MRS EILEEN O'HARA

(1) Where and when the death occurred

Mrs O'Hara was born on 9 October 1930 and died on 7 May 2003 at Stobhill Hospital in Glasgow.

(2) The cause of death

The cause of Mrs. O'Hara's death, recorded on the death certificate, was:

" I (a) Hepatic Failure

(b) Septic Shock….

II Mitral Valve Disease"

Dr Mutimer's evidence was that the cause of Mrs O'Hara's death was infection due to pancreatitis but that her liver disease probably affected her ability to survive the final illness. Similarly, in a report dated 23/02/11, Dr Petrie stated that a better summary of the cause of Mrs. O'Hara's death was overwhelming sepsis, likely secondary to pancreatic collection, which was poorly tolerated due to longstanding liver and heart disease and her developed new acute renal failure.

Although Hepatitis C was not recorded on the death certificate, Dr. Mutimer and Dr Dunn both gave evidence to the effect that it would have been appropriate for it to have been mentioned.

(3) Reasonable precautions, if any, whereby the death might have been avoided

(4) Facts relevant to the circumstances of the death

Mrs O'Hara had a complex medical history. She developed mitral valve stenosis as a consequence of having had rheumatic fever as a child. As a result she was required to undergo cardiac surgery on three occasions; in 1963 she underwent a closed mitral valvotomy, in June 1985 she had a mitral valve replacement and in October 1991 she had

a prosthetic valve inserted. Mrs O'Hara also experienced obstetric and gynaecological difficulties and was required to undergo a Caesarian section in March 1972 and a vaginal hysterectomy in December 1979. In addition Mrs. O'Hara suffered from long-term type II diabetes.

Mrs O'Hara's medical records show that she received blood transfusions during each of the 1972, 1979, 1985 and 1991 procedures. Although there is no evidence that she received a blood transfusion during the 1963 procedure, it is possible that she received a transfusion then too. Dr. Mutimer deduced that of the various transfusions, the one most likely to have caused Mrs. O'Hara to have become infected with Hepatitis C was the transfusion that she received in 1972.

When Mrs. O'Hara first showed abnormal liver function tests in February 1984 it was suggested that this might have been secondary to her cardiac disease. However, when in May 1990 she again showed abnormal liver function tests the cardiologist was of the view that this could not be explained by cardiac failure. Consequently, in November 1990 her blood was tested for Hepatitis C antibodies but the result was negative, although it is likely that this was a false negative result.

In August 1994, during a routine examination at the diabetic clinic, Mrs. O'Hara was noted to have hepatosplenomegaly. In February 1995 her blood tested positive for Hepatitis C antibodies and was confirmed to be HCV PRC positive in April 2003. A liver biopsy carried out in June 1995 confirmed the presence of cirrhosis.

The possibility of antiviral therapy was considered. However in November 1995, and again in July 1997 a gastroenterologist, who apparently reviewed Mrs. O'Hara's medical history, expressed the opinion that she would not be a good candidate for antiviral therapy. He also advised that, in any event, the NHS would not prescribe Interferon for chronic Hepatitis C, that they had instructed GP's not to prescribe it, and that even though they were funding a trial for Interferon he doubted that Mrs. O'Hara would be a candidate. Dr Mutimer testified that, with hindsight, it was probably fortunate that Mrs. O'Hara did not receive treatment as she would probably have had a lot of side effects and no success. The question of antiviral treatment was of ongoing concern to Mrs. O'Hara

yet she was never seen by the gastroenterologist and she consequently never had the opportunity to discuss the issue with him.

Between 1997 and 2003 Mrs. O'Hara continued to attend clinics for her diabetes and cardiac condition. During this time her health deteriorated gradually and on 26 March 2003 she was admitted to Stobhill hospital where she subsequently died.

(5) **Defects in any system of working**

Following her negative Hepatitis C result in 1990, and until further investigations were carried out in 1994/1995, Mrs. O'Hara's liver condition was not monitored by a liver specialist despite the fact that she had abnormal liver function tests that had not been explained. No consideration appears to have been given to carrying out further investigation once the second generation tests became available.

The question of antiviral therapy was an ongoing issue for Mrs. O'Hara yet she was never given the opportunity to discuss it with the gastroenterologist who had concluded that she would not be a good candidate for such therapy. Mrs. O'Hara was unaware that her notes had been reviewed by gastroenterologist who deemed her unsuitable for treatment. She never saw a liver specialist and the specialist at diabetic and heart clinics could not answer questions in relation to liver disease.

(6) **Systemic Issues examined by the Inquiry relevant to this death**

1. **The information received by patients.** Mrs. O'Hara did not receive appropriate counselling and support for her hepatitis C and its consequences despite the diagnosis having been made. The diagnosis of infection with hepatitis C was made at the same time as the diagnosis of cirrhosis. Mrs. O'Hara and her family were not told about the danger of secondary infection and the appropriate precautions.

2. **The recording of Hepatitis C as a cause of death.** Hepatitis C was not recorded on Mrs. O'Hara's death certificate despite the fact that it was the cause of her liver failure, which was recorded as a cause of death.

3. **Traceability of Donations -** The Inquiry has followed up a request from the Chairman in response to Chairman's request for further information concerning the inability to trace the relevant donors of the transfusions received by Mrs O'Hara due to the absence of Glasgow Royal Infirmary records, which could have enabled cross referencing to SNBTS pack numbers. [see letter of 25 August 2011 from Dr. Rachel Green to Tracey Turnbull]