Witness Name: Dr Alexandra Rice
Statement No.: WITN3866001
Exhibits: WITN3866002–12
Dated: 14 November 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ALEXANDRA RICE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 October 2019.

I, **Dr ALEXANDRA JOAN RICE**, of the Royal Brompton and Harefield NHS Foundation Trust, Sydney Street London SW3 6NP **WILL SAY AS FOLLOWS**:

Section 1: Introduction

1. I am a Consultant Thoracic and Transplant Pathologist, Lead Cardiothoracic Transplant Pathologist & Head of Department as well as an Honorary Senior Lecturer at Imperial College. I am Consultant Histopathologist at the Royal Brompton Hospital, London, which position I have held from 2009 to date. Prior to that I held a Consultant Histopathologist post at St Mary's Hospital, London, from 2003-2009. St Mary's is part of the Imperial College Healthcare NHS Trust and is independent of the Royal Brompton Hospital. I have been Head of Department at the Royal Brompton Hospital since April 2015.

2. My role at the Royal Brompton at the time of Mr Angus Stewart was treated by us was to report on tissue samples taken from the lungs and hearts of patients being treated at the Royal Brompton Hospital. Before changing jobs to work at the Royal Brompton I had reported skin, GI, breast, ENT, bone marrow, lymph node and lung pathology at St Mary's Hospital.

Section 2: Responses to criticism of WITN1001

Summary

3. I have been asked to address points made in paragraphs 30 to 45 of the witness evidence of Annette Hill-Stewart (WITN1001) and paragraph 13 of the statement of Debra Pollard (WITN3094) of the Royal Free Hospital. There is a specific criticism that an operation on Ms Hill-Stewart's husband on Tuesday, 7th February 2019 was cancelled.

4. I can confirm that an operation on Mr Stewart scheduled for Tuesday, 31st January 2012 was postponed until 7th February 2012, whilst I and colleagues at the Royal Brompton Hospital sought to establish what the risks were of providing clinical services to Mr Stewart. Having satisfied ourselves as to the relevant risks on the basis of the best information available, the operation went ahead on 7th February 2012. I cannot comment on the further criticisms raised by Ms Hill Stewart in paragraphs 31 to 45 as the Royal Brompton Hospital was not the hospital responsible for her husband's care and treatment in relation to those issues.

Care and treatment provided by the Royal Brompton Hospital

5. I can confirm that following a referral from the Royal Free Hospital, Mr Stewart was initially listed by Mr Eric Lim, Consultant Thoracic Surgeon at the Royal Brompton Hospital, for a bronchoscopy, left thoracotomy and possible lung resection on 31st January 2012. I attach the Discharge Summary dated 31st January 2012 confirming the cancellation of the operation on 31st January 2012 and the fact it was to be rescheduled the following week. This document can be found at **Exhibit WITN3866002.**

6. The Royal Brompton Hospital (RBH) Histopathology department received a request for a diagnostic frozen section (FS) on a tissue sample from Mr Angus Hill-Stewart on the morning of the day of surgery, 31st January 2012. Only at that time were colleagues and I in the histopathology department informed that the patient had hepatitis C and was at risk of variant CJD (vCJD). This was a very unusual situation and our laboratory had never previously been asked to deal with tissue at risk of containing vCJD and did not have a standard operating procedure (SOP) in place for this scenario.

7. Both myself (as on-call pathologist for FS on that day) and the Laboratory Service Managers (Mr David Butcher and Richard Florio) decided that we needed to obtain specialist advice to ensure we had the appropriate Health and Safety and Infection Control measures in place for staff and equipment decontamination, before agreeing to perform the FS. In the limited time available that morning I obtained advice that a frozen section should not be performed. Regrettably I do not have a note of whom I obtained that advice from at the time.

8. I relayed this information to Mr Lim, who was due to carry out the operation. Mr Lim decided to cancel the operation on that day, 31st January 2012. I believe Mr Lim spoke to Mr Stewart and Ms Hill Stewart about this in person on 31st January 2012.

9. The next day, Wednesday 1st February 2012, Mr Lim and I exchanged emails during the course of the day in relation to Mr Stewart's email to Mr Lim [11:14]. Mr Lim and I were initially told Mr Stewart was "at risk" of vCJD by his haemophilia centre, but we were then given information by Mr Stewart that his risk may be no higher than other patients who received multiple transfusions during the BSE era. This is recorded in the email chain dated 1st February 2012 at 14:00 - **Exhibit WITN3866003.**

Phone advice Haemophilia Centre, St Thomas's Hospital

10. I sought further advice from our Consultant Haematologist, Dr Tillier, at RBH who contacted Dr David Bevan, the Director of the Haemophilia Centre, St Thomas's Hospital. Dr Tillier informed me that Dr Bevan confirmed that the official guidance was that FS should not be performed in these cases regardless of the tissue type and that within the "at risk" group no distinction is made between low and high risk patients based on whether they have received blood products from a donor known to have vCJD or not.

Advice from National Hospital for Neurology and Neurosurgery

11. I sought additional advice from the Histopathology Department of The National Hospital for Neurology and Neurosurgery (Queens Square Hospital). I spoke to one of the Specialist Registrars in the department at Queens Square who liaised with the Consultant Neuropathologist on site (Dr Rahul Phadke). The verbal advice that Queen's Square gave to me on 1st February 2012 was very clear that FS were not done to be done on tissue with any risk of exposure to vCJD. In the meantime Mr

Butcher obtained the protocol from Queens Square for handling formalin fixed tissue from these patients. I am unable to provide a copy of that protocol as it is not in my possession and Mr Butcher has retired.

12. I also conducted my own research and came across relevant guidelines called "*Transmissible Spongiform Encephalopathy Agents: Safe Working and Prevention of Infection: Annex K*". I emailed this information to Mr Florio at 16:32 on 1st February 2012, asking whether he has heard from his contacts, as there was nothing on this topic on the Royal College of Pathologist's website and the advice in the guidance was at odds with the advice we had received from both Queen's Square and St Thomas's Haemophilia Centre. My email to my colleague, Mr Florio, and the guidelines appear at **Exhibit WITN3866004.**

13. Later in the afternoon of 1st February 2012 I emailed Mr Lim with details of the advice I had been given by both Queens Square and the Haemophilia Centre at 17:28, which email chain (starting on 2nd February at 08:16) I attach at **Exhibit WITN3866005.**

14. . I also expressed my apologies in relation to the delay in that email, stating at the start of the letter that: *"… I completely understand and am sorry for the distress delaying this procedure has caused the patient, however this situation is extremely unusual and outside the experience of our laboratory…"* as well as stating at the end of the letter: "*I do appreciate how difficult this is for yourself and the patient and the inconvenience caused, but I hope you can understand the reasons why we cannot offer a frozen section service in this case."*

15. On the evening of Thursday 2nd February Mr Stewart emailed Mr Lim, supplying Mr Lim with information that Mr Stewart had received from Dr Simon Mead, a Consultant Neurologist at the National Prion Clinic, part of the University College London Hospitals NHS Foundation Trust (UCLH). Dr Mead described that he sat on the panels which were responsible for the guidelines. That email chain starts with Mr Lim's email to me at 19:20, which can be found at **Exhibit WITN3866006.**

<u>Advice from the National Prion Clinic</u>

16. On Friday **3rd** February 2012, Dr Mead made direct contact with Mr Lim and with me in his email timed at 17:16. Dr Mead's email describes that he had been contacted by Angus Stewart in relation to obtaining a blood test for vCJD. Dr Mead was not

able to help the patient with a blood test but he emailed us to address the issue of whether any precautions really did need to be taken. In his email Dr Mead provided a link to guidelines in relation to the handling of FS tissue, which was contradictory to the advice I had been given by the Queens Square Neuropathologist and the St Thomas's Haemophilia Centre. I raised that with him. The guidance which Dr Mead directed us to is the same guidance that I had myself located (Exhibit WITN3866004) which suggested that FS should not be performed in high risk cases, but that it was safe to proceed in low risk cases. I therefore asked Dr Mead to provide us with details of laboratories who performed FS in similar cases to Mr Stewart's circumstances so that I could confirm their protocols.

17. My concern was that whilst the guidance said one thing, peers who were carrying out the clinical procedures on a daily basis were telling us that they did things differently in practice because of the risk. The email exchanges with Dr Mead on 3rd and 6th February 2012 are attached at **Exhibit WITN3866007**, starting at 14:00 on 6th February 2012.

Advice from National CJD Research and Surveillance Unit

18. In response to my emailed request to Dr Mead, he put me in contact with Professor James Ironside at the National CJD Research and Surveillance Unit. Professor Ironside emailed Simon Mead and me directly on Monday, 6th February 2012 at 14:05 and 17:41. He confirmed that a FS could be done on lung tissue in these cases. I attach his emails at **Exhibit WITN3866008**. He also sent me the guidance that I had researched and which Dr Mead subsequently sent me (Exhibit WITN3866004).

19. Based on this further advice from Professor Ironside, we advised Mr Lim that we could do a frozen section. The operation was rescheduled for 7th February 2012. That operation went ahead and we performed an intra-operative frozen section diagnosis. For the sake of completeness I attach Mr Lim's letter to the Royal Free Hospital dated 7th February 2012, confirming the outcome of the operation and the biopsy that Mr Lim conducted and which I examined. Mr Lim enclosed the Operation Note also dated 7th February 2012. I attach both documents at **Exhibit WITN3866009**.

20. The further procedures described by Ms Hill Stewart **(WITN1001)** in paragraphs 31 to 45, which the Inquiry has formally requested that I reply to, were not carried out by the Royal Brompton Hospital. I note from the documentation supplied to me that Debra Anne Pollard **(WITN3094)** of the Royal Free Hospital has answered those allegations. Mr Stewart was seen post-operatively by Dr Noorani, the specialist registrar to Mr Lim, at an out-patient clinic on 22nd March 2012. Mr Noorani wrote to the Royal Free Hospital that same day, in which letter he described that Mr Stewart had made excellent progress and that Mr Stewart no longer needed services from RBH. This letter is attached as **Exhibit WITN3866010.**

Section 3: Other Issues

21. I have been asked to comment on other issues upon which I may have relevant evidence. I have nothing further to add, save that my colleague, Mr Butcher, drew up a local SOP for the handling of tissue from patients with prion disease or potentially exposed to prion disease, based on the SOP from Queen's Square. I attach Mr Butcher's email dated 10th February 2012 **Exhibit WITN3866011** as well as the current version of the same SOP, **Exhibit WITN3866012.**

Statement of Truth

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

Signed GRO-C

Dated 21st November 2019

Table of exhibits on the following page

Table of exhibits:

Date	Notes/ Description	Exhibit number
31st January 2012	Discharge Summary	**Exhibit WITN3866002**
1 February 2012 at 14:00	Emails between Dr Rice and Mr Lim; as well as Mr Lim and Mr Stewart	**Exhibit WITN3866003**
1 February 2012 at 16:32	Email from Dr Rice to Mr Florio attaching the guidelines titled "*Transmissible Spongiform Encephalopathy Agents: Safe Working and Prevention of Infection: Annex K*".	**Exhibit WITN3866004**
2 February 2012 at 08:16	Emails between Dr Rice and Mr Lim further detailing external advice	**Exhibit WITN3866005**
2 February 2012 at 19:20	Emails between Dr Rice, Mr Lim and Mr Stewart	**Exhibit WITN3866006**
6 February 2012 at 14:00	Emails between Dr Rice, Mr Lim and Dr Mead,	**Exhibit WITN3866007**
6 February 2012	Emails between Professor Ironside, Dr Mead and Dr Rice	**Exhibit WITN3866008**
7th February 2012	Letter from Mr Lim to the Royal Free Hospital and the enclosed the Operation Note.	**Exhibit WITN3866009**
22 March 2012.	Letter from Dr Noorani to the Royal Free Hospital.	**Exhibit WITN3866010**
10 February 2012	Mr Butcher's email	**Exhibit WITN3866011**
2017-19	RBHT SOP titled "Instructions for handling tissues from Patients with or at risk of CJD or VCJD.	**Exhibit WITN3866012**