Foreword

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Currently, there is huge media interest in the Infected Blood Inquiry into patients harmed by historical infected transfusions. This relates primarily to the transmission of hepatitis C in the 1970s and 1980s, an era when as an entity hepatitis C was not recognised and serological testing or screening of blood and blood components had not yet become available. The hepatitis C virus was discovered in 1989, and it was soon realised that this accounted for many of the cases of 'non-A non-B hepatitis' seen up to that time. An early screening test for hepatitis C was developed and introduced within a few months after that; and a more sensitive and effective test was developed in 1992. Since then, transmission through blood and blood products has reduced dramatically. In the current Annual SHOT Report, we tabulate the risk of failure to detect potential infectivity in the window period (before sero-conversion) for hepatitis B, to be around 0.5 per million transfusions. For hepatitis C and human immunodeficiency virus (HIV), it is orders of magnitude lower. While this should be immensely reassuring for patients and the public at large, the press nevertheless conveys a sense of considerable bitterness and anger over the transfusion-related virus transmission which happened before screening measures were in place.

Undoubtedly, there are lessons to be learned, and the Inquiry will hopefully highlight ways in which we can mitigate 'unknown' risks in the future. These may include proper rigorous data collection and tracking, so that those at risk of transfusion-related complications can be identified, and offered appropriate help at the earliest juncture.

There is also a risk which arises from the Inquiry, or rather, from popular reaction to it (including reporting). A sense of public anger may fuel blame culture, which ultimately can only defeat the processes of reporting and learning. The principle of a 'just culture' is often poorly understood, and is clearly not the same as a 'no blame' culture.

A system in which both complications of transfusion, and near misses (including delays and omissions) are openly reported and shared is crucial to advancing safety, building on the advances of the last 25 years. At an individual and organisational level, it may be helpful, instead of conceptualising a 'reporting' culture, to think in terms of a 'sharing' culture. Sharing our errors has a number of advantages. First, it enables us to mitigate any further or ongoing harm which may already be in train. Second, it establishes the conditions for learning and pattern recognition, so that we better understand what has happened (or could have happened). Third, this in turn enables us to change practices and systems, reducing the chance of similar events in the future. Fourth, it establishes a culture where the individuals involved support each other, and share their concerns and the emotional elements of the experience. This fosters future openness and sharing.

In the current report, there were 20 deaths related to transfusion, and 109 cases of major morbidity. These figures seem low, and might imply relative safety. However, it is also quite clear that the blood component usage and reporting rates by centre are not linked as one might expect if all incidents were reported. There are a number of perceived barriers to sharing transfusion errors and near misses. These may include staffing levels, the perception of the value of reporting, the perception of the difficulties and inconvenience involved in reporting, and importantly, the possibility that evidence from reports is used to discipline individuals. This latter possibility, of which there are anecdotal reports, would of itself have a disproportionate effect on sharing and safety. For this reason, it is important that such practices do not enter the healthcare culture, and that unsubstantiated rumours are likewise addressed. Haemovigilance should stand out as a beacon of safety in healthcare; there should be very clear separation between the safety culture to which we all subscribe, and the popular culture of blame which we encounter on a daily basis in the outside world and the media.