

## **Guidelines for the Blood Transfusion Services**

### **10.5: Closing TTI investigations**

<http://www.transfusionguidelines.org/red-book/chapter-10-investigation-of-suspected-transfusion-transmitted-infection/10-5-closing-tti-investigations>

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Each investigation must be formally closed, with a conclusion and written notification to the reporter and any other interested party. In those cases where the recipient has been discharged from hospital, agreement should be reached as to who will notify the recipient: normally the GP or another clinician. It must be remembered that confidentiality of donor details is paramount and no information should be released which could lead, either directly or indirectly, to identification of any donor.

In cases of proven transmission, the recipient (or family, in the case of fatal cases) should be provided with an explanation of the cause of the transmission, and should be given the opportunity of a meeting with relevant staff, in keeping with Health Service guidelines following a serious adverse event. Details of legal implications and the availability of any ex-gratia payment schemes should be provided, as appropriate.

Each case investigated must be reported to the appropriate surveillance system: NHSBT/UKHSA transfusion-transmitted infection surveillance scheme for England and Wales, SNBTS National Microbiology Reference Unit for Scotland, Northern Irish Blood Transfusion Centre for Northern Ireland. These reports are collated and published in the annual report of the Serious Hazards of Transfusion (SHOT) scheme.