

**NHSBT Board Meeting
Thursday 25th May 2017**

A Donor Story: The Duty of Care to our Donors

When someone donates blood to us we screen the donor for their haemoglobin level and screen the donation for microbiology and other haematology tests. Where these tests indicate that there may be a health issue in the donor we have a duty of care to them and follow these results up. We are not, however, a health screening service and these results are only ones that arise in the processing of donations. All results are managed by clinical teams of doctors and nurses and are largely unexpected by the donors.

The Microbiology Services Clinical Team is responsible for the care and onwards referral of donors who test positive for one of the markers of infection. The team comprises administrators, who are the first point of contact for donors, scientists, and a clinical team with expertise in infectious diseases and public health. We work closely with GPs, sexual health clinics and other specialist services including our colleagues at Public Health England to ensure that donors are followed up and given appropriate support and treatment. This includes the follow-up of donors with evidence of viral infection or syphilis, which has been well established for many years. Donors are invited to speak with the clinical team who will explain the results of the tests, answer any questions they may have and arrange referral to their GP or a specialist clinic. During 2011 bacterial screening was introduced for platelet components. This has been very effective at detecting contamination and preventing the issue and transfusion of affected components. When screening was first introduced there was little information from other blood services on what sort of bacteria we might detect or what a positive result might mean for the donor so we follow-up all donors with potentially significant results. We have led the world in this area. Here we describe a memorable case.

Mr F was a regular platelet donor who had given over 40 donations. The National Bacteriology Laboratory reported that *E. coli* had been isolated from all three of Mr F's platelet packs. This bacterium is usually found in the gut and we thought that this could be a 'one-off' event where the bacterium may have entered the bloodstream during apheresis donation, or could potentially be a sign of something more serious. On checking his donor record we also found that he had a recent note on his medical history about a low haemoglobin count. We contacted Mr F and explained that we had found bacteria in his platelet packs and that we thought he should be seen by his GP to make sure that he had no underlying gut problems. As with many of our apheresis donors he was usually fit and well and hadn't seen his GP in years but he was happy for us to contact his GP. Following additional blood tests Mr F was referred to the local gastroenterologist for further investigations including colonoscopy and scans. A mass was found in his colon, which after subsequent surgery, was confirmed as colon cancer which unfortunately had also spread to his liver. He was very

grateful that we had referred him to his GP; he said that this had allowed him to get his things in order, spend some time with his family and make the most of whatever time he had left. Mr F has since died; his story has been presented to several different audiences because it has informed our practice and made us more aware of the potential significance of something as 'ordinary' as *E. coli* but also because our donor wanted his story to be told.

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