Witness Name: Dr Pall Agustsson
Statement No.: WITN3416001
Exhibits: WITN3416002
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF Dr Pall Agustsson

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 4 June 2019 addressed to Mr Grant Archibald, Chief Executive of Tayside Health Board.

I, Dr Pall Agustsson, will say as follows: -

Section 1: Introduction

1. Dr Pall Agustsson
   DOB: GRO-C 1951
   Address: C/O Tayside Health Board, Ninewells Hospital, 230 Clepington Road, Dundee, DD2 1UB.
   Qualifications: Cand. Med. & Chir.(Iceland), MRCOG

2. I was appointed a consultant in Obstetrics and Gynaecology at Tayside Health Board in April 1991 and held that position until retirement in 2013. I worked predominantly in the field of Obstetrics and was in charge of Obstetrics and Gynaecology Ultrasound. I was one of a team of lead clinicians providing management and care in high risk Obstetrics both antenatally and during labour. I was the clinical team leader for Obstetrics and Gynaecology in the last few years of my employment. This included a leading role in the general management of the department, risk management and clinical complaints.

Section 2: Response to Criticism of Gillian and Stanley Fyffe

3. I have unfortunately, no direct recollection of this case from 31 years ago and must rely on the case notes to prepare this Response. I have also prepared a review of the case notes which is submitted as an appendix to this Response. I have also identified, and again submit with this Response, extracts from the medical records which I consider to be relevant in addressing the criticisms raised by Mr and Mrs Fyffe.

4. According to the notes, on Thursday 6th of October 1988 I was the Senior Registrar on call for Labour Suite management and the notes also indicate that I was the Senior Registrar on call for the weekend 7th ,8th and 9th of October. There is no mention in the notes of who the Consultant on call was for the 6th to the 7th (Thursday/Friday).

5. In 1988 the on-call team for Labour Suite Obstetrics in hours (0900 -1700) and out of hours (1700-0900) consisted of a Senior House Officer, a Registrar, a Senior Registrar and a Consultant. The Senior House Officer and the Registrar were resident on call, the Senior Registrar and the Consultant were resident on call between 0900 and 1700 on weekdays and as required between 1700 and 0900 and at weekends.

6. I have been asked to comment on criticisms made by Mrs Gillian Fyffe and her family. The first criticism is that Mrs Fyffe was pressured into accepting a blood transfusion after the birth of her daughter. I respond as follows:

7. Mrs Fyffe was very opposed to a blood transfusion mainly on the grounds of the risk of infection and she clearly felt pressurised into accepting one. I accept that I would have given strong encouragement to go ahead with the blood transfusion but I did so believing that her life could potentially be in danger were she not to have it. As stated further on in this Response, I believe that advice was correct in the circumstance. Advice was given as stated in the review of case notes attached, and this would have included the risk of the potential consequences of a further bleed and a prolonged recovery. In light of this, expert opinion was sought and colleagues at the SNBTS were contacted and asked to advise Mrs and Mr Fyffe regarding the safety of blood transfusion. I am unable to state categorically that Dr Young was a member of SNBTS but, from reading through the medical and midwifery notes, I think that he most likely was.

8. The second criticism is that doctors suggested to Mrs Fyffe that her condition was life threatening and that if she had a haemorrhage during the night, they would be unable to transfuse her quickly enough and her life would be in jeopardy. According to Mrs Fyffe, this was at odds with the 16hour delay from when she accepted the transfusion to when she ultimately received the transfusion. I respond as follows:

9. I am confident that I made the right clinical decision recommending a blood transfusion in light of Mrs Fyffe's severe acute anaemia due to blood loss and her clinical symptoms. With a haemoglobin of 6.2 (11.2g/dl prior to delivery on the 15/09) this would have left blood volume reserves very low. Had a secondary postpartum haemorrhage occurred a life-threatening clinical situation could have occurred especially if blood transfusion was not an immediate management option. Once the patient has consented to having a blood transfusion the blood can then be cross-matched and prepared meaning it can be administered immediately if and when required. This would also be in line with best medical practice in 1988. It is important to remember that postpartum haemorrhage (bleeding after delivery) is a leading cause of maternal death in the world. The medical/ midwifery notes do not specify the reason why a blood transfusion was not commenced once consent had been obtained and I therefore cannot offer an explanation for that decision. As stated above, blood transfusion could have been administered at short notice (15 minutes) in the event of a secondary postpartum haemorrhage. Mrs Fyffe was still symptomatic the following day and the risk of a further bleed was still present. The clinical situation had not changed and I believe that the decision to administer blood transfusion at this time was correct.

10. The blood loss at delivery is likely to have been underestimated as demonstrated by the low haemoglobin levels measured following delivery (6.2g/dl). Insidious blood loss following delivery may have been continuous, but not noticed as significant (it is not recorded as being measured) and bleeding may also have occurred into the pelvic tissues due to delivery procedures. All these factors are likely to have been present and to have contributed to the anaemia. Blood level (haemoglobin) measurements are routinely obtained following operative delivery. The timing depends on the recorded blood loss and/or clinical symptoms. Mrs Fyffe's clinical symptoms would have prompted an early assessment. Underestimation of significant blood loss, if not recognised, can lead to unexpected system collapse if clinical symptoms are ignored.

11. Other potential management options include expectant management with oral iron accepting the aforementioned risks. Recovery period is prolonged and protracted resulting in longer hospital stay and making it difficult looking after a new born baby. Intravenous iron infusion employed commonly in present day practise was not considered a management option in this clinical situation in 1988.

Section 3: Other issues

12. I first learned about Mrs Fyffe's Hepatitis C infection when the Central Legal Office contacted me in July 2019. This was the most devastating news and I can only begin to comprehend the significance of the impact this has had on Mrs Fyffe and her family. I don't doubt my clinical decision recommending a blood transfusion given the clinical situation, but the consequences of that decision are extremely distressing. I sincerely offer Mrs Fyffe and her family my deepest condolences.

Statement of Truth

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

Signed: GRO-C

Dated 20/2 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
	Case Review	WITN3416002
	Gillian Fyffe Medical Records	WITN3416003