NHS
Blood and Transplant

Board Meeting in Public
Tuesday, 20 May 2025

Title of Paper	Board Story – Written Statement from David Abdo	**Agenda No.**	2.1
Nature of Paper	☒Official	☐Official Sensitive	
Author(s)	David Abdo – Brand and Studio Manager, NHSBT		
Lead Executive	Denise Thiruchelvam, Chief Nursing Officer (CNO)		
Non-Executive Director Sponsor	-		
Presenter(s) at Meeting	Denise Thiruchelvam, Chief Nursing Officer and David Abdo – Brand and Studio Manager, NHSBT		
Presented for (tick all that applies)	☐ Approval ☒ Information ☐ Assurance ☐ Update		

Executive Summary (max 300 word count)

The following summary is based on the evidence I, David Abdo, presented to the Infected Blood Inquiry. It details the tragic consequences of the contaminated blood scandal on my family, highlighting systemic failures, lack of support, and the ongoing fight for justice.

My personal involvement with the IBI (Infected Blood Inquiry), as an employee of NHSBT, gives me a unique perspective on the need for change and reform. My statement concludes with a powerful reflection on the universal nature of this tragedy: "I understand that this is a mammoth task but will continue to tell my family's story and hope people's mindset will change and systems are in place to make the patient at the heart of any care with compassion and empathy. This tragedy could have happened to any one of us reading this summary."

Previously Considered by	
N/A	
Recommendation	The Board is asked to note the contents of this paper.

Risk(s) identified (Link to Board Assurance Framework Risks)

No risks associated with this paper. However, the story links to risks: P-01 and P-06

Strategic Objective(s) this paper relates to:

☒ Collaborate with partners ☒ Invest in people and culture ☐ Drive innovation

☐ Modernise our operations ☐ Grow and diversify our donor base

Appendices:	Appendix 1 - David Abdo Statement to Infected Blood Inquiry

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Here is a summary of the key points from David Abdo's statement to the IBI inquiry:

1. Introduction

The following summary is based on the evidence that I, David Abdo, presented to the Infected Blood Inquiry. It details the tragic consequences of the contaminated blood scandal on my family, highlighting systemic failures, lack of support, and the ongoing fight for justice.

My personal involvement with the IBI (Infected Blood Inquiry), as an employee of NHSBT, gives me a unique perspective on the need for change and reform. The statement I gave to the IBI concludes with a powerful reflection on the universal nature of this tragedy:
"David understands that this is a mammoth task but will continue to tell his family's story and hopes people's mindset will change and systems are in place to make the patient at the heart of any care with compassion and empathy. This tragedy could have happened to any one of us reading this summary."

I have an extensive design background, including involvement with new donor centre designs like the Brixton Donor centre and others currently in planning, and leadership of the team that won the London Olympics 2012 bid. I have received recognition for my interior designs, marketing materials and graphic assets at the Home Office, for which I have won various awards in the design industry. This demonstrates my dedicated commitment to improving public spaces and services.

2. Background

I am employed by NHSBT as a Brand and Studio Manager and am personally involved with the IBI (Infected Blood Inquiry), therefore have a strong personal commitment to addressing the issues.

My father died on 7th June 1990 at the age of 54 from hepatic failure caused by chronic liver disease due Hepatitis C and Hepatitis B, contracted from a blood transfusion. This is a stark reminder of the fatal consequences of the scandal. My mother and I have issued statements to the IBI on behalf of my father. My parents were very close. My father worked at Friern Barnet Psychiatric Hospital as a Head Chef and my mother was a catering manager there. My father also worked evenings at Walthamstow Stadium as a head chef, holding down two jobs to provide for his family, such was the work ethic of my family and my father's dedication.

3. Infection Circumstances

My father contracted hepatitis B and C from a blood transfusion received during a renal transplant at the Royal Free Hospital in early 1985. We felt an incredible betrayal of trust because the infection stemmed from a routine medical procedure. We had to gather this information from sick notes, a letter from the Royal Free Hospital (dated 13 August 2018), and my father's death certificate. Our fight for this information highlights the difficulties families have had in obtaining information and the accountability of others.

My mother was given hepatitis B vaccinations, presumably because she was in an intimate relationship with my father after he was infected, and I was tested when I was young without the knowledge of my mother. This illustrates how the infected blood scandal also encompasses the potential for wider family transmission and the lack of informed consent.

4. Lack of Information and Consent

My parents were not informed of the potential need for a blood transfusion nor the associated risks prior to the kidney operation. The giving of blood was treated as routine, and my parents would not have suspected it as a cause for concern. This demonstrates a systemic failure to provide patients with critical information. The attitude from the medical staff during this period was that the Doctor knows best and was never questioned.

The news of the infection was a "massive shock." This understatement conveys just a fraction of the emotional devastation experienced by my family.

I believe that my father was treated without full knowledge and consent, partly evidenced by my father's reaction to the news. This raises serious ethical questions about patient autonomy and informed decision-making. I have questioned why my father was tested for hepatitis without our family being informed. The communication from the hospital was very poor, which left our family feeling anxious and distressed. I recounted to the inquiry that my father was asked numerous very inappropriate questions by the doctor, such as whether he slept with men, was a drug user, or slept with prostitutes These questions were deeply offensive to my father and mother and are an example of the insensitivity and lack of compassion shown to us.

5. Impact of Infection

My father experienced both mental and physical effects from the hepatitis which is a progressive and debilitating illness. These included chronic fatigue, yellow eyes, swelling, itching, and depression, ultimately requiring round-the-clock care.

My father's illness and death had a devastating impact on our family. I had to take on more responsibilities to support my mother, which affected my education and career plans. This is one example of the long-term impact on the family, extending beyond the direct victim.
Our family became socially isolated, and my mother was reluctant to discuss the illness and had a nervous breakdown. The stigma associated with the infection led to social isolation and psychological trauma.

My father was pressured to take early retirement from his job at the NHS, due to stigma around hepatitis and hygiene. He felt he was being discriminated against. Discriminatory treatment has been widely experienced by infected individuals.
The extreme stigma and fear surrounding the infection and illness even extended to his burial as no undertakers would accept his body which was an extremely harrowing experience for us.

The wider community impact of the stigma associated with blood-borne infections is demonstrated by another affected family in our area who were targeted, with their house walls being sprayed and children having to move schools due to bullying. This demonstrates the far-reaching consequences of the scandal, affecting entire communities.

6. Lack of Treatment and Support

My father did not receive any treatment, only routine follow-up appointments to monitor his deteriorating condition. I have questioned why my father was not considered for a liver transplant, but no one would answer that question. Doctors closed ranks and would not explain or disclose anything. The lack of treatment and transparency raises questions about medical negligence and a potential cover-up.

Neither my father, mother nor I received any counselling or psychological support which we really would have benefited from, especially given that my father worked within the NHS. The absence of psychological support highlights a failure to address the emotional needs of those affected. We were also not given any information about available financial assistance, showing a lack of support in helping us navigate the financial repercussions of my father's illness and death.

I faced significant obstacles in retrieving my father's medical records, having to persist through numerous applications and being told initially that no records were available, which suggests a systemic attempt to conceal information.
Medical institutions would not engage with my questions, so our family was left feeling very alone. (During the 1980's we didn't use the Web or Google, so we didn't know of others in the same situation). My persistence over the years unearthed various information on my father's cause of death. This process was debilitating and time-consuming, requiring me to be "very creative", such were the bureaucratic barriers and lack of empathy encountered by our family.

7. Way forward for David

Given my employment as Brand and Studio Manager at NHSBT, I am in a unique position to influence internal culture. I am committed to advocating for more compassionate and transparent communication, particularly with patients and their families. This commitment was further solidified at the end of last year when our family had a very poor experience with medical staff who were treating my sister-in-law at Kings College Hospital. I feel a strong personal commitment to improving the system from within.

I continue to work to promote the positive work of NHSBT, ensuring that the organization's public image reflects a patient-centred approach as I wish to balance accountability with a commitment to the organization's future.

My involvement with the Infected Blood Inquiry and engagement with campaigners demonstrates my dedication to seeking justice and systemic change. I aim to collaborate with patient advocacy groups to push for these changes within healthcare, promoting a more ethical and patient-centred approach. I hope this will help to prevent similar tragedies and encourage systemic reform.

I understand that this is a mammoth task but will continue to tell my family's story and hope that people's mindsets will change and that systems are put in place to make sure that the patient at the heart of any care is treated with compassion and empathy. This tragedy could have happened to any one of us.

I'm seeking the Board's support in achieving agreed objectives and would like to discuss any concerns regarding the resources, potential challenges, and implementation strategies to ensure the successful adoption of any recommendations.

8. Recommendations for NHSBT:

Some of the comments below might have been thought of already but thought I would mention this first. By implementing these recommendations, NHSBT can demonstrate its commitment to learning from the past, supporting those affected by tragedy, and ensuring a safer future for all patients.

This will involve a multifaceted approach, including not only systemic changes within the organization but also a commitment to ongoing dialogue with those affected and a willingness to be held accountable for progress. The organization must strive to become a leader in patient safety and compassionate care, setting an example for other healthcare providers to follow.

8.1 Patient-Centred Approach:

- Ensure that patients are at the heart of any care, with compassion and empathy.
- Implement systems that prioritize the patient's well-being and emotional needs.

8.2 Transparent Communication:

- Adopt a policy of full transparency and Candor when communicating with patients and families, especially in cases of adverse events.
- Provide clear, accurate, and timely information about treatments, risks, and potential complications.

8.3 Improved Support Systems:

- Establish comprehensive support systems for patients and families affected by adverse events, including:
- Access to counselling and psychological support.
- Information about available financial assistance and other resources.
- Assistance in obtaining medical records and other relevant information.

8.4 Learning from the Past:

- Acknowledge the failures of the past and take concrete steps to ensure that similar tragedies do not occur again.
- Implement robust systems for monitoring and reporting adverse events, and for identifying and addressing systemic risks.

8.5 Cultural Change:

- Foster a culture of openness, accountability, and continuous improvement within the organization.
- Encourage staff to speak up about concerns and to prioritize patient safety above all else.

8.6 Memorialization and Remembrance:

- Support the creation of a permanent memorial to honour those affected by the Infected Blood Scandal.
- Use the memorial as a tool for education and awareness, to ensure that the lessons of the past are not forgotten.

8.7 Collaboration and Engagement:

- Engage with patient groups, advocacy organizations, and other stakeholders to ensure that the voices of those affected are heard and that their needs are met.
- Collaborate with other healthcare organizations and government agencies to share best practices and improve patient safety.