which
was stretching of the valve, and then I looked after her
up until the time of her first valve operation in 1985.
Thereafter she was followed up at the
Glasgow Royal Infirmary until 1994. So the
post-operative follow-up was under the care of the
cardiothoracic surgeons at the Royal Infirmary. So I
didn’t see Mrs O’Hara over that period of time. And her
preparation for her second operation in 1991 was also
undertaken through the Glasgow Royal Infirmary and when
I wrote that letter, I was unable to get her
Glasgow Royal Infirmary notes. So really I only could
comment on the Stobhill notes that I had available at
the time.
Q. I see. I wonder, doctor, if I could perhaps take
a slight short cut, which is to say to you that in
relation to blood transfusions over the years, the
Inquiry team has looked through the records and has
found a reference to a transfusion before 1971, which
might have been the valvotomy in 1963. So there is
a reference -- it’s in a letter from 1971 -- it says she
has previously had a blood transfusion. Not specific
but one might speculate that that would be in relation
to the valvotomy in 1963. And then also in relation to
a Cesarian section in 1972.
You covered this in your paragraph but I think I’m
really giving you a little more information, that there
THE CHAIRMAN: Then is there a cut above the mitral valve itself?

A. Yes, to get entry from the fingers in, there is a little vent put in and the fingers are then put down, usually through the left atrium, and then the valve is widened up in a way.

THE CHAIRMAN: And then a sprint to sew everything up again quickly.

A. That's right, yes.

THE CHAIRMAN: Are fingers used nowadays?

A. No, valvotomy is now undertaken by interventional cardiologists where they can actually put a balloon in now through a percutaneous procedure.

MS DUNLOP: I suppose to some extent, the success of the procedure is self-evident because in the 1960s and in 1972 Mrs O'Hara had four pregnancies and she didn't need her first valve replacement operation until 1985. Does that show us that --

A. I think that was often the case with that operation, that the patients would get a great result for many years.

Q. I think perhaps we could go to the second paragraph of your letter and you say the question of abnormalities in her liver function were first noted in Glasgow Royal in 1984.

A. I think that was often the case with that operation, that the patients would get a great result for many years.

Q. And does the heart continue to beat when the surgeon has got his fingers in the mitral valve?

A. Sometimes it might.

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Q. And does the heart continue to beat when the surgeon has got his fingers in the mitral valve?

A. Sometimes it might.
A. I think it would be regarded as not unusual in the run-up to an operation.

Q. I see.

A. Because we knew that the pressures on the right side of her heart were significantly elevated in 1985 and that gives rise to back pressure on the liver.

Q. Can we look at 2486, please. This is your clinic. We see you at the top. This is a letter typed in January 1995. It is from a Dr Tate, who I think is a registrar, I can't remember, and the two of you had seen Mrs O'Hara together in the clinic. In fact, it looks as though you have had some discussions with Dr McLaren who is the diabetes physician. Is that right?

A. That's correct, I think he in fact asked us to see the patient at the clinic and this was the first time we had seen Mrs O'Hara, I believe, since 1985, just before her first operation.

Q. Right. There is this reference to hepatosplenomegaly during routine clinical examination, and I suppose you are wondering, are you, at this time, if that is connected to heart problems?

A. I think Dr McLaren wondered whether it was related to heart but I think we felt, because of the success of her second operation and her satisfactory cardiac status at that time, that it was unlikely to be related to her heart, or solely related to her heart.

Q. Right. If we look at the second page, we see that Dr Tate, no doubt in consultation with you, has taken blood for various tests including a hepatitis screen. This is a question that I have already put to another doctor but it seems slightly unusual that a cardiologist would be asking for a hepatitis screen.

A. I think that's probably a fair comment but I guess that the -- often we are gatekeepers to an extent for other specialties; we would conduct what we thought were the initial investigations that would perhaps clarify the cause of her enlarged liver and spleen. So that would be fairly standard that you would think most of the doctors here will have trained in a broad general medicine basis and therefore be able to direct initial investigations before it gets to a specialist level.

Q. Right. Please don't think in anything I say that I'm being critical of what you actually did.

A. Not at all.

Q. It was just that it seems to be the cardiologist having to go above and beyond the normal role. But you have answered that.

A. 2475. This is you in March 1995 and you have obtained a positive Hepatitis C result and you are going on to organise a biopsy, although we see that you have discussed it with your gastroenterologist colleagues. Then 2469. Again, this is a report going from your department, saying that there has been an arranged admission for liver biopsy. I mean, was the liver biopsy actually done within your department?

A. Well, this was an admission to the ward, the cardiology ward or the ward that I had beds in, to continue the investigations. We weren't sure at that time -- I mean, I had a concern that this may have had a malignant source, for example, lymphoma. We really didn't know so we had enlisted the help of haematologists and also spoken to the gastroenterologists, and also the patient was on a drug called warfarin, which is critical for patients who have a metal prosthesis, which the St Jude was. So you have to watch these patients very closely when you undertake any biopsy or other procedure that might lead to bleeding. So you have to re-adjust the warfarin for as short a period of time as possible.

Q. You stopped the warfarin and started her on heparin. So heparin has a slightly different impact from warfarin, does it?

A. It probably has the same effect on keeping your blood thin but it is much shorter acting and it is given by a non-oral route, either through the muscle, or in this case the vein, and you can stop it very shortly before you undertake the biopsy and the effects are reversed. So that you can undertake. So they wanted her to have as short a period as possible of anti-coagulation, of which warfarin and heparin are two examples.

Q. I wanted to ask you about 2464. I just wondered what these findings -- and this is November 1995 -- mean from a cardiology point of view. I'm looking at the last paragraph. You say she had a pulse of 72, blood pressure 170/70. Really from that bit onwards, what is going on here?

A. Right, well, the JVP refers to the pressure on the right side of the heart. 2 centimetres is very borderline. That would be regarded really as not significantly elevated. In some patients who, especially those in whom the liver would be affected, you would expect the JVP to perhaps be 10 centimetres or above, and at times it can go right up to the angle of the jaw. So that in itself didn't indicate that the valve was struggling. No significant oedema. There was no swelling of the lower limbs. Again, that would go along with a very high JVP as a sign that the right heart wasn't functioning properly.

"The cardiovascular examination revealed the right Page 119
ventricular heave," suggests perhaps that the right ventricular pressure was slightly increased, but it is very difficult to assess that in patients who have had two bypasses, because the right side of the heart could be pushed more towards the sternum. So I think, I wouldn't necessarily deduce from that that the pressures were up. And it says that the apex, which was left ventricular in character, suggesting that the left side of the heart was thickened and there was a murmur there, which presumably was a degree -- often you can still hear a murmur in patients who have had a valve replacement whether it is in the mitral or in other positions.

So these cardiac findings would, depending on the last letter and so on, indicate their cardiac status overall was stable. We can see that her heartrate was 72 beats per minute, again indicating that the overall heart situation was stable. You know, once they start to struggle from the heart point of view, the heartrate would start to go up and you might expect, in a patient who is moving towards heart failure, a heartrate of 90 or 100 beats per minute.

Q. You referred to these two operations as "bypass operations". So when, in ordinary parlance somebody is described as having had a bypass, that can mean a valve replacement, can it?

A. Yes, there is confusion here. There is two bypasses going on in many patients. In coronary artery surgery, the vessels are bypassed by veins or other parts of arteries but in any kind of operation like a, you know, a coronary operation or a valve, there is a machine which bypasses the circulation and supports the circulation during the time that the surgeon is either transplanting the new vessels or putting in a new valve. So the heart is as rest, it is not moving for a period of perhaps up to an hour while the operation is being undertaken. So it is confusing because the valve patients all go on bypass; in other words, they are supported by this circulation out with the body, whereas the coronary patients get, as it were, two bypasses. Their vessels are bypassed and they have a bypass machine.

Q. So broadly speaking, from a cardiology point of view, the findings in this letter, as at November 1995, are not concerning. Is that --

A. No, I think that we were reasonably happy really up until about 1998 that her cardiac status was fairly stable.

Q. We had better just look at the end of that letter. Can we turn the page, please and look at 2465, and actually right side rather than the left side of the heart.
<table>
<thead>
<tr>
<th>Q.</th>
<th>Thank you. Actually the seventh problem in the list of</th>
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<tr>
<td>A.</td>
<td>Yes. It is usually the result of a lack of oxygen to</td>
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<tr>
<td>the heart muscle and there can be a number of reasons</td>
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<tr>
<td>for that. I think in her case, narrowed arteries would</td>
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<td>be one of the less likely reasons because we knew in</td>
<td></td>
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<tr>
<td>1985 and 1991 that her arteries were normal.</td>
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| Q. | Actually she has atrial fibrillation. Can you just |
| explain that? |
| A. | That's a very common type of heart rhythm disorder in |
| patients who have valve disease. The atrium, the |
| chamber at the top of the heart, when it enlarges, which |
| nearly always does in patients with valve disease, the |
| electrical stability of that chamber starts to |
| change, so instead of pushing the blood down into the |
| main chamber, it just kind of flutters, and the blood |
| still flows in but in a less effective way. It is |
| a common disorder even in patients without valve disease |

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| Q. | Lastly, could we go to II12, please. This is a letter |
| to the general practitioner from 2002, and in fact it |
| looks as though the angina, in the circumstances you |
| have described to us, has improved. So much so that she |
| is very rarely using her GTN spray. GTN spray is for |
| immediate relief of angina. Is that right? |
| A. | Yes, that's right. |

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| Q. | I see. Finally, Dr Dunn, I would like you just to have |
| a look at a report from Dr Mark Petrie. This is |
| [PEN0100157]. As we can see, that's emails in |
| connection with Dr Petrie's letter. [PEN0100182] could |
| we have, please, [PEN0100182]. |
| Sorry, I didn't catch your answer, doctor, do you |
| remember Dr Mark Petrie? |
| A. | Very well. |

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| Q. | You know him and he has written on 23 February this year |
| in relation to Mrs O'Hara's final illness really, in the |
| coronary care unit in Stobhill. He tells us information |
| which we have learned from other sources, that she had |
| multiple medical problems. Just looking at the first |
| paragraph. She was not fit for admission to intensive |
| care. She had a very poor prognosis. He says he looked |
| after her from 4 May until 7 May 2003. I think at that |
| point Dr Goodfield would be the consultant and Dr Petrie |
| was his registrar. Is that correct? |
| A. | Yes, I think that would be. |

---

| Q. | Right. And then Dr Petrie has addressed what it was |
| that was the cause of Mrs O'Hara's death, and he |
| narrates that the infection, pancreatitis, and then that |
| she had several longstanding chronic conditions: |
| Hepatitis C, cirrhosis, longstanding diabetes and that |
| she had had two previous mitral valve replacements. |

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| Q. | Thank you. Actually the seventh problem in the list of |
| the -- I think there is probably a misprint in this |
| letter. I think the dose of frusenide that she was on, |
| I think it should have been 120 milligrammes twice |
| a day. That is quite a significant dose. So although |
| we were achieving stability, it was with quite a high |
| dose of that particular water tablet. |
| Q. | So where it says "frusenide 20", maybe it should be -- |
| A. | That should be 120, yes. |

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| Q. | I see. Finally, Dr Dunn, I would like you just to have |
| a look at a report from Dr Mark Petrie. This is |
| [PEN0100157]. As we can see, that's emails in |
| connection with Dr Petrie's letter. [PEN0100182] could |
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| which we have learned from other sources, that she had |
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| that was the cause of Mrs O'Hara's death, and he |
| narrates that the infection, pancreatitis, and then that |
| she had several longstanding chronic conditions: |
| Hepatitis C, cirrhosis, longstanding diabetes and that |
| she had had two previous mitral valve replacements. |
Dr Petrie goes on to say that the cause of her death was multi-organ failure, secondary to overwhelming sepsis. Her C-reactive protein was very high, as was her white cell count. We have learned that these are both markers of infection: the C-reactive protein and the white cell count:

"She had renal failure and worsening hepatic failure in the context of her overwhelming sepsis."

He says:

"In summary, this lady had overwhelming sepsis, felt likely secondary to pancreatic collection. She tolerated this poorly due to her longstanding liver and heart disease and developed new acute renal failure."

Does that seem to you to reflect the circumstances of Mrs O'Hara's death, that summary?

A. Yes, I think that's fairly accurate. Often in these situations -- I mean, acute pancreatitis is in itself a very severe illness and when the patient is afflicted with that and already has significant multi-organ difficulties, and in her case I think her diabetes and her extensive past cardiac conditions were put under the kind of stress with the pancreatitis, that while she was managing not too badly, the pancreatitis just led to a failure of these other organs. I think it is just an effect almost like a domino effect. If one system goes, then the next system goes under pressure and so on and so forth. So I would think that certainly the sepsis was the -- the result of the pancreatitis was what caused this.

So I would agree with that. I get the impression that on reflection, Dr Petrie felt that Hepatitis C should have been mentioned in the death certificate and I would agree with that.

Q. Thank you. I realise, Dr Dunn, that I have failed to put to you your other letter, which you sent, I think, on 22 February, 2011. It is [PEN0100114]. I think it may be Dr Dunn, that this should say "2011". You see, you are replying to a letter of 15 December 2010. So perhaps it should be dated 22 February 2011.

A. I would agree with that.

Q. You will accept that correction, will you?

A. I was out of the country up until then, so I must have been still been in 2010.

Q. Right. I think that letter was provided really because you had been asked to address any potential connection between the cardiac condition and the cirrhosis from which Mrs O'Hara suffered, and you go on to say that there is a condition known as cardiac cirrhosis, which people have if they have a failure or can have if they have failure of the right side of the heart.

But you say this rarely causes the classic cirrhotic pattern seen in primary liver disease and then you talk about the success of the second valve replacement operation, and that there will have been perhaps some more short-lived elevation of the right heart pressures. Then you go on to deal with the course of events from 1995.

You say there was no clinical evidence of cardiac failure at that time, that Mrs O'Hara's cardiac status was stable for several years, more or less up until the time of her terminal illness. We looked at the letter, 1083, relating to June 1999 and you interpreted that for us, and then you say -- and we have looked at this too -- an entry in the case sheet in March 2002 indicated her cardiac situation was stable.

Then you say:

"It is my view that the patient's cardiac condition did not pre-dispose in any significant way to the development of cirrhosis."

Even having looked at the records again today, is that still your opinion?

A. Yes, I think it would -- it may have been a factor but not a significant factor or a major factor.

Q. You say:

"Finally, in regard to her terminal illness, I have..."
Q. I think perhaps the easiest metaphor for us as, lay people, to understand is the domino principle. The pancreatitis started a chain of events and these other conditions feature in the chain.

A. I don't use that term disrespectfully but it does, I think, allow people to understand the effect that one event has on subsequent events.

Q. Thanks very much, Dr Dunn.

THE CHAIRMAN: Mr Di Rollo, did you wish to ask any questions.

MS DUNLOP: Yes, indeed.

THE CHAIRMAN: Are you content with that?

MS DUNLOP: Mr Di Rollo, did you wish to ask any questions.

THE CHAIRMAN: With the greatest of respect, that's the chance was 100 per cent because she did die.

THE CHAIRMAN: Ms Dunlop, before you start on yours, perhaps I should take up just where I ended off speaking to Dr Dunn and say why.

As I understand it, a person who has severe pancreatitis and is over the age of 70 probably has a 10 to 20 per cent mortality at that stage. It is a severe condition. At the other end of the spectrum and not necessarily involving pancreatitis, I understand from Professor James that a person who has serious compromise of three or more organs has a high mortality risk and indeed it may be very difficult to measure the prospects of success in hospital treatment.

So if one has a person going into hospital with pancreatitis that can lead to sepsis, the question arises whether the multiplicity of compromised organs should be looked at as additive features, as it were, each making a contribution of, let's say, 10 per cent, which was the figure, or whether the proper way to look at it is that cumulatively they have a very significant impact upon mortality.

So you can't break it down into 10 per cent hepatitis. Hepatitis is part of an overall picture and has the same value, as it were, cumulatively, with the other elements, increasing significantly the mortality risk of the patient.

That's why I was trying to avoid the domino effect and look at the total. Now, I don't know if that helps. In a sense it increases the importance of hepatitis as part of the package and it may help Mr Di Rollo, but I don't know if that's consistent with what you understand the position to be.

MS DUNLOP: Well, we would like to reflect, I think, on it a bit more, but my only observation would be that talking about a 10 per cent, 20 per cent, 30 per cent chance of mortality might be acceptable in an epidemiological sense, if one was looking at 100 patients, but we know that for this person the chance was 100 per cent because she did die.

THE CHAIRMAN: With the greatest of respect, that's the
event, not necessarily the prospect and there can be a
difference between risk and event.
MS DUNLOP: Well, for whatever reason --
THE CHAIRMAN: But for whatever reason.
MS DUNLOP: -- Mrs O'Hara's chance was very much higher than
10 per cent, 20 per cent or 30 per cent --
THE CHAIRMAN: Well, you can all contemplate this
proposition and see whether it is helpful or not. If it
is necessary to take it up, then I can make help
available, to give you an expert view on it rather than
my attempt at summarising it.
MR DI ROLLO: Could I just ask one question of
Professor James really or just generally? Is there any
link between Hepatitis C and pancreatitis?
PROFESSOR JAMES: Very, very remote, if at all. There is
a very plausible, indeed probable, cause, if I may say
so in her gallstones already. So I don't think one
needs to invoke, sort of cast around for, any other
cause.
Very briefly, if I may, if I could supplement what
Lord Penrose has said and try to, by proxy, defend
myself against Ms Dunlop, what I was trying to get
comfort, sort of cast around for, any other
cause.
Mr GIBSON: And I will just say two things to you.
I thoroughly apologise to all my learned colleagues if
that was too big an intervention.
THE CHAIRMAN: I don't think I want my more comment at the
moment. You can ponder on these things, ladies and
gentlemen, and we will see what happens.
I'll do what I ought to do and let you get on.
MS DUNLOP: There are two things, sir, I still need to
cover. One is brief and one is, I am afraid, a little
Page 138
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Page 139
Page 140
"We understand Mrs O'Hara was given a blood transfusion ..."

This is the information which is apparent from the records and should, if all is going well, match what we looked at this morning. In relation to where this information was found.

One unit was transfused:

"We realise that transfusion took place many years ago."

Then the paragraph in times new roman comes from the blood transfusion service:

Mrs O'Hara was transfused with one unit of B negative blood on 31 March 1972, bottle number 5209.

The donor of this unit of blood has been identified:

This B negative unit was donated at Lockerbie on 5 March 1972 and issued to Stobhill on 25 March. The SNBTS have no record of this donor being Hepatitis C tested."

Of course, sir, that perhaps was a bit of a long shot but if this had been a donor who returned after 1991 and had given a donation and had been tested and been found to be Hepatitis C positive, then it would be possible to pinpoint the source of the infection but that has not been possible.

The second is in relation to the 1979 transfusion, to Mrs O'Hara was transfused with one unit of whole blood and one unit of packed cells on 28 November 1979. The donors of these units have been identified. The B negative unit, 142610, was donated at Coatbridge on 20 November 1979 and issued to Stobhill on 27 November.

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Turning the page, 1985 -- and you may recall, sir, that this is a situation in which five packs of concentrated red cells were identified -- the answer is that Mrs O'Hara was transfused with five units of concentrated red cells on 5 June 1985.

Actually, I think from examination that we carried out, the actual transfusion, that was, as it were, the reservation of the material rather than the actual transfusion because the surgery was 7 June. Anyway, no matter:

"The donors of these units have not been identified because the pack numbers of these units quoted above are numbers allocated by Glasgow Royal Infirmary. Previous enquiries to GRI have shown they are unable to provide a cross-reference from their numbers to the SNBTS pack numbers. Without such cross-reference, we are unable to trace the donors."

The next answer relates to HPPF. No batch number was recorded. There is some information which is perhaps more familiar to us, that human PPF is an albumin product prepared from a large batch of plasma:

All human plasma protein fractions prepared according to the monograph contained in the British Pharmacopeia, which includes pasteurisation. Ten hours at 60 degrees.

Then there is a possible transfusion with a unit of plasma:

"No batch number was recorded and the donor of that unit can't be identified."

In 1991 the catheter studies in a transoesophageal echocardiogram, and the Inquiry says:

"We would assume these products would not have involved a transfusion. We would appreciate if this could be confirmed."

And I did actually ask Dr Dunn about this and he said not in the ordinary course of events, he wouldn't expect there to be transfusion.

Then 24 July 1991, which is associated with the angiogram and ventriculogram, Dr Dunn said you wouldn't normally expect a transfusion of products. So there must have been some particular reason for it and the donation has been tested and found to be Hepatitis C negative.

And then the answer on that:

"24 July 1991. With one unit of fresh frozen plasma. This unit was first tested at the time of collection, 11 July, and was Hepatitis C negative."

In fact, there has been further testing in 2008 and then there is further research but I would suggest, sir, that as we get further on, on to the 1990s, these results are really not relevant because all the evidence suggests that the 1990 test was a false negative.

After that some more questions were posed. I don't think we need to look at it but for the record, the email in which further questions were posed is [PEN0020762], and there is a supplementary response which is [PEN0020760]. This is February 2011. We do need to look at that.

This is back to 1985 and the Glasgow Royal Infirmary pack numbers. The Inquiry asked to be provided with more information on why Glasgow Royal Infirmary couldn't provide a cross-reference. And indeed, also suggested another mode of enquiry which would be to follow up the fact that Mrs O'Hara had a relatively rare blood type, B negative. We are told again that the donors of the five
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| 145 | units of blood couldn't be identified because of the inability to cross-reference the Glasgow Royal Infirmary numbering system and the SNBTS number. Then this suggestion of using the blood group didn't work either. It was before the introduction of a computerised system known as LAB Lan and the paper records from that period don't still exist. Then the plasma. Again, there is a problem with not being able to recognise the number. Mr Anderson will help us understand it fully in due course? We have SNBTS number as part of a coherent system covering the blood transfusion system as a whole. Blood is delivered to the hospital blood bank, and in this case Glasgow Royal Infirmary abandons the inheritance and puts on new numbers that cannot be traced back to source. So there is a significant break in the chain. Ms Dunlop: Well, there is more. The Chairman: There is more? Ms Dunlop: Yes. The Chairman: In the same direction or is it going into reverse at any stage? Ms Dunlop: I don't know what direction you would call it. I think it is a complete standstill but it represents another attempt. The document we have just been looking at also covers, on the other page, the 1991 products, which again was a bit of a dead end. It didn't give us an answer, but, as we said earlier, it is perhaps not really relevant. Then we should look at [OHA0012676]. This letter has not been written specifically for this Inquiry but it relates to October 1991. In the second paragraph it says: "There are records dating back to 1985 which indicate we issued five unit of red cells. It was in Ward 66. we don't have records to tell us ..." In fact, the medical records seem to suggest they were all used. So this letter from Dr Tate doesn't really take us any further, but finally, in [PEN30100074], there having been, I suppose, a rather insistent focus on the 1985 episode. Can we look at page 2? Just to explain. It is perhaps obvious but this is a copy of the original letter from 10 December 2010 with answers interlined in it. If we look at the second page, there is an explanation which is: "It certainly looks as if all five of these units were transfused. At the time, Glasgow Royal Infirmary blood bank used a mini Apple PC which did not recognise SNBTS barcode donation numbers, hence we generated our own. We think these GRI barcode numbers could be tied in with SNBTS numbers by looking at either the original request form or possibly ledgers completed for blood issue on a daily basis. However, a summary of data held by GRI blood banks suggests we only have request forms from 1988 onwards and we only have ledgers from 1968 to 1984."

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<td>1970s lauding the effectiveness of Glasgow's system of tracing blood as collected, issued and used on patients by use of punched paper tape, computerisation, which you won't remember but which I do as a young auditor trying to audit advanced companies' books. So if there had been a comprehensive system that broke down, I would like to know about that. Indeed, I would like to know all about the systems of recording which appear, at the moment at least, perhaps to have some holes in them. Mr Anderson: No doubt that will be looked into. The Chairman: Thank you very much. Mr Anderson: Very thoroughly. The Chairman: Ms Dunlop, is that the end of today's -- Ms Dunlop: There is no further evidence to present in relation -- The Chairman: I think we can reasonably adjourn until tomorrow. Thank you all very much. (4.17 pm) The Inquiry adjourned until 9.30 am the following day) Mrs Roseleen Kennedy (sworn) ........................1 Questions by MS Dunlop .............................1 Dr David Mutimer (continued) .........................26 Questions by MS Dunlop .............................26 Dr Kevin William Robertson (sworn) ....................89 Questions by MS Dunlop .............................89 Dr Francis Gerard Dunn (sworn) .......................108 Page 146</td>
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