

Wednesday 23 April 2011

1

2 (9.30 am)

3

(Proceedings delayed)

4

(10.05 am)

5

THE CHAIRMAN: Good morning. Yes, Mr Mackenzie?

6

MR MACKENZIE: Thank you, sir. We continue with topic C1

7

this morning and the first witness is

8

Professor John Cash.

9

PROFESSOR JOHN DAVID CASH (sworn)

10

Questions by MR MACKENZIE

11

MR MACKENZIE: Good morning, Professor Cash. I would like

12

to look first at your CV, please, which will appear on

13

the screen. I think you may also have a hard copy

14

before you. The number is WIT0030353.

15

That is your CV, professor. We can see your full

16

name is John David Cash CBE. When and why were you

17

awarded the CBE?

18

A. Oh, dear, it must have been 1998/1999. Why? The

19

citation was: services to the Blood Transfusion Service

20

of the United Kingdom.

21

Q. Thank you. If we look at your education and academic

22

history, we can see you went to Edinburgh University.

23

You have graduated with a bachelor of science honours

24

degree in 1958. In 1961 you graduated with a bachelor

25

of medicine and you obtained a PhD in 1966. We can see

1 you are a fellow of the Royal College of Physicians in
2 Edinburgh and the Royal College of Pathologists. We can
3 also see you were a honorary professor in
4 Edinburgh University from 1987. Is that to date or have
5 you now retired?

6 A. I have retired.

7 Q. And we also see you were a visiting professor at
8 Sheffield University in 1994. You then list positions
9 held. We can see you were a member of the Medical
10 Research Council subcommittee on hepatitis virus B,
11 1970. Then in 1971 you joined the Southeast of Scotland
12 regional Blood Transfusion Service as a consultant and
13 you were in that post until 1974. Then in 1974 you
14 became the director of the Southeast of Scotland
15 Regional Blood Transfusion Service. You held that post
16 until 1979, when you became the medical director of the
17 SNBTS. You held that post until 1988, when in 1989 you
18 became the medical and scientific director of the
19 Scottish National Blood Transfusion Service and you held
20 that post until 1997.

21 In short, professor, what is the difference between
22 the medical director post you initially held and the
23 medical and scientific director post?

24 A. In short, the difference is that in 1988, on the advice
25 I gave to the Scottish Office, a general manager was

1 appointed as the first general manager of the Scottish
2 Transfusion Service and they insisted I had to change my
3 name, the medical and scientific director. But in terms
4 of function, in terms of medicine and science, there was
5 no change.

6 Q. Thank you. I should perhaps just check, professor, if
7 everyone in the back can hear you clearly. There are
8 nods there. I'm grateful, thank you.

9 A. I should say the reasons for this, as may or may not
10 emerge in the Inquiry, is there were really quite
11 significant and interesting management problems,
12 straightforward management problems until these were to
13 an extent resolved in 1989.

14 Q. Thank you, professor. If we can then turn over the page
15 in your CV, please, I should perhaps say, did you
16 retire, professor in 1997?

17 A. Hm-mm.

18 Q. And over the page we have a list of memberships of
19 various bodies. Could you, perhaps, professor, start
20 listing them for me, please?

21 A. Yes. I was a founding member, very founding indeed, of
22 the British Blood Transfusion Society.

23 Q. In 1981?

24 A. In 1981. Formerly all blood transfusion matters were
25 incorporated into the British Society for Haematology.

1 I persuaded some of my colleagues that we needed to go
2 alone for the development of transfusion medicine in the
3 UK. I was a member of the MRC research committee on
4 blood transfusion and that was a very sad story. It was
5 disbanded in 1982 in the middle of doing some very, very
6 important work.

7 I was a member of the DHSS expert advisory group on
8 AIDS and I regret to say I felt I had to resign because
9 the chairman of that group, who was a CMO in England,
10 advised that Cabinet Office officials were modifying the
11 minutes of this advisory meeting and I felt I couldn't
12 work in that environment.

13 I was a member of the European regional committee of
14 the International Blood Transfusion Society. I was
15 adviser on blood transfusion for the WHO for quite
16 a long period of time.

17 Q. Between 1980 and 2004, we can see.

18 A. Yes. I was a member of the UK standing advisory
19 committee on transfusion-transmitted infection. Between
20 1985 and 1997. I was a member of the executive
21 committee of the UK Transfusion Service operational
22 guidelines. This is the famous red book. It does not
23 appear in the preliminary report but the red book was an
24 initiative that had a profound effect and it was an
25 initiative that had its birth in Scotland.

1 I was chairman of one of the subgroups between 1990
2 and 1995. I was a member of the scientific policy
3 advisory committee of the UK National Institute for
4 Biological Standards and Control. Again, we call that
5 NIBSC for short. NIBSC was to play a major role in
6 enhancing the safety of all aspects of blood transfusion
7 in the UK. It was a great privilege for me to lead
8 those developments in this period of time.

9 I was a member of the university medical faculty
10 board from 1988 to 1993. I was a founding member of the
11 European Plasma Fractionation Association. This was an
12 association which we felt needed to be developed in
13 Europe because it was an association of those like
14 ourselves, state-run fractionation organisations, and
15 they didn't have a voice in the EU, whereas our
16 commercial counterparts did. So we established that.

17 I became a full board member of NIBSC in 1995 and
18 remained so until 2004. That again, was extremely
19 exciting work. We were heavily involved in further
20 developments in the transfusion field, in stem cell work
21 and in the development of UK and international standards
22 for PCR, for Hepatitis C, HIV and so on.

23 I have been external adviser on chairs and
24 readerships for London University from 1990 to 1995.
25 I was president of the Royal College of Physicians for

1 Edinburgh from 1994 to 1998. I was president of the
2 Blood Transfusion Society from 1997 to 1999.

3 Q. Thank you, professor.

4 Could we then move on, please, to your publications.
5 You list that you were the editor of a book, "Progress
6 in Transfusion Medicine", 1985 to 1990. You were also
7 a member of the editorial board of the scientific
8 journal Vox Sanguinis, 1980 to 1986. Over the page,
9 please. This is page 3 of the CV, please. We can see
10 at the top of the page peer reviewed scientific papers,
11 120. Is that 120 papers in which you were an author or
12 co-author?

13 A. Yes.

14 Q. Then we can see you were the author of several chapters
15 in surgical and medical textbooks. Then you go on to
16 list your professional experience and what's called
17 track record, and under "Scientific research" you set
18 out various matters which I won't dwell on today.

19 You then, under the heading "NHS management",
20 explain that during the period 1979 until 1997:

21 "I was a director of the SNBTS. This is a complex
22 multicentred organisation. Its annual budget in 1996
23 was approximately 28 million, a total staff of
24 approximately 1,100, involving interactions between
25 medical, scientific and nursing professionals and

1 a large multiskilled support staff."

2 Then you list the non-NHS management. Just beneath
3 that we can see:

4 "Between 1997 to 1999 I was president of the British
5 Blood Transfusion Society. Chairing a council whose
6 membership is multi-professional was especially
7 challenging, as did persuading the Society to change its
8 management structure and operational activities."

9 Then over the page, please, professor. We see two
10 final matters on the last page, page 4. We see first
11 international experience, and you explain that your
12 research activities and management role in the SNBTS led
13 to extensive travel outside the UK and the establishment
14 of good friends and colleagues in many countries and
15 much of that overseas activity was directed to
16 scientific communication and teaching.

17 You also explain you have worked for several
18 governments by way of advising them in blood transfusion
19 development issues, including the UK Government. A
20 study of the National Blood Transfusion Service in
21 England and Wales for the Secretary of State for Health
22 in 1998. Also the Republic of Ireland in 2003. Also in
23 Hong Kong, Malaysia, Canada, India, Bangladesh and
24 Denmark. Also on several academic visits to Australasia
25 you were invited to discussions with senior government

1 and Red Cross officials. Then finally under "Relevant
2 board memberships" there is reference, again, to the
3 NIBSC. Et cetera.

4 So I think we can now put your CV to one side.
5 Thank you, professor.

6 The topic today I would like to ask you some
7 questions about is labelled "C1" and to give it its
8 proper formulation for the benefit of the ladies and
9 gentlemen in the audience, the topic is formulated as
10 follows, namely:

11 "The acceptance of blood from higher risk donors, in
12 particular (a) prisoners and (b) donors who had
13 a history of jaundice."

14 Professor, I would like firstly, on the question of
15 collection of blood from prisoners, to look at some
16 statistics in that regard and firstly document, please,
17 [\[PEN0100026\]](#).

18 Professor, I don't think you have seen this document
19 before; rather it has been provided by the SNBTS as an
20 organisation in response to various queries by the
21 Inquiry and we can see in the first line it is stated:

22 "The following is the SNBTS corporate response
23 to..."

24 Various questions on this topic. If we go please to
25 question 2, about half way down the page, we can see the

1 question was asked:

2 "From which penal institutions in each region were
3 donations collected."

4 There is reference to a table attached, which we
5 will come to shortly. Question 3 was asked:

6 "Were donations from penal institutions put to any
7 particular use or did they simply form part of the
8 general pool of donations."

9 The answer is that:

10 "All donations collected from penal institutions
11 were treated in exactly the same way as donations from
12 any other donor session and formed part of the general
13 donor pool."

14 Is that correct?

15 A. Yes, absolutely so.

16 Q. And question 4 was asked:

17 "Were donations from penal institutions sent to the
18 protein fractionation centres for the manufacture of
19 blood products."

20 And the answer is:

21 "Yes, as donations from penal institutions formed
22 part of the general pool, they were treated in the same
23 manner as all other donations and were sent to the PFC
24 for processing."

25 Again, is that your understanding?

1 A. It is, indeed, sir.

2 Q. I'm grateful. Then over the page, please, I think this
3 should be page 0027. It's page 2 of the document. About
4 half way down, professor, the paragraph explaining:

5 "This table has been expanded to include donations
6 collected in the years 1971 to 1974."

7 So when we come to look at the tables shortly, we
8 will see that the statistics provided helpfully set out
9 the collections, I think, from 1971 to 1991 and we will
10 come to that shortly, but it is also explained here
11 that:

12 "No donation numbers are available from the
13 southeast RTC, Edinburgh region, for 1971 to 1974 and
14 the total number of donations collected in the northeast
15 region in Aberdeen in 1971 is not available."

16 If we go to the next page, please -- it is page 3 of
17 this document; the reference is 0028 -- we can see the
18 heading of this is "Prisons in each Scottish blood
19 transfusion region visited by SNBTS."

20 The left-hand column lists the BTS region and the
21 right-hand column, the various prisons. We can see in
22 the West of Scotland, I think, there were eight
23 institutions which were visited in the 1970s and 1980s.
24 In the southeast of Scotland and Edinburgh only Saughton
25 prison. In the east of Scotland, Dundee, there are four

1 institutions. In the northeast and Aberdeen there are
2 two. In the north and Inverness, simply
3 Porterfield Prison and Inverness.

4 If we could then go up to the next page of the
5 document again, this is page 4 of the document, court
6 book reference 0029. This table provides some context
7 for our Inquiry into the question of collection from
8 prisons. This table 2 is entitled "Donations collected
9 in each Scottish region 1971-1991".

10 The far left-hand column, the year is stated, from
11 1971 all you the way through to 1991. We then have the
12 total number of donations for each region, for
13 Edinburgh, Aberdeen, Inverness, Glasgow and Dundee. We
14 then see the column headed "Total Scottish donations".

15 The next column is the total number of prison
16 donations and then the final column are the percentage
17 of donations which prison donations formed compared to
18 the total donations. So very much by way of example.

19 If one looks to the year 1975, one can see the total
20 Scottish donations were 248,558. If one looks at
21 Glasgow, one can see that Glasgow collected
22 approximately half of the total Scottish donations. If
23 one then looks at the total prison donations, one can
24 see, of the 248,558 donations, we can see that prison
25 donations formed 5,915. As a percentage, that is

1 2.38 per cent.

2 If we go down to 1984, when the practice of
3 collecting from prisons stopped, we can see that the
4 total Scottish donations have gone up to 308,617. Again
5 we can see that Glasgow accounted for approximately half
6 of the total Scottish donations, but in this year the
7 number of prison donations were only 342. As
8 a percentage of the total that is 0.11 per cent.

9 If one then sticks with the prison donations total
10 percentage column, the far right-hand column, one can
11 see from a high of 2.38 per cent in 1975, there are
12 fluctuating numbers until the final percentage in 1984
13 is 0.11 per cent. I think if one does the arithmetic
14 between 1975 and 1984, the average percentage is
15 1.12 per cent in terms of the percentage of donations
16 overall in that period, which were collected from
17 prisons.

18 I think if one then goes over the page again,
19 please, to page 5 of the document, which is page 0030 in
20 the court book, this table is headed "The donations
21 collected at penal institutions in each Scottish region,
22 1971-1984". I won't dwell on this table but one can see
23 the number of donations from each of the regions and
24 perhaps unsurprisingly, I think, if we look at the
25 number of prison donations collected in the West, that

1 quite comfortably, I think, is greater than the number
2 of donations collected from the other regions, which may
3 perhaps at least partly reflect the fact that Glasgow
4 was collecting about half of the total Scottish
5 donations in any event. And for completeness we can
6 see, the far right-hand column, the northern RTC in
7 Inverness, no figures are available at all. A reason is
8 given for that which we will come to shortly.

9 We can put that document to one side, please,
10 professor, and simply to complete this look at the
11 statistics. If we could next, please, look at document
12 [\[PEN0100003\]](#). This is a similar document, in that if
13 one looks at the first line again, this is a corporate
14 response which has been provided by the SNBTS. I think
15 again, perhaps, professor, you haven't seen this
16 document before either?

17 A. No.

18 Q. If we look at paragraph 1, this explains how the
19 statistics have been compiled. Paragraph 1 stated:

20 "The total amount of blood collected annually from
21 penal institutions by southeast, west, east and
22 northeast RTCs in Scotland between 1975 and 1984 are
23 shown in table 1. The data are presented as number of
24 donations. The data were collect in total for each year
25 by trawling through donor cards and donor session

1 records, which were stored under the management of each
2 RTC."

3 Then:

4 "The north of Scotland RTC Inverness has no donor
5 card nor donor session records dating from this period
6 as all records were destroyed in a flood in
7 Craig Dunain Hospital."

8 Then paragraph 2 explains:

9 "The total amount of blood collected annually by
10 each Regional Transfusion Centre in Scotland between
11 1975 and 1991 is shown in table 2."

12 The second bullet point explains:

13 "The total donation figures were taken from a report
14 provided by SNBTS microbiology reference unit
15 in April 1994."

16 They explain the provenance of those figures. Over
17 the page, please, at page 2 of this document, which is
18 court book reference 0004, and about a third of the way
19 down the page, professor, a sentence commencing:

20 "The data indicate the number of screening tests
21 performed by each of the five SNBTS testing laboratories
22 and represent total donation numbers, including failed
23 or part donations and also those that failed
24 on haemoglobin levels. Therefore, the numbers are
25 higher than the number of usable donations."

1 The next sentence states:

2 "The total number of screening tests performed has
3 been estimated to be on average between 5 and 6 per cent
4 higher than the number of usable donations."

5 That's really making the point that one should look
6 at the number of usable donations perhaps rather than
7 the actual total donations collected.

8 I think if we could then, please, professor, go to
9 page 6, which is court book reference 0008. Essentially
10 what the document now does is for each region it sets
11 out the total donations in each region, the number of
12 donations from prisons and the percentage from prisons
13 for each region. So by way of example, table 3 in the
14 Glasgow West of Scotland region, again the left-hand
15 column provides the year, the next column, the total
16 donations for each year, the next column is the number
17 of prison donations for Glasgow and the West, and the
18 next column is the percentage of prison donation rates.

19 Sticking with Glasgow and the West, we can see that
20 the percentage of total donations from prisons was
21 a high of 2.83 per cent in 1975 down to a low of
22 0.23 per cent when the practice finished in 1984.
23 Again, if one does the arithmetic, there is an average
24 percentage of 1.376 over those years in terms of the
25 percentage attributable to prison collection compared to

1 total numbers, and I think we have seen earlier the
2 Scottish average overall was about 1.12 per cent. So
3 fairly close to the Scottish average.

4 If one goes over the page, please, at page 7 of the
5 document, this is a similar figure for Edinburgh and the
6 Southeast of Scotland, and again, perhaps looking at the
7 percentage prison donation rate, a high of 1.37 per cent
8 in 1975 down to a low of 0.23 per cent in 1981, the year
9 in which the last collection took place. If one does
10 the arithmetic, the Edinburgh average is 0.67 per cent.

11 Just to complete this exercise, please, professor,
12 over the page again, page 8, which is court book
13 reference 0010. This is a similar table for Dundee and
14 the East of Scotland. We can see in Dundee in 1975
15 a high of 3.1 per cent down to a low in 1983 of 1.02.
16 I think the average there, if one does the arithmetic,
17 is 2.22 per cent, which is perhaps a little higher than
18 the Scottish average in terms of the percentage of the
19 total Dundee collection.

20 Then a similar exercise finally with Aberdeen on the
21 next page, if we can go to that. It is page 9 of the
22 document. We see for Aberdeen, similarly, in 1975
23 a high of 2.67 per cent in terms of the prison donation
24 rate and then in 1983 the final percentages is 0.51, the
25 Aberdeen average is about 1.19 per cent.

1 Then finally, professor, to this document, the next
2 page, page 10 of the document. This table shows the
3 date and location of the last prison donor session in
4 each RTC and I think Edinburgh was first to stop. Their
5 last collection was on 22 December 1981 at Saughton.
6 Inverness, the last session was 24 February 1983.
7 Aberdeen was 28 July 1983. Dundee was 2 August 1983 and
8 then Glasgow, finally, 25 March 1984.

9 Thank you, professor. I think that completes the
10 introduction to put what follows in some context.

11 Professor, I think you have also provided
12 a statement to the Inquiry on this topic. I would like
13 to go through that with you, please, and ask you various
14 questions. The reference number for this is
15 [\[WIT0030120\]](#). Is this the statement you provided,
16 professor?

17 A. It looks very like it, sir, yes.

18 Q. I think you may have a hard copy of it as well?

19 A. I do indeed.

20 Q. Feel free to look at that. Personally I find it easier
21 to look at a hard copy I have to say. So feel free to
22 do that. The first two questions we have dealt with
23 already. They concern statistics. So we can ignore
24 them. Over the page, please, at page 2, at the top of
25 page 2 you say:

1 "I would advise that placing these annual figures in
2 context with those above should be done with some
3 caution. More appropriate data may be available from
4 SNBTS which would allow a better view of the way prison
5 donations supported the supply of red cells in the early
6 1980s, at critical but short periods throughout the
7 year."

8 I think, professor, you are suggesting some caution
9 in looking at the bare statistics in themselves. Can
10 you explain that, please?

11 A. Yes. Indeed. I think if you found in a region -- and
12 at some time they would all fit into this scope -- that
13 the prison donations were used at certain times in the
14 year, in some instances to plug a gap in terms of the
15 supply from the non-prison population, and so you may
16 find -- like, for instance, there were 342, I see, for
17 Glasgow in its last year -- this might have been
18 a collection that covered half a week. So you see it in
19 terms of an annual. You think it is only 0.22 per cent.
20 It is a very insignificant. In fact, for that week I'm
21 simply saying it might have been more than half their
22 supply and critically important.

23 I do remember vividly that when we had our heated
24 debate, to which I refer, it was made very clear to
25 me -- and I still remember it very clearly -- that

1 Dr Mitchell made it very clear that his prison donor
2 sessions, he believed, were extremely important during
3 the period of the Glasgow Fair. Not being a Glasgow
4 man, I wasn't terribly familiar with that but clearly he
5 used to tell us how the whole of the West of Scotland
6 disappeared off to Blackpool and as a consequence of
7 which there were really quite significant problems for
8 them.

9 So they targeted, he said, their prisons in that
10 way. So all I'm saying is, if you look at it annually
11 it looks rather small. If you take a really short
12 period of time and link up to these when the sessions
13 took place, I'm simply saying you may get a completely
14 different picture in terms of the importance in the
15 concept of blood shortages and so on, that's all.

16 Q. I understand, and certainly Dr Mitchell gave some
17 evidence to that effect yesterday.

18 A. Really? I'm very relieved.

19 THE CHAIRMAN: Just before you leave, I'm interested in that
20 observation, Professor Cash. Does it follow that simply
21 to take the annual average would underestimate the
22 impact in terms of risk of taking blood from prisons
23 since it would have tended to be concentrated in short
24 periods of time, rather than spread over the year?

25 A. Yes, I think that is possible, sir. I think -- that is

1 a possibility.

2 THE CHAIRMAN: It is the other side of the coin.

3 A. Indeed.

4 MR MACKENZIE: Yes. So perhaps, professor, if you were in
5 Glasgow during the trade period and needed
6 a transfusion, you perhaps have a higher likelihood of
7 receiving prison blood?

8 A. Indeed, that's the point, I think, Lord Penrose was
9 making.

10 Q. Yes, thank you.

11 Then question 3, professor, we have looked at this.
12 Question 3 asked when the practice of collecting blood
13 from penal institutions stopped in each region in
14 Scotland. There is one inconsistent figure. For
15 Edinburgh the reply here states 7 April 1980, whereas
16 the table we looked at previously said December 1981.
17 Is the table more likely to be correct?

18 A. Much more -- I need to be careful, sir. I'm just
19 handing information there, from a very distinguished
20 doctor, Anne Welsh. There may be the hiccup. I was
21 just transmitting information that I was given. So I'm
22 really not in the best position but I'm pretty certain
23 that the data we have seen has been carefully looked at
24 and was collected later and is more likely to be
25 accurate, but I couldn't swear that.

1 Q. I think Dr McClelland also spoke to the September 1981
2 date as well. We also see for completeness, Belfast,
3 their last collection from a prison was on
4 26 October 1983 as well. I think that's new information
5 for us. Then question 4, professor, asks:

6 "Why did the practice stop?"

7 You explain:

8 "It may be helpful to acquire information from those
9 regional centre directors who are still alive. But it
10 can be assumed that it had much to do with the comments
11 of the MCA inspectors."

12 Who are the MCA inspectors?

13 A. The Medicines Control Agency. We called it the
14 medicines inspectors, the MIs, and they were an integral
15 part of the DHSS down in London. For us they were the
16 key auditing people against the background of the
17 Medicines Act 1968. They came and inspected us.

18 Q. Can you explain to us a little what the medicines
19 inspectors did and the role their body played at the
20 time?

21 A. I can tell you what they did; their role I can give you
22 an opinion. I should add that this was the cutting edge
23 of inspections into blood transfusion in the UK. In the
24 period 1975 to 1980 we interacted with the inspectors
25 because it was made absolutely clear from the

1 Scottish Office that both the fractionation centre at
2 Liberton and the Regional Transfusion Centres would have
3 to fall in line with the Medicines Act in terms of
4 regulatory control. That meant that we needed to get
5 a manufacturing licence for these establishments and
6 thereafter product licences. And the medicines
7 inspectors played the key role in determining whether
8 they were satisfied that the facilities we had, the way
9 we were conducting our processes and so on -- they had
10 to be satisfied before there was issued a manufacturing
11 licence.

12 My understanding was product licences followed that
13 and these submissions went to the
14 Committee on Safety of Medicines, but the inspectors --
15 and no doubt they were advising there -- played the
16 major role in the issuing of manufacturing licences and
17 one of the fundamental problems we had, all of us, was
18 that we, in 1975, when we were told we had to go down
19 this track, we, as transfusion folk, knew very little
20 about good manufacturing practice to be honest.

21 By the same token it was very quickly evident to us
22 that the inspectors knew nothing about blood
23 transfusion. As a consequence of which I invited the
24 senior inspector, a chap called David Haythornthwaite,
25 to spend a week or ten days up in Scotland in which we

1 looked closely as what we got up to and at the same time
2 he began to teach us about the orange guide about good
3 manufacturing practice in general. When this was all
4 completed, we learned a huge amount and at that point
5 the inspections from which the prison story emerged took
6 place.

7 So these inspectors were inspecting against
8 standards that at that time had not been delineated.
9 This is for the Regional Transfusion Centres. The
10 ultimate was, as I was saying, they were asking the
11 question: are we going to issue a manufacturing licence
12 to Edinburgh centre, Glasgow and so on.

13 Q. I think you used the expression "good manufacturing
14 practice". Did that have a particular meaning, say in
15 1975? Equally in 1982, did that have a particular
16 meaning?

17 A. I would be unsure about this. I have only recently
18 discovered from my good friend Dr Peter Foster, that the
19 original guide, the government's orange guide, which is
20 for the pharmaceutical, hospitals pharmaceutical
21 industry and so on in terms of good manufacturing
22 practice -- he tells me that in fact the guide was not
23 yet created in 1975. Some time between 1975 and 1980
24 the orange guide on GMP was actually created.

25 For Regional Transfusion Centres there was the

1 additional thing, which came later, and that was the red
2 book, because the inspector was the man that drew our
3 attention to the fact that every transfusion centre he
4 went into had different approaches to delivering their
5 production of X, Y and Z, and it was he that persuaded
6 me that we had to develop a UK approach.

7 Q. Is it essentially a term of art? Is it to do with their
8 standard operating procedures and so on?

9 A. Standard operating procedures, also specifications of
10 materials coming in. I'm not a fractionator but the GMP
11 is about documentation; it's about specification.
12 I mean, documentation of the whole process, right
13 through to auditing and batch release. The question of
14 how you in fact specify your products, and if you want
15 to change a bit of a process, there is very strict rules
16 as to who is responsible for that and documentation that
17 it needs to be done.

18 Q. So good manufacturing practice is about achieving
19 certain objectives, standards and documentation and that
20 has been done, that sort of thing?

21 A. Yes, indeed. And certainly we took a view that it had
22 a major effect on the safety of the products that were
23 coming through.

24 THE CHAIRMAN: Professor, you have just indicated that you
25 have had some recent information from Dr Foster.

1 A. Yes.

2 THE CHAIRMAN: So you may not be the person to know the full
3 range of published guidance --

4 A. You are absolutely right.

5 THE CHAIRMAN: -- at any time.

6 Mr Mackenzie, I think that somehow or other we have
7 got to try and sort out what books were around because
8 witnesses are going to get into trouble. I have
9 a reference from Dr Mitchell to a red book in 1975 at
10 a time that Dr McClelland tells me there wasn't a red
11 book. So somehow or other, if we can take this out of
12 contention by getting a reasonable picture, it would be
13 to everybody's advantage. I don't know who can do that
14 best. Mr Anderson, you might be the person to procure
15 it for me?

16 MR ANDERSON: When you say --

17 THE CHAIRMAN: In other words, I don't expect you to know
18 but someone behind you might find out.

19 MR ANDERSON: When you say procure it, the information or
20 the book itself?

21 THE CHAIRMAN: The information, but the book would be far
22 better because we could hold it up and people wouldn't
23 be confused.

24 MR ANDERSON: We can look into that.

25 MR MACKENZIE: Between the Inquiry team and Mr Anderson's

1 team I'm quite certain we can produce an objective list
2 with references to the various books and documents at
3 various stages.

4 THE CHAIRMAN: Thank you.

5 A. I should point out, sir, that the red book, and no doubt
6 the orange guide, there are current editions and I'm
7 clear from what you say, sir, you want to know when
8 edition one started, and that's well-known among the
9 people that are in the game. I was responsible for the
10 first issue of the red book. I can't remember what date
11 it was, I am afraid.

12 MR MACKENZIE: I think, as well, sir, we will come to --

13 A. But it will be available.

14 MR MACKENZIE: I will come to some guidance documents with
15 Professor Cash. I think I'll try and avoid the use of
16 colours and stick to titles and dates and I might be
17 able to pin things down as well.

18 THE CHAIRMAN: I think that might be a great help because
19 undoubtedly the documentary records do confuse
20 expressions from time to time and it is not helpful,
21 certainly not helpful to the witness that is confronted
22 with a quotation that doesn't fit with one's
23 recollection.

24 MR MACKENZIE: I'm grateful, sir.

25 Returning to your question 4, please, we were

1 looking at why the practice had stopped and you provided
2 some helpful background to the medicines inspectors'
3 visits in 1982. Just starting again, you say:

4 "But it can be assumed that [the practice stop] had
5 much to do with the comments of the MCA inspectors,
6 (though this issue was not raised at the Glasgow,
7 Inverness, Aberdeen or Northern Ireland inspections);
8 the lively/heated discussions of the directors at their
9 meeting on 29 March 1983, when no consensus was
10 achieved; and subsequent regional reflections on ways of
11 sustaining supplies without prison sessions. What is
12 more certain, however, is that these dates do not derive
13 from a national (SNBTS directors') management decision
14 because such decisions required consensus or an
15 instruction from SHHD ..."

16 That's the Scottish Home and Health Department.

17 "Neither was forthcoming. What we did do, as did
18 the MCS inspectors, was seek guidance from the DHSS.
19 None came."

20 I think it would be helpful for us to follow the
21 chain of documentation at that time, ie in 1982 and
22 1983. I can perhaps ask you various questions which
23 arise from the documents.

24 I think perhaps the first place to start, please, is
25 document [\[SGF0010086\]](#), which we will shortly see. It is

1 a report of the medicines inspectors following their
2 visit to Dundee in 1982. We will see that shortly.

3 The writing is fairly faint but we can see top of
4 the page states:

5 "Visit to East of Scotland Blood Transfusion
6 Service, Dundee (Nine Wells Hospital)."

7 The date is 25 March 1982. We can see the
8 inspectors are Mr Ayling and also Mr Haythornthwaite we
9 referred to earlier. In paragraph 10, please, we can
10 see the inspectors state:

11 "The brief discussions were also held on sources of
12 donated blood. At the time of this visit, the
13 inspectorate had not visited donor sessions with mobile
14 teams, however, it would seem most unlikely that we
15 could continue to endorse the continued collection of
16 blood from such places as prisons and borstals."

17 Paragraph 11:

18 "This recommendation is based on the following:

19 "12(a) prison medical officers are often not
20 involved in assessing the suitability of donors;

21 "13(b) the increased risk of infection associated
22 with prison populations and the increased risk of
23 transmitting disease through such donations;

24 "14(c) the unreliable answers to the pre-donation
25 questionnaire that can occur in such environments, as

1 well as the motivation of some of the donors."

2 So essentially, professor, three main reasons given
3 by the inspectors for their concern as to the practice
4 of collecting blood from prisons and borstals. Can you
5 remember, professor, at the time when you first saw this
6 document and you saw these comments, what was your
7 initial response to each of their concerns or the
8 reasons for the concern listed by the inspectors?

9 A. To be absolutely honest, I can't remember at all. It is
10 so far back. Certainly, when we debated the issue, the
11 heated debate, I happened to be on the side of pulling
12 out of prisons, but I don't think we should put any
13 stock on that, that I remember that, but I don't recall
14 seeing this document.

15 There were problems in terms of my seeing this
16 document. It has not emerged in the preliminary report
17 but there was a great tension between the Scottish Home
18 and Health Department civil servants and the whole
19 concept of the inspectors, and there were instructions
20 given to us that we should not be dialoguing apart from
21 the particular day when they inspected -- and I wasn't
22 there, I left this to the team -- with the MCA
23 inspectors. It was up to the Scottish Home and Health
24 Department to do that. So there was a problem of
25 a communication difficulty. That said, to be honest,

1 I'm not entirely -- I have no recollection of seeing
2 this report. I'm sure I did but ...

3 Q. I'll just continue with the chain of documentation.

4 A. I do apologise.

5 Q. No, it may help. The next document, I think, is
6 [\[SNB0087582\]](#). The next document I think I would like is
7 [\[SNB0087582\]](#).

8 I think we can see, professor, this is a letter
9 dated 4 June 1982, addressed to yourself and we will
10 come to see from the last page, shortly, that it is from
11 Mr Haythornthwaite of the Medicines Inspectorate. We
12 can see he writes:

13 "Dear John, inspection reports. I have enclosed
14 copies of the draft reports for your attention. Perhaps
15 I might make a number of observations which may be
16 disconnected but nevertheless apply to many centres."

17 If we go to the next page, please, which is
18 reference 5783, in paragraph 7(a) it provides:

19 "Source material. I have not observed donor
20 sessions under the worst conditions, however, I wonder
21 whether certain high risk areas are necessary or
22 desirable. Prisons and detention centres would seem to
23 come under this category and I would be interested in
24 your views on this."

25 So the question of the practice of collecting blood

1 from prisons and borstals is one of, I think, the issues
2 which may apply to a number of centres. It wasn't
3 simply to do with Dundee, I don't think.

4 A. No.

5 Q. We can see some handwriting at paragraph 7, professor,
6 and in particular:

7 "Is the concern prisoners or prison environment?"

8 Do you recognise that writing?

9 A. I don't actually. I apologise. I don't. I can be
10 fairly sure it's not mine.

11 Q. Certainly, when we heard from Dr McClelland yesterday
12 and he explained why Edinburgh didn't go back to collect
13 in Saughton prison, he explained that both of these
14 concerns were relevant; both the question of collecting
15 from prisoners but also, I think, Dr McClelland's member
16 of staff who organised collections was uncomfortable in
17 putting the staff into the prison environment to
18 collect.

19 I think the next link in the chain is reference
20 SNB0011983. There is, professor, a letter -- I am
21 afraid we don't have it in the court book system but
22 what I'll do is read out the relevant passages and then
23 perhaps hand it to you to have a quick look at it as
24 well.

25 It is simply a letter dated 5 July 1982 from

1 yourself to Mr John Watt, who was the director of PFC.

2 A. Yes, I think I know that letter.

3 Q. The letter is headed "Dear John, Medicines Inspectorate
4 report."

5 You say:

6 "You will no doubt have received a copy of a letter
7 to me from Mr Haythornthwaite dated 4 June 1982. There
8 are one or two items which emerge from this letter which
9 I believe deserve our collective national attention.
10 These can be summarised as follows."

11 In item 7 you say:

12 "We need to consider formally, in the not too
13 distant future, the question of sessions in prisons
14 et cetera. I would very much welcome your comments as
15 to whether we should abandon this practice."

16 I'll pass this letter to you, professor. I think it
17 is sufficient at this stage just to let the professor
18 have a look at it.

19 A. I'm familiar with that. (Handed)

20 Thank you.

21 Q. It may be we have a different number for this letter.
22 So I'll try again, professor, with this. [\[SNB0056703\]](#).
23 That way maybe everyone could see it.

24 Yes, that's the letter. We can all now see. I'm
25 grateful to Mr Di Rollo for that.

1 So in short, professor, you sent Mr Watt at PFC
2 a copy of Mr Haythornthwaite's letter and asked Mr Watt
3 for his views on the practice of collecting in prisons.

4 Did you receive any response from Mr Watt, do you
5 recall?

6 A. I don't. I can't recall now, sir. Knowing John, I'm
7 sure I did get one but I don't recall it.

8 Q. If you don't know the answer to this question, please,
9 of course, say so, but can you recollect whether Mr Watt
10 was in favour of collecting from prisons, whether he was
11 against it or whether he didn't have a view on it?

12 A. I can't recollect, sir.

13 Q. I see. Now, the next document in this chain, professor,
14 is a minute of the directors' meeting on 29 March 1983,
15 and this is reference [\[SGF0010234\]](#).

16 THE CHAIRMAN: I think you may have responded to the
17 inspectorate in the interval. In November 1982. Would
18 that be possible?

19 A. Yes, I do recall writing to David Haythornwaite and got
20 into terrible trouble for it, sir -- directly to David
21 Haythornthwaite, but that was the point, as I recall,
22 when we had discussed it and I had said to David, "We
23 couldn't get a consensus but we are going to see if we
24 can work this through and come back to you later," and
25 I suspect that's after the meeting which your colleague

1 is about to talk about.

2 THE CHAIRMAN: The letter I have in mind is [\[SGH0035165\]](#),

3 Mr Mackenzie. I have not got full details of it.

4 MR MACKENZIE: Perhaps we can see if we can bring that

5 letter up, sir. I'm sorry, I missed the number,

6 I apologise.

7 THE CHAIRMAN: [\[SGH0035165\]](#).

8 A. Very helpful, sir, yes, thank you.

9 MR MACKENZIE: Thank you.

10 A. That's the 29 March 1983 meeting.

11 MR MACKENZIE: I'm grateful. We can see, professor, the

12 bottom left-hand corner in this document is

13 dated November 1982 and we can see the title of the

14 document is:

15 "A general response by the Common Services Agency of
16 the Scottish Health Service to the inspection of SNBTS
17 Regional Transfusion Centres by officers of the
18 medicines division."

19 My recollection from having looked at this
20 documented some time ago, I think, is that there is no
21 reference in this document, in this response, to the
22 question of collection in prisons. Do you have any
23 recollection of that, professor?

24 A. I think that's right. This is a document I prepared to

25 brief the Blood Transfusion Service committee of the

1 CSA, and I am reasonably certain, you are quite right,
2 that I made no reference. There were some big, big
3 other issues and I suspect this was a casualty, yes.

4 Q. What were the big other issues which were perhaps in the
5 forefront of your mind at this time?

6 A. Well, as an example, as I recall, the inspectors had
7 never seen plasma processing accommodation as bad in all
8 its experience as we saw in Edinburgh. A major issue
9 developed with the Scottish Office that major
10 investment, capital investment, was going to be required
11 to keep us on track with self-sufficiency.

12 Q. And, professor, did that apply to what was happening at
13 the Edinburgh Regional Transfusion Centre or PFC?

14 A. No, no, no, the Edinburgh transfusion centre. There
15 were other issues with PFC and that is that in PFC's
16 visitation medicines inspectors had seriously criticised
17 the accommodation. I can't recall the details but
18 Dr Peter Foster does, and Bob Perry: the accommodation,
19 storage things and all sorts of things, again massive
20 development in investing in capital buildings, and this
21 didn't happen. This was in 1982/1983. This didn't
22 happen until 1988/1989/1990. So these were major issues
23 in which great concern developed in the Scottish Office
24 with regard to the activities of the
25 Medicines Inspectorate and the impact it was going to

1 have on budgets and treasury and so on and so forth.

2 I think, to be honest, there is another document
3 somewhere in the CSA which is all about the buildings
4 and so on and so forth.

5 Q. Yes, so the buildings, and in particular the Edinburgh
6 Regional Transfusion Centre building, required capital
7 expenditure?

8 A. Indeed. Historically, it needed a new centre and I was
9 responsible for all this because I was doctor there and
10 was so determined that we got our plasma going we
11 finished up processing plasma in the cellars of
12 a building near the old Royal Infirmary and the
13 inspectors, when we finally arrived, were horrified, and
14 quite rightly.

15 THE CHAIRMAN: Just as us back to Lauriston.

16 A. Indeed.

17 THE CHAIRMAN: But going back to the topic that we are
18 dealing with, one shouldn't draw any inferences from the
19 failure to deal with blood from prisons in this document
20 because its focus was on something quite other than
21 that.

22 A. I'm saying that that is a possibility.

23 THE CHAIRMAN: A possibility?

24 A. Yes, no more than that.

25 MR MACKENZIE: I'm grateful, sir.

1 So this document does form part of the chain of this
2 line of documentation but you have explained why the
3 question of collecting blood in prisons doesn't appear
4 in this particular document. But if we could then,
5 please, go to a document where that practice is
6 discussed and this is the document [\[SGF0010234\]](#). We can
7 see from the heading these are the minutes of
8 a directors' meeting held in SNBTS headquarters unit on
9 29 March 1983. Professor, at this time how often,
10 approximately, did the directors meet?

11 A. I think every two to three months. I have forgotten,
12 sir, but it was pretty regular. And we had a facility
13 if there was a hot thing -- we would have extraordinary
14 meetings if necessary to keep the impetus going.

15 Q. And we can see from those present that you were there,
16 chairing the meeting, and we can see a list of the
17 Scottish transfusion directors. We can see, I think,
18 see Dr Bell and Mr Wastle from the Scottish Home and
19 Health Department. In general, what role did officials
20 from the SHHD play at these meetings?

21 A. Well, I imagine technically, sir, they were there as
22 observers, but one thing is absolutely sure, that
23 Dr Bell, whom I got to know extremely well, would not
24 hesitate to give me a call before a meeting, because he
25 had the agenda papers to discuss items on the agenda so

1 that I got a feel as to the department's view of certain
2 topics. This was not frequent but it was an avenue
3 which he used.

4 Similarly, I could anticipate that the next day, or
5 the next to or three days after the meeting, Bert would
6 phone me, not always, to discuss what he had listened to
7 in the context of their normal practice; they were there
8 as observers. It was, however, evident at this
9 meeting -- I think I put in my witness statement -- that
10 Bert Bell made it pretty clear to us that the Department
11 of Health were a little unhappy that the inspectors had
12 wandered into this donor area. This was the debate we
13 had about prisons. This actually emerged.

14 There are papers that you have in your big database
15 here in which Dr Boyd Moir in the Department of Health
16 interacts with David Haythornthwaite, and it is an
17 interaction expressing concern that the inspectors are
18 moving into the area of the donor environment. And
19 David Haythornthwaite -- I have a copy of this -- makes
20 it abundantly plain that he feels -- I happen to agree
21 with him -- he felt that it was very important in terms
22 of inspections and manufacturing licence, that they
23 actually looked at the source of where the blood and so
24 on, plasma, is coming from.

25 Q. So there was a bit of a debate at the time, perhaps?

1 A. There was a debate.

2 Q. About the role and locus of the inspectors, whether they
3 should stick to questions of good manufacturing practice
4 or whether they were also entitled to look at issues of
5 donor selection.

6 A. Yes, I mean, it wouldn't be good manufacturing practice,
7 it would be sticking to the areas of donation testing
8 and plasma processing. But the whole business of the
9 selection of donors and so on and so forth was viewed in
10 some quarters at that time -- it all eventually changed,
11 as it wasn't appropriate. And I think this was a part
12 of the complexity of this particular problem in relation
13 to prison donations.

14 Q. Albeit, professor, looking at matters this way, did it
15 really matter what the correct locus of the inspectors
16 was, in that if they made certain comments, surely the
17 bottom line was whether these comments or concerns were
18 valid or not? In a way did it matter who was making the
19 comment?

20 A. I think to some extent that is quite right. I would
21 agree with it. Having said that, I inherited, as all my
22 colleagues there did, a service in which the Department
23 of Health in London in fact dictated the whole business
24 of donor selection as you, I know, are aware. The CMO
25 in London issued this, and you might ask, "What on earth

1 was he doing that for? What was his involvement?"
2 There is a excellent document from Dr -- ultimately sir
3 William Maycock, dated 1966, in which he describes the
4 organisation of the transfusion service. In many ways
5 he describes the whole question of donor selection and
6 so on as a matter that is national and will be
7 considered by the Department of Health in London.

8 So there was no question about it that when I became
9 a director and subsequently national director, we tended
10 to say that the Department of Health will tell us what
11 to do there. By 1985, in the height of the AIDS
12 disaster, we, the Scots, decided to break loose and
13 develop our own guidelines, because the department in
14 London wasn't able to move quick enough for us.

15 You are absolutely right, I think. We discussed the
16 issue and in fact, as you will see emerges, people went
17 home and spoke to their donor organisers and said, "We
18 are going to get out of prisons". We didn't make
19 a policy decision. Those individual doctors decided to
20 do that.

21 Q. Yes, professor, I will come back at the appropriate
22 stage in your statement to look at specific donor
23 selection guidance documents and to see who drafted
24 them, to look at the respective roles of Government and
25 the Blood Transfusion Service, but sticking, if I may,

1 with this line of documentation just now and going back
2 to the minutes of this meeting. This is a point of
3 detail but if we look at those who were present, we see
4 two Dr McClellands. There is a Dr D B L McClelland, who
5 I think is a Scottish McClelland at Edinburgh?

6 A. That's Brian, yes.

7 Q. There is also a Dr W M McClelland. Was he
8 a Northern Irish director?

9 A. He was indeed.

10 Q. We should perhaps bear that distinction in mind if we
11 are looking at future documentation.

12 Could we then please go to page 0238, which is
13 page 5 of the minutes. In paragraph 7, if we could
14 perhaps blow that up. Paragraph 7 is entitled "Blood
15 collection in prisons and borstals":

16 "Professor Cash reported that the medicines
17 inspector had commented adversely on the practice of
18 collecting blood in prisons and borstal institutions and
19 he invited doctors to comment on the practices in each
20 region, and to give their views on the medicines
21 inspector's criticism. It was reported by all directors
22 present that sessions were held in penal institutions in
23 all regions, although Dr Brookes and Dr Urbaniak
24 intended to review the situation in their regions. It
25 was not possible for the directors to agree on future

1 policy but it was agreed that Dr Brookes, as the
2 Scottish representative, should ask the working party on
3 the selection and care of blood donors to consider this
4 issue. In the meantime, D Cash agreed to inform the
5 Medicines Inspectorate of these SNBTS discussions and
6 conclusions."

7 Do you, professor, have any recollection of that
8 meeting and this discussion?

9 A. Yes, but I'm not sure. It is going to be very helpful
10 to you. My main recollections were that I was not the
11 boss, that all consultants are equal, that I was merely
12 there to co-ordinate and chair; that individual regional
13 directors had the authority to stick to their view and
14 so on and so forth. That was one of the main things.

15 I remember it being very heated because my old
16 friend Dr Mitchell was very concerned that if this was
17 precipitously implemented, he would run into problems of
18 blood supply. These were regarded as local matters and
19 we respected his position at that time.

20 Q. Can you explain that a little more, professor, in that
21 we know at this time you were the medical director of
22 the SNBTS, and on the face of it it may come as
23 a surprise to those not involved to hear you say that in
24 a discussion of this issue you felt you were not the
25 boss. Can you explain that a little more, please?

1 A. Yes, there are documents, plenty of documents, available
2 in your database in which I write to the CSA and the
3 department and we have letters back from them. In
4 actual fact, trying to get clarification as to my
5 management role in the SNBTS at that time, and what
6 clearly came back -- and I had long discussions with
7 Graham Scott, the deputy chief medical officer -- was
8 that I was the first among equals.

9 Eventually, I took the view -- this is much later in
10 the 1980s -- that this wasn't, when we were running into
11 really serious difficulties, going to work and we needed
12 a general manager and they changed the management
13 structure; hence the change that I alluded to earlier
14 on.

15 So I was there chairing a meeting, and if we didn't
16 get consensus and all agreeing there was no way on
17 a particular issue we could go forward. Looking back,
18 the wonderful thing is in the main we nearly always did
19 get consensus, as a result of which we were enormously
20 successful in many other areas.

21 MR MACKENZIE: I think it is almost time to take a break,
22 but perhaps there is one or two final questions to
23 conclude. This minute, professor, is what you have
24 explained a situation of while there is a National Blood
25 Transfusion Service, the regions have a certain amount

1 of autonomy?

2 A. Yes, absolutely. And that was very, very clear and did
3 not change, compared, however, to our colleagues and
4 friends south of the border, because we were coming from
5 single budgeting money into the service, there was huge
6 opportunities for us to collaborate closely together.
7 But, yes, in terms of blood supply at this period of
8 time, we eventually were able to change it. It was very
9 slow. Each region was autonomous. They did their own
10 thing. As the medicines inspectors discovered, each
11 region was doing some things quite different to the next
12 region and so on, in terms of the technology. But, yes,
13 there was huge autonomy.

14 THE CHAIRMAN: Professor, I'm interested in the fact of
15 autonomy but even more in what the basis of assertion of
16 autonomy might be, and if you can help me to understand
17 that, perhaps after the break, I would be grateful
18 because if it comes down simply to personality and the
19 assertion of independence rather than structural
20 factors, that might interest me.

21 Anyway, we will have a break now.

22 (11.30 am)

23 (Short break)

24 (11.58 am)

25 MR MACKENZIE: Professor, before the break we were looking

1 at the minutes of a meeting of the directors on
2 29 March 1983 and you mentioned a feeling that you were
3 not the boss during this discussion. In short,
4 presumably, professor, what you mean is that you did not
5 have the power to tell the other regional directors what
6 to do?

7 A. That's correct.

8 Q. So in any discussion of this sort, presumably there were
9 essentially three possibilities: either, firstly, the
10 directors agreed on a common position; secondly, the
11 directors did their own thing; or, thirdly, someone from
12 above, who did have the power to tell the directors what
13 to do would have to give an appropriate instruction or
14 a direction.

15 A. Yes, I think that would be correct, sir.

16 Q. Who had that power to tell the directors what to do?

17 A. I would have to say in the environment we worked, it
18 would be none other than the Scottish Home and Health
19 Department and in terms of individuals, I would have to
20 nail poor old Dr Graham Scott, the deputy chief medical
21 officer, because it was one of his many
22 responsibilities, the Blood Transfusion Service.

23 Q. Did the Common Services Agency play any role in the
24 hierarchy?

25 A. In my view, no.

1 Q. I think, professor, I'll continue with the chain of
2 documentation we started earlier. After the meeting on
3 29 March 1983, I think the next document, if we can go
4 to it, is [\[SNB0026408\]](#).

5 This is a letter, professor, dated 12 April 1983.
6 You are writing to Mr Haythornthwaite, after the
7 directors' meeting, and you state:

8 "Dear David, donor sessions at prisons and borstals.
9 This matter was discussed at length by the SNBTS
10 directors at their meeting on 29 March 1983. Opinion
11 was strongly divided and it was not possible at this
12 time to obtain a consensus view."

13 And Dr Brookes was to raise the matter at the next
14 meeting of the UK working party, which was currently
15 reconsidering the whole question donor selection and
16 care, et cetera.

17 Do you remember, professor, what was your personal
18 view at this time about the appropriateness of
19 continuing to collect donations in prisons?

20 A. I am as sure as I can be but not absolutely certain that
21 my view was we should get out of that.

22 Q. Why?

23 A. On the grounds that the inspectors had raised, this is
24 an issue, and for all the reasons that they had stated.

25 I have to confess that I'm very uncertain that I was

1 aware of the work that had gone on in the West of
2 Scotland which was published, but I certainly, in the
3 heated debate, sided -- I don't think it matters -- but
4 I sided with those who wanted to get out.

5 Q. And when you refer to the work in the West of Scotland,
6 I think that may be a reference, which we will come
7 to --

8 A. Indeed.

9 Q. -- to the higher prevalence of Hepatitis B in the prison
10 population in the West?

11 A. Indeed.

12 Q. We will come to that.

13 Sticking with this chain of documentation,
14 professor. I think the next document we can go to is
15 reference [\[SGH0026764\]](#).

16 Professor, this is a document which has come from
17 the Scottish Home and Health Department. If we go to
18 the very bottom of the page, the bottom left-hand
19 corner, we can see the author is a Mr J G Davies and the
20 memorandum is dated 6 May 1983. At the very top
21 left-hand corner, I think the "PS" may stand for private
22 or permanent secretary -- that may be explained in due
23 course -- of Mr Mackay. I take it, professor, you
24 wouldn't have seen this document at the time?

25 A. No, not at all.

1 Q. Today may be the first occasions --

2 A. It is, indeed.

3 Q. I'll bear that in mind, professor, when I take you to
4 it. I think it may be helpful just to refer to all of
5 the main documents in the chain in one go for ease of
6 reference later. So that's why I take you to it at this
7 stage, professor. We can see the heading here is "AIDS"
8 and then at the third numbered paragraph "donation
9 policy", it is stated:

10 "The blood transfusion directors in Scotland are
11 very aware of the problem and have it under constant
12 consideration. They are currently considering ...

13 "(d), avoiding collection in high risk locations
14 such as prisons or where there is known to be a high
15 proportion of homosexuals or drug abusers in the
16 population."

17 That forms part of this background. We can put that
18 to one side and the next document is [\[SGH0010575\]](#). We
19 now jump to the Department of Health and Social Security
20 and if we look, a Mr -- or perhaps a Miss J B Brown.
21 I think the reference here is to the DHSS and you can
22 see the date of this memo was 27 July 1983. Again,
23 professor, you will not have seen this document at the
24 time --

25 A. No.

1 Q. -- and probably not until now, but I simply refer to it
2 to complete this line and to complete the background.

3 This memo is addressed to a Mr Parker and states:

4 "Use of blood from prisons. 1. At a recent meeting
5 of medicine and divisions inspection actions group,
6 concern was expressed about the collection and use of
7 blood from borstal institutions and prisons. Blood
8 transfusion centres in Scotland were making use of these
9 sources, particularly the prisons, and some at least of
10 the English blood transfusion centres were also
11 understood to do so.

12 The group consider this practice to be highly
13 questionable because of the incidence of homosexuals and
14 homosexual activity in prisons and the present unease
15 about the incidence of AIDS among this group of people.

16 "3, the group asked to be advised of departmental
17 policy on the practice of collecting and using blood
18 from borstals and prisons. I shall be grateful if you
19 will let me have a note about this which I can pass on."

20 If we then, please, go to the next document, it is
21 reference [\[SGH0010572\]](#). Again, professor, you won't
22 have seen this at the time. We are now back to the SHHD
23 in Scotland. If we go to the next page, please, we can
24 see at the top the date of this handwritten memo is
25 11 August 1983. If we go back to the first page,

1 please, and I'll read the memo. The memo provides:

2 "Mr Winstanley, DHSS rang. He has received an
3 enquiry from the Medicines Inspectorate re departmental
4 policy on donor sessions in prisons and borstals, given
5 there is now AIDS. He explained that England and Wales
6 have tended to shy off in part because of hepatitis but
7 he wondered what Scottish position was.

8 "2, Mr Wastle directed me to the discussion at RTD
9 Scotland meeting on 28 March 1983 ..."

10 Which we have just looked at the minutes off:

11 "I outlined to Mr Winstanley what was said then and
12 referred to the general position. He was interested in
13 the reference to Dr Brookes approaching the working
14 party on selection and care of blood donors and will try
15 to explore that avenue. He will copy his response to
16 Medicines Inspectorate to us and mention the subject is
17 being put to English RTDs at their next meeting. He
18 made the point that if policy was to be withdrawn, would
19 probably need to consult Home Office in view of the
20 importance placed on the social responsibility aspect of
21 such sessions."

22 Then put that to one side, I think the next document
23 is then [\[SNB0026554\]](#). We can see this is a letter dated
24 23 August 1983 from Dr Brookes, the regional director at
25 Dundee, addressed to yourself, professor, on the

1 question of the working party on the selection of donors
2 and notes for transfusion and under the heading "Donor
3 sessions at prisons and borstals" Dr Brookes states:

4 "You asked me to discuss this with my colleagues.
5 In fact no discussion was necessary since, as far as
6 England and Wales are concerned, these sessions have
7 already been stopped. It is now left to the Scottish
8 regions to decide whether they will do the same."

9 Then the next document is [\[SGH0010574\]](#), which takes
10 us back to the DHSS. We can see the date of this memo
11 is 23 August 1983, written by P A Winstanley, addressed
12 to a Mr J B Brown, whom we saw before, on the collection
13 and use of blood from prisons. I assume again,
14 professor, you wouldn't have seen this memo at the time.
15 I think you shook your head to indicate no?

16 A. No, I didn't see it.

17 Q. Paragraph 2:

18 "It is difficult to advise of any particular
19 departmental policy on the collection of blood from
20 borstals and prisons at the moment. It is for
21 individual regional transfusion directors to determine
22 how and from where donations are sought in the light of
23 the targets they need to achieve and the numbers of
24 donors on their panels.

25 "3. However, transfusion directors have been aware

1 of the dangers of relying too heavily on prisons as
2 a sort of donations for some time, ie prior to the
3 advent of AIDS, as a cause of concern because of the
4 risk of hepatitis in prisons (also connected with the
5 higher incidence of homosexuality) which can be spread
6 through blood transfusion. Nevertheless, although most
7 regions, especially those with no shortage of donors,
8 may not need to use prisons, there is at least one which
9 has to view them as a major source of donations in order
10 to meet targets.

11 "4 AIDS has now, of course, called the wisdom of
12 continuing to view prisons as a source of blood even
13 further into question, and the directors are due to
14 discuss it at their next meeting in September. If the
15 risks are now considered too great to justify continued
16 collection from prisons, some measures will be needed to
17 compensate for the loss of that source of donors,
18 perhaps, for example, a system whereby regions with no
19 need to rely prisons can take extra blood to be
20 transferred to those regions for whom the loss of
21 prisons as source of blood will cause difficulties.

22 "5. I shall of course advise you of any
23 developments which occur. I gather that this problem
24 has been debated by transfusion directors in Scotland
25 but no particular policy line emerged. We shall

1 obviously need to liaise closely with Home Office also,
2 since they have in the past been very much in favour of
3 blood donation by prisoners."

4 As a slight diversion, professor, in paragraph 4,
5 where there is a reference to the English directors are
6 due to discuss it at their next meeting in September,
7 I have looked into this and I can't find any reference,
8 I have to say, to the English directors having discussed
9 this at their meetings and I provide it simply for the
10 record.

11 If one looks at [\[SNB0013412\]](#), that is a meeting of
12 English directors meeting on 22 September 1983 and there
13 doesn't appear to be any discussion of collection of
14 blood from prisons. Nor can I find any discussion in
15 any of the minutes after that meeting, either.

16 Professor, the next document then takes us back to
17 Scotland and a meeting of the Scottish directors on
18 13 September 1983, and that is reference [\[SNF0010072\]](#).
19 We can see again, professor, from the first page that
20 you are in the chair. The Scottish directors are there.
21 Dr Bell and Mr Wastle from SHHD are there. We can also
22 see Dr Wagstaff, one of the English directors from
23 Sheffield, was there. Was that a common concern,
24 professor, for the English and Scottish directors to
25 have one representative at each other's meetings

1 observing?

2 A. Yes, it was.

3 Q. So Scottish directors would also attend the English

4 directors' meetings to observe as well?

5 A. They would do yes, a representative, yes.

6 Q. If we can go, please, to page 6 of this minute --

7 A. Perhaps, I might just interject, you make the point

8 about Dr Wagstaff, Dr Harold Gunson, who was the DHSS

9 adviser in blood transfusion, I'm sure as you know, he

10 normally attended and I noticed that he issued his

11 apologies for that particular meeting but Harold and

12 I were pretty close.

13 Q. Yes --

14 A. And he was well aware of this issue.

15 Q. What role did Dr Gunson have at this time in 1983? What

16 was he? What did he do?

17 A. I would need a little notice of that. Certainly he was

18 DHSS adviser in blood transfusion and I think he was

19 part of the directorate that had been created, but that

20 may have come year or so later.

21 Q. Would it be fair to say he was one of the leading

22 English transfusion figures --

23 A. No question.

24 Q. Then page 6 of this minute, professor. The reference is

25 0077. We can see in paragraph 8 the heading "The

1 working party on selection of donors/notes for
2 transfusion". About half way down the page, the
3 paragraphs commences:

4 "On the matter of collection in prisons and
5 borstals. It was noted that the medicines inspector had
6 expressed concern at this practice. Owing to different
7 circumstances in the transfusion regions, the directors
8 had been unable to reach a consensus. The chairman of
9 the working party thought that the practice was
10 diminishing in all regions in England and Wales.
11 Dr Brookes felt strongly that donations should not be
12 collected from prisoners because of the uncertainty
13 about replies to questions concerning health.

14 "It was reported that the practice had been raised
15 at the medicines inspectors' action group who had
16 referred it to the DHSS administrative division who
17 confirmed that some transfusion centres in England still
18 collected from prisons and borstals and that cessation
19 of this practice would place them in difficulty. The
20 NBTS directors were due to discuss the matter and the
21 DHSS would wish to consult the Home Office who had been
22 anxious previously to encourage donation in prisons.

23 "It was acknowledged that prisons and prisoners
24 differed greatly from one place to another and some
25 directors felt that a blanket decision to cease visiting

1 prisons would be a mistake. Dr Mitchell in particular
2 felt that it would be unfortunate if such
3 a recommendation was to be included in the red book and
4 Dr Brookes undertook to circularise the English/Welsh
5 transfusion directors and report back to the meeting."

6 Professor, does that capture the main matters
7 discussed at the meeting or was anything else discussed
8 that you can recollect that we should be aware of?

9 A. Not that I can recall, sir. It seems to me to cover my
10 memory pretty well.

11 THE CHAIRMAN: Can I go back to the top of the page with
12 you, professor. There is a reference to the "the
13 working party" there, chaired by Dr Entwistle.

14 A. Yes.

15 Q. As far as I can see, Dr Entwistle's name appears without
16 much background. Can you tell me anything about this
17 working party?

18 A. No. To the best of my recollection, sir,
19 Colin Entwistle at that time was the director of the
20 Oxford Regional Transfusion Centre.

21 THE CHAIRMAN: And Dr Ewa Brookes had been on this group,
22 perhaps before she came to Dundee.

23 A. Dr Brookes was representing the Scots on that. In fact
24 it was an English -- an NBTS -- and they invited us to
25 have an observer. So Ewa was there on that job.

1 THE CHAIRMAN: Mr Mackenzie has mentioned he cannot find any
2 reference in the English directors' meetings but does it
3 appear that at this time, in the summer of 1983 and into
4 the early autumn, there was a working party looking
5 particularly at the selection of donors which covered
6 selection from prisons?

7 A. Yes, indeed.

8 THE CHAIRMAN: Thank you.

9 MR MACKENZIE: Thank you, sir.

10 Going back to Dr Gunson, professor, I think he was
11 the regional transfusion director in Manchester at this
12 time.

13 A. Manchester.

14 Q. I'm grateful.

15 A. Thank you.

16 Q. The next document, if we go back to the SHHD. The
17 reference is [\[SGH0010571\]](#). Again, professor, I take it
18 you won't have seen this memo at the time?

19 A. No.

20 Q. Well, we can't see much from it at all other than it is
21 headed "File note". It is undated but it does state:

22 "Use of blood collected in prisons. The details in
23 Mr Winstanley's minute of 23 August were reported to the
24 meeting of RTDs on 13 September 1983."

25 I think that must be a reference to the meeting of

1 the SNBTS directors:

2 "With the exception of the West of Scotland, RTDs
3 were ceasing collection of blood at prison sessions."

4 The subject would be kept under review, particularly
5 to hear of developments in England which might be
6 influenced by Home Office views.

7 Then the next document, professor, goes back to the
8 next meeting of the SNBTS directors. I think the last
9 meeting in 1983. The reference is NNF0010178]. I'm
10 sorry, it might actually be helpful to look at one
11 document prior to that. Could we please have up
12 [\[SNB0143030\]](#).

13 We have looked at this document before, professor,
14 but we can see these are the minutes of the fourth
15 meeting of the UK working party on
16 transfusion-associated hepatitis on 27 September 1983.
17 If we go over the page, please, we can see the
18 membership at the top of the page and the meeting is
19 chaired by Dr Gunson. I don't think, professor, you
20 were a member but we can see Scottish representation at
21 this meeting, in particular Dr Cuthbertson,
22 Dr Brian McClelland and Dr Mitchell.

23 If we then go to page 9, which I think is court book
24 reference 3037. Paragraph 7 at the bottom, "Donor
25 sessions in prisons". We can see:

1 "Members asked if the chairman could provide details
2 of which centres took donations at prisons. They
3 realised the definition of 'prison' ranged from closed
4 to open prisons. The working party felt that problems
5 should be considered in the context of a high risk
6 population in terms of several of the
7 transfusion-transmitted infections and as such should be
8 avoided as a donor source."

9 Would you have seen these minutes at the time,
10 professor?

11 A. I don't recall seeing them at all, sir, no.

12 Q. Does the view of the working party as set out there,
13 that prisons should be considered in the context of
14 a high risk population in terms of several of the
15 transfusion-transmitted infections and as such should be
16 avoided as a donor source, accord with your view at the
17 time?

18 A. That would be my view when we had our contentious
19 meeting, yes.

20 Q. I see. So that would have reflected your view when the
21 matter was discussed at the SNBTS directors' meetings in
22 1983?

23 A. That's correct.

24 Q. I'm grateful.

25 If we could then put that document to one side and

1 turn to the minutes of the meeting of the SNBTS
2 directors on 8 December 1983, which is reference
3 [\[SNF0010178\]](#). We can see again who was present at that
4 meeting. Again, apologies were notified from Dr Gunson,
5 then at page 0181, please, under the heading "Age
6 working parties on the selection of donors/notes for
7 transfusion":

8 "Dr Brookes had circulated to her colleagues,
9 Dr Entwistle's final version of the above ..."

10 In terms of prisons, we can then see her reporting
11 her consultation with the English/Welsh transfusion
12 directors concerning corrections in prisons and
13 borstals:

14 "Dr Brookes explained that only one of the 12 which
15 she had consulted was attending prisons. It was noted
16 that the only Scottish region to continue holding
17 sessions in prisons was the West."

18 Can you remember anything more about the discussion
19 of collection of blood in prisons other than what is in
20 this minute, professor?

21 A. I can't, beyond the recollection that we were waiting to
22 hear from other sources as to whether there was a strong
23 recommendation coming but I can't remember that.

24 Q. Thank you.

25 A. Any more than that.

1 Q. The final document in this chain, professor, can we go
2 to, please, [\[SNB0048628\]](#)?

3 We can see from the top, professor, these are the
4 draft minutes of a meeting of the infectious hazards of
5 blood products, the NIBSC, 9 February 1984. I think,
6 professor, you were at this meeting and we will come on
7 to that shortly. In the introduction we see that, in
8 introducing the meeting, Dr Smith of the NIBSC welcomed
9 participants and explained that NIBSC was not the
10 licensing authority in the UK but the institute that
11 gave scientific advice to the licensing authority and
12 the Committee on Safety of Medicines:

13 "The meeting had been called to examine the
14 infectious hazards of blood and blood products, with
15 particular reference to hepatitis and AIDS."

16 Could we then please go to page 8633. About half
17 way down the page we see a paragraph commencing:

18 "In discussion, Dr Cash commented that paid donors
19 are perhaps less likely to be truthful about their
20 activities than volunteer donors."

21 Can you explain that comment, professor?

22 A. Yes. And one saw this -- I did a major visit to the USA
23 in 1969 and looked at the commercial plasma phoresis
24 centres there and saw at first hand that if you are
25 being paid money for your donation, the question then

1 arises if somebody asks you a whole series of health
2 check questions, would you be absolutely truthful. And
3 I came to the conclusion that certainly in California,
4 I wasn't convinced that people were being very truthful.
5 So the question of paid donors and safety emerged as
6 a major issue.

7 Q. In the context of collection from prisons, would it be
8 reasonable to assert or suggest that prison donors are
9 perhaps less likely to be truthful about their
10 activities than non-prison donors?

11 A. Yes, I took that view, yes. I'm not sure it can be
12 justified, however, but I mean, I took that view. It
13 was a personal view and a view that was in fact fairly
14 widely shared.

15 Q. During this period in 1983, you took the view that
16 prison donors were perhaps less likely to be truthful
17 about their activities than non-prison donors?

18 A. Yes.

19 Q. Is that a view which it would have been reasonable for
20 one to have held in, say, the early 1970s, the mid
21 1970s, the late 1970s?

22 A. Yes, I think it is, in a sense, a generic view that if
23 you incarcerate people and they can get an afternoon off
24 out of our their cells or whatever -- there is no
25 payment -- yes, I think it could apply to the early 70s.

1 Q. It really perhaps just comes down to a judgment or
2 common sense or one's experience or perhaps prejudices
3 in life, perhaps.

4 A. Sorry, I didn't --

5 Q. Sorry. It may be there is no hard evidence for such an
6 opinion but it really refers to one's judgment or common
7 sense or perhaps prejudice?

8 A. It may be all those things, absolutely right. Certainly
9 I was not aware of any data and evidence base that would
10 confirm what I am saying.

11 THE CHAIRMAN: There is nothing worse than fama as the basis
12 for forming a view, professor. Is this just something
13 that one acquired by osmosis, as it were, sitting around
14 the table and absorbing it from others, or was there
15 discussion of it as an issue?

16 A. I'm reasonably convinced -- satisfied, sir, that at some
17 point Dr Brookes raised the issue of the truthfulness in
18 terms of responding of prisoners.

19 THE CHAIRMAN: I think I have seen --

20 A. Yes, I think it did enter -- this wasn't a private view
21 of mine that was not shared. I think it was a view that
22 was discussed.

23 THE CHAIRMAN: Before coming to Scotland, Dr Brookes had
24 operated in the London area.

25 A. That's right.

1 THE CHAIRMAN: And from other material it is clear that she
2 did attend prison sessions.

3 A. She had actually been to prison session, that's right,
4 sir.

5 THE CHAIRMAN: So she had personal information available to
6 her.

7 A. Yes.

8 THE CHAIRMAN: I could understand if you were to tell me
9 that you had listened to Dr Brookes and formed a view on
10 that basis but I'm rather concerned that perhaps you are
11 giving the impression that there was a more prejudiced
12 view that prevailed generally. An evidential basis for
13 a view is much better than a prejudice. Can you help?

14 A. Absolutely. I think in my statement I spent some time
15 visiting Armley Gaol in Leeds and spent some time
16 talking to prisoners, and I did come away thinking that
17 some of these chaps are likely to be less truthful than
18 those who are not in prison if there was some gain to be
19 had, whether it is just free time or whatever. That may
20 be a prejudice and you would hardly say three or four
21 conversations with prisoners represented an evidence
22 base. But that's the way we are, I think.

23 THE CHAIRMAN: Yes. So those of us who have had many
24 conversations with people in prisons, perhaps shouldn't
25 enter into this debate.

1 A. Indeed, I appreciate that, sir.

2 THE CHAIRMAN: Yes.

3 MR MACKENZIE: Thank you, sir.

4 Having looked at that chain of documentation,
5 professor, I can perhaps ask two principal questions.
6 You have seen a reference to the Home Office having
7 a view that collection in prisons was a good thing,
8 perhaps from a perspective of seeking to rehabilitate
9 prisoners. Are you aware when the SHHD ever sought to
10 influence or encourage the collection of blood in
11 prisons in Scotland?

12 A. No, I'm not aware, sir. Encouraged? No, I'm not aware.
13 Nor am I aware that they discouraged either.

14 Q. Yes. So would it be fair to say that the SHHD were
15 aware of the practice of collecting blood in prisons in
16 Scotland but they were essentially passive or neutral on
17 the issue?

18 A. Yes. I really can't speak for them and you will be
19 speaking to some of them. I think that is probable.
20 I would add that there is this strong tradition, as
21 I have explained before, that these matters were under
22 very much the governance of DHSS and I suspect, to be
23 fair to my Civil Service colleagues in Scotland,
24 erstwhile colleagues, that they were waiting for
25 a judgment to come up from London on this and they

1 waited.

2 Q. So on this topic, professor, just to take this to its
3 conclusion, I think I'm right in saying there is no
4 evidence to suggest the DHSS sought to directly
5 influence the SNBTS in relation to collection of blood
6 from prisons. Is that correct?

7 A. No, I agree with that.

8 Q. So any influence the DHSS exerted on the SNBTS would be
9 through the SHHD?

10 A. That is correct, sir.

11 Q. Certainly you have no recollection of the SHHD seeking
12 to influence or encourage the collection of blood in
13 prisons in Scotland?

14 A. Nor do I even have any recollection at all of some of
15 the documents you have shown me that I hadn't seen
16 before, that there was an opinion emanating out of DHSS.
17 Is that it was up to individual directors to determine
18 these practices, depending on -- I think it said their
19 targets for supply. That never came back either.
20 I think that was a communication from London to
21 Edinburgh. I don't recall ever being aware of that.

22 Q. My second principal question in this area, professor is
23 this: who do you consider was best placed to consider
24 whether it was appropriate to collect blood from prisons
25 in Scotland? Do you consider the SNBTS were best placed

1 to consider that or do you consider Government was best
2 placed to consider that question?

3 A. In retrospect, I have no doubt it should have been SNBTS
4 but at that time these matters -- we broke away
5 eventually in Scotland at that time. These matters, the
6 question of donor selection, were very much in the hands
7 of the DHSS and I think we eventually recognised that
8 this wasn't right.

9 Q. We will come back to look at that point, professor, but,
10 before leaving this, would it be fair to say that
11 medical and scientific matters relating to transfusion
12 were primarily for the SNBTS, whereas wider policy
13 matters may involve government?

14 A. Yes, but there are, I think, quite a number of issues
15 that policy affected medicine directly.

16 Q. I understand. It is hard to ring-fence each area; there
17 is a certain amount of overlap and interlinking, I can
18 understand that. Thank you, professor.

19 If I may now return to your statement, please, which
20 we had before us, [\[WIT0030120\]](#), I think at page 2, a few
21 lines from the bottom, the paragraph commencing:

22 "My father was a prison chaplain ..."

23 I think we had reached as far as this. You say:

24 "On several occasions I did visit HM Armley prison."

25 Where is that prison?

1 A. Leeds.

2 Q. You explain you:

3 "... judged the health of many paid donors seen by
4 [you] in 1969 in plasma collection centres in
5 Los Angeles was much worse than that of inmates of the
6 Leeds HM prison in 1983. As I recall, the problem of
7 drug addiction in UK prisons in 1983 was not the problem
8 it is now."

9 Can you remember, professor, what was your
10 knowledge, if any, about drug addiction in UK prisons in
11 1983?

12 A. I imagine very little, sir. It is again an impression.

13 Q. And when you assert in your statement that the problem
14 of drug addiction in UK prisons in 1983 was not the
15 problem it is now, what's the basis for that statement?

16 A. Nothing more than an intelligent guess. I have no
17 evidence basis. It is not my field.

18 Q. I see. Just continuing with your statement, you
19 explain:

20 "Whilst arguably not relevant, it may be worth
21 pointing out that MCA inspectors did not seek to impose
22 a ban on prison donors used by commercial plasma
23 collection agencies in the US which supplied plasma for
24 coagulation factor concentrates destined for the UK. It
25 is my understanding that prison donors were not excluded

1 in the US until 1990 (I have a reference for this if
2 required)."

3 I don't think we have that reference. If you were
4 able to supply that in due course, that would be
5 helpful.

6 A. I'll do my best.

7 Q. You state there, professor, that:

8 "Prison donors were not excluded in the US until
9 1990."

10 Does that refer to some government instruction that
11 blood should not be collected from prisons or what?

12 A. Yes, it would be the FDA.

13 Q. Do you have any knowledge -- and if not, please say
14 so -- about the actual practice in the US in the 1970s,
15 1980s, in terms of which states were actually collecting
16 from prisons?

17 A. No, I don't have any knowledge, nor do I have any
18 knowledge -- certainly in 1969, when I was in
19 San Francisco and Los Angeles, I was aware that prisons
20 were being used. That's the only knowledge I have, sir.
21 I'm not aware of -- we are talking about commercial
22 plasma phoresis here -- what the situation was with the
23 American Red Cross in terms of ordinary blood
24 transfusion. But it is possible that the FDA could
25 provide that information.

1 Q. Thank you, professor. Returning to your statement,
2 please, in paragraph 5 you were asked of:

3 "The consideration given between 1975 and 1984 by
4 those in the SNBTS to whether blood collected from
5 prisons carried a higher risk of hepatitis, including
6 a particular non-A non-B hepatitis, and whether that
7 practice should continue."

8 And you say that:

9 "As far as I can recall, this topic was not
10 discussed by the SNBTS directors until the matter was
11 raised by the medicines inspector in 1982, and
12 furthermore, to the best of my recollection, the news on
13 29 March 1983 that Edinburgh had abandoned prison donor
14 sessions in 1980 came as a complete surprise to me and
15 all other SNBTS directors."

16 Professor, this may be a point of detail but when we
17 looked earlier this morning at the minutes for
18 29 March 1983, there was no reference to Edinburgh
19 having abandoned prison donor sessions in 1980. Is it
20 possible you are mistaken on that or do you have
21 a recollection of being surprised at hearing such news?

22 A. Yes, I have always been cautious about minutes and
23 whether they cover everything, and indeed in the expert
24 advisory group on AIDS that became a major issue for me
25 personally. I have a recollection -- and in fact this

1 was part of the chemistry of the SNBTS, that it was not
2 known to me or my colleagues, when it was discussed in
3 1983 during that heated debate, that Edinburgh had
4 already moved. It may not be 1980. It may be the date
5 is 1981.

6 Q. You have a recollection of Dr McClelland saying at that
7 meeting that Edinburgh --

8 A. I have a recollection.

9 Q. -- no longer collected from prisons. Yes?

10 A. The chemistry being such that that raised the
11 temperature another notch or so.

12 Q. I see. Is that perhaps another example of the autonomy
13 of the different regions?

14 A. It is indeed, sir, yes.

15 Q. At that time at least?

16 A. Yes.

17 Q. Going on to question 6, please, professor, in your
18 statement you were asked whether:

19 "Ceasing the practice of collecting blood from penal
20 institutions led to any difficulties in maintaining
21 a sufficient supply of blood in Scotland."

22 And your reply is:

23 "None that I recall."

24 But you suggested that each former living director
25 should be consulted, and you explain:

1 "Certainly, I am aware that on a number of occasions
2 after 1983 surgical procedures were postponed due to
3 blood shortages in the West of Scotland. Whether these
4 shortages had anything to do with the abandoning of
5 prison donor sessions is not known to me but it is worth
6 pointing out that the annual blood collection figures
7 per million of population in the west was significantly
8 below all other regions in Scotland throughout the
9 1980s. Thus supply difficulties for red cell was a not
10 infrequent anxiety for colleagues in the West, where
11 poverty and deprivation were significant challenges for
12 those responsible for the blood collection programmes.
13 It is almost certain that it was never a problem for
14 Edinburgh or any other SNBTS region."

15 We have looked, professor, at the beginning of your
16 evidence at how many collections were taken from prisons
17 and we saw the average in Scotland between 1975 and 1981
18 was about 1.12 per cent, although you explain one would
19 have to be slightly cautious in considering how
20 important that contribution was at particular times of
21 year.

22 Dr McClelland, professor, gave evidence to the
23 effect that stopping collecting blood from Saughton
24 didn't cause any problems to the blood supply in the
25 east. I think Dr Mitchell's position essentially was

1 that there were from time to time difficulties in the
2 blood supply but they weren't insurmountable because of
3 the work carried out by him and his colleagues in the
4 west to overcome any difficulties.

5 Would you agree -- and if you are not aware of this,
6 then please say -- that the general picture appears to
7 be that if a decision had been taken in 1975 that
8 collection in prisons in Scotland should have stopped,
9 that is unlikely to have caused any insurmountable
10 problems in terms of the blood supply in Scotland?

11 A. Yes, I would agree now in retrospect and I think -- but
12 it would in my experience have required a little less
13 autonomy, a little more cross-regional support, when
14 times got difficult. But if you take the total input of
15 red cells to the whole of Scotland, I don't believe that
16 1 per cent would have -- we could have easily coped with
17 it.

18 Q. I'm grateful. I think you have prepared a separate
19 short paper on this, professor, and we will come to look
20 at that at the end of your statement.

21 A. Yes.

22 Q. Thank you.

23 Moving on, please, then to question 7 in your
24 statement, you were asked whether you were aware of the
25 evidence produced by the NBTS for England and Wales

1 around July 1974 that the incidence of Hepatitis B in
2 donors from prisons was approximately five times greater
3 than the incidence in donations from the general public.

4 You replied to that on page 4. You answer:

5 "I cannot recall whether I was aware of this
6 evidence or the work published from the West of Scotland
7 BTS."

8 You then refer to the Wallace 1972 paper, which is
9 [\[SGH0029831\]](#), and the Barr 1981 paper, which is
10 [\[PEN0140068\]](#). I think in short both the Wallace 1972
11 paper and the Barr 1981 paper had similar findings to
12 English evidence, that prison donors had an
13 approximately five times greater prevalence of
14 Hepatitis B antigen than non-prison male donors. You
15 explain that:

16 "If it was discussed by the SNBTS directors, then
17 I would imagine it would have been raised by
18 Dr John Wallace in the West of Scotland RTD ... "

19 A. Yes. This is very early.

20 Q. Yes:

21 " ... in 1974/1975 and by Dr Mitchell in 1981/1982."

22 You then explain:

23 "I must confess I do not recall having ever given
24 the matter on prison donors any consideration until it
25 was raised by the Medicines Inspectorate in 1928/1983."

1 To pause on the last sentence, professor, we know
2 that in 1974 you were appointed director of the
3 Southeast of Scotland Regional Transfusion Service and
4 then, of course, in 1979 you became medical director of
5 the SNBTS. So is it the position, professor, that
6 really from 1974 through to the 1982 and the arrival of
7 the medicines inspectors you didn't give the matter of
8 collecting blood from prisons really any consideration?

9 A. I have no recollection, and the only explanation I am
10 bound to give is that we were heavily committed to many
11 other areas related to haemophilia, addressing the
12 problems of plasma and haemophilia. That's the only
13 explanation I can give but I have no recollection of
14 discussions on this topic at all until the medicines
15 inspectors.

16 Q. Yes, and to try and put this issue in some context,
17 professor, can you recall what were the main issues
18 which were being discussed and considered by the
19 Scottish directors throughout the 1970s and into the
20 early 1980s? Is it possible to summarise that?

21 A. Yes, very briefly, without any shadow of doubt: the
22 problem of national self-sufficiency in plasma products.

23 Q. That's a very short summary, professor, thank you.

24 A. It was a monumental task.

25 Q. Yes, and we may come back to that in a different topic.

1 A. Yes, indeed.

2 Q. Thank you.

3 THE CHAIRMAN: Just before we leave what was happening,
4 I have got information about the service in England and
5 Wales, having looked at the collection of donations from
6 prisons in 1973, when, it is fair to say, seven were for
7 it and seven were against it and that leading to
8 a report by Dr Maycock to the SNBTS directors on
9 4 October 1973 informing them of this background. Is
10 that something you would have known about at the time?

11 A. I don't know. Certainly, I have just been reminded that
12 I was appointed a regional director in 1974, sir. I'm
13 not sure when in 1974 that was. But, no, I would have
14 been a young consultant, a very young consultant, and
15 was not engaged in any of the national discussions at
16 all.

17 THE CHAIRMAN: Thank you.

18 MR MACKENZIE: Thank you, sir. We will come back to that
19 shortly, professor, but just sticking at this point in
20 your statement with the paper by Wallace in 1972 and
21 also the Barr paper in 1981, before we actually look at
22 those papers, could I ask you firstly, professor: in the
23 1970s did you ever attend donor sessions, whether within
24 or outwith prisons.

25 A. There were lots outwith prisons, the whole of Fife and

1 the Borders. It was part of the duty for me on a Sunday
2 to go down to these session, yes.

3 Q. Including sessions in prison?

4 A. No.

5 Q. I'm sorry?

6 A. No.

7 Q. So at sessions outwith prisons, what steps were taken to
8 try to try to exclude donors who may have injected
9 drugs?

10 A. I do not recall in terms of specifics. I must confess
11 that my attendance at these sessions in that period was
12 one of director and thanking people for turning up. In
13 other words, I was not involved in the staff that were
14 actually doing the job. So I have no idea, to be
15 absolutely honest.

16 Q. Do you think it may have been the practice -- and if you
17 can't answer this, just say -- in the 1970s for staff at
18 donor sessions to directly ask a donor, "Have you ever
19 injected drugs?"

20 A. No, I can say, I don't know but my gut feeling is
21 certainly when we got into the area of AIDS, there was
22 great difficulty for some of our staff asking very
23 straight questions about people's lifestyles.

24 Q. We really see a step change, I think, in what questions
25 are asked with the arrival of AIDS and we will come to

1 that topic shortly.

2 A. That's my memory, yes.

3 Q. Some of the AIDS questions are really very direct and
4 intrusive.

5 A. Yes.

6 Q. As I say, we will come to that.

7 A. Yes.

8 Q. Just to finish this small line, professor, could you
9 look, please, to one donor leaflet we do have? It is
10 [\[PEN0131395\]](#). We can see, professor, from the top, this
11 leaflet is from the Glasgow and West of Scotland Blood
12 Transfusion Service. If we go to the very bottom
13 right-hand page, we can see somebody has written on
14 "16 June 1983". We can see at the bottom left what
15 appears to be a label that has been stuck on the leaflet
16 asking:

17 "Have you heard of AIDS?"

18 Can you see that?

19 A. Yes, thank you.

20 Q. Which again may help to date the leaflet to about that
21 period. If we then scroll up the page a little, please,
22 we can see a list of questions on the leaflet. There is
23 no reference, professor, to any history of drug use on
24 this leaflet. If you can recall, is the leaflet we see
25 here similar to the type of leaflet and type of

1 questions we may have seen in a donor leaflet in
2 Edinburgh in the 1970s? Is that something you can
3 answer?

4 A. I can't. My gut reaction is it may be a little
5 different, the way things were. But I have no clear
6 recollection at all, sir.

7 Q. Thank you.

8 Could we then, please, go to the Barr paper, 1981,
9 which is [\[PEN0140068\]](#).

10 Professor, this is a paper by Mr Barr and others on
11 the question of Hepatitis B virus markers in blood
12 donors in the West of Scotland. Can you recall whether
13 you saw this paper at the time or a draft of it?

14 A. No. I'm as certain as I can be that I did not see it.
15 I have to say that in 2011, when you think of giant
16 databases for publications, life is significantly easier
17 and I am aware that one of the reasons I introduced in
18 our annual reports the listing of publications coming
19 out of the SNBTS was I became aware that publications
20 would come out from centres, and other centres in
21 Scotland were not aware of them. So we attempted to
22 make that.

23 I have to say I was not aware of this paper.

24 Q. Also, just for completeness, could we also have the
25 Wallace 1972 paper up, please, which is [\[SGH0029831\]](#)?

1 THE CHAIRMAN: Professor, would you look at the very top of
2 the one that we have just got before it disappears. It
3 is published in the medical services laboratory --
4 medical laboratory services or something. Is that
5 a publication you know of?

6 A. I do know of it. It is not one that I looked at but in
7 the MLSO, the technology world, it was a very important
8 and prestigious journal.

9 MR MACKENZIE: I think we can see, professor, Medical
10 Laboratory Sciences.

11 A. Sciences. These were the medical laboratory scientific
12 officers, the MLSOs as we used to call them. I think it
13 related to their institute, the publication.

14 THE CHAIRMAN: But it wouldn't necessarily be a publication
15 read by the medical profession generally.

16 A. No, it wouldn't. That's no excuse, sir, but no, it
17 wouldn't, I have to say that.

18 THE CHAIRMAN: Thank you, Mr Mackenzie.

19 MR MACKENZIE: Going back to the 1972 paper, professor, for
20 completeness. That was [\[SGH0029831\]](#). I think this is
21 Dr Wallace's paper in 1972 published in the British
22 Medical Journal. Is that a publication you would have
23 read at the time?

24 A. Yes, BMJ. It would be very likely. I was a paid-up
25 member. So I would certainly have got it on my desk.

1 Q. I think between 1971 and 1974 you were a consultant with
2 the Southeast of Scotland BTS and again I appreciate it
3 is many decades after the event, professor, but do you
4 have any recollection of having seen Dr Wallace's paper
5 at the time?

6 A. I have no recollection but I don't think after all this
7 time that means terribly very much. I would only add
8 that it's in a professional area that, at that time,
9 I was not involved in at all. So I can well imagine
10 I have seen it, flicked it over and took no great
11 interest.

12 Q. It is 1 o'clock, sir. I think perhaps we will finish
13 this chapter with another two or three minutes. I could
14 just stop now?

15 THE CHAIRMAN: I think if you are going to finish the
16 article, it would help.

17 MR MACKENZIE: I'm grateful, sir.

18 Professor, you were appointed director of the
19 Southeast Scotland in 1974 and the medical director in
20 1979 onwards. At any time between 1974 and 1982 can you
21 recollect, were you aware of the evidence suggesting
22 there was a higher prevalence of Hepatitis B among
23 prisoners in the West of Scotland?

24 A. No, I regret to say.

25 Q. Finally, professor, if I can take you back to the 1981

1 Barr paper, [\[PEN0140068\]](#). In short, professor, this
2 paper reported a higher prevalence of about five times
3 more of Hepatitis B surface antigen in prison donors
4 compared to non-prison donors, both of which groups
5 tested for the first time. We see in the second
6 paragraph, half way through, the statement:

7 "Despite the high incidence of HBsAg in male
8 prisoners, viral hepatitis is not a serious clinical
9 problem in the institutions surveyed and the positive
10 donors are not drug addicts. This high incidence is
11 probably related to social habits and hygiene."

12 If, professor, you had read that at the time in
13 1981, what would your response have been to those
14 assertions?

15 A. I'm not at all sure, to be absolutely honest. I think
16 in 1981 I was national director. If I had been that
17 conscious of it, I would have popped it up on to the
18 agenda of the directors to get it knocked about and
19 discussed. That's surmise, sir. I can't be absolutely
20 certain.

21 THE CHAIRMAN: Professor, if you look at the bottom, there
22 is a note that the paper was presented at the workshop.

23 A. Yes, and the question, when I saw it, was I there?
24 I must have been there. But I have no recollection,
25 I regret.

1 MR MACKENZIE: What confidence, professor, do you think one
2 could assert that positive prison donors are not drug
3 addicts in 1981?
4 A. I mean, now, when challenged, I imagine very little
5 confidence.
6 Q. And --
7 A. The difference between males and females outside
8 prison --
9 Q. Final question, professor, from myself: looking at these
10 assertions now, and I'll repeat them again shortly, what
11 are your views on them? So an assertion that the
12 positive donors are not drug addicts and this high
13 incidence is probably related to social habits and
14 hygiene. Knowing all we know now, what views do you
15 have on these assertions?
16 A. I think that was an error. I suspect.
17 Q. And knowing what we know now, what do you think is the
18 most likely explanation for that higher prevalence of
19 Hepatitis B in prison donors?
20 A. I imagine it would be drugs.
21 Q. Thank you, sir.
22 A. And needle sharing. Which would apply to a major area
23 of Edinburgh as well at that time, I imagine.
24 Q. Thank you. It may be an appropriate moment, sir, to
25 break for lunch?

1 THE CHAIRMAN: If, of course, those who were suspected of
2 having a drug problem were excluded from the potential
3 donor group by prison authorities, the view might be
4 different, might it?

5 A. Yes, sir, I think so.

6 THE CHAIRMAN: This is one of those areas where I can see
7 speculation both ways but, without knowledge of the
8 mechanisms adopted perhaps to avoid the embarrassment of
9 admitting that the prison had a drug problem, one can't
10 really come down on one side or the other, can one?

11 A. No, I agree, sir.

12 (1.03 pm)

13 (The short adjournment)

14 (2.05 pm)

15 MR MACKENZIE: Can I please return, professor, to your
16 witness statement and carry on going through that? You
17 were at, I think, page 4. I had come on to question 8.
18 Could we have that up again please? It is [\[WIT0030120\]](#).
19 Thank you.

20 Question 8, professor. You were asked whether you
21 were aware of a letter dated 6 January 1975 by
22 Dr Garrot Allan of Stanford to Dr William Maycock of the
23 Blood Products Laboratory warning of the increased risk
24 of hepatitis including non-A non-B hepatitis from the
25 blood of prisoners.

1 I think the Inquiry has looked at that letter
2 already, so we don't have to go back to that but you
3 answer that as far as you can recall you were not aware
4 of that letter and first discovered its existence when
5 reading Douglas Starr's book in 2007. I think,
6 professor, Dr Garrot Allan had also published a book,
7 perhaps in the early 1970s, on the subject of his
8 research. Were you aware of that book or not?

9 A. No, not at the time, no.

10 Q. So the gist of Dr Garrot Allan's studies, I think, were
11 to show the higher prevalence of perhaps
12 post-transfusion hepatitis in paid donors. Is that
13 correct?

14 A. That's correct, sir.

15 Q. But you were not aware of that research in the early
16 1970s?

17 A. I was not aware of his book. I was certainly aware and
18 wrote myself about the whole issue of the dangers of
19 paid donors.

20 Q. And this then comes back to your visit to Los Angeles in
21 the late 1960s?

22 A. Indeed.

23 Q. I understand.

24 The next question, professor, question 9, moves off
25 on to a different document and you were asked whether

1 you were aware of a letter dated 1 May 1975 by
2 Dr Yellowlees, the chief medical officer of England and
3 Wales to all regional medical officers in England and
4 Wales on the subjects of blood donation and hepatitis.
5 We will come to that letter shortly. You answer that as
6 far as you can recall you were not aware of that
7 communication but the SNBTS may have access to copies of
8 directors' meetings which reveal the contrary.

9 We shall perhaps look at some documents in this
10 regard, professor. The first document, to put this
11 letter into some context, is document [\[SNB0012494\]](#). We
12 can see from the top of this letter, professor, that it
13 is a note -- it is made by Dr Brodie Lewis -- from the
14 Aberdeen blood transfusion region. I think this is an
15 example of one of the Scottish directors, having
16 attended one of the English meetings then reporting
17 back. Dr Lewis's notes of the English directors'
18 meeting held in London on 24 March 1974 address this
19 item, the question of donors from tropical areas. In
20 short, professor, it had been noted that donors from
21 tropical areas had a higher incidence of Hepatitis B.

22 If we can perhaps go on to page 2498, 2498 is an
23 attachment to Dr Lewis's note and is the memorandum by
24 Dr Cleghorn, the director of the North London Blood
25 Transfusion Service. If we go over to the next page,

1 please, we can see the date of this memorandum is
2 18 April 1974. If we could go back to the previous page
3 again, please, the memorandum is headed "Memorandum on
4 HBAG carriers":

5 "There has been some comment recently by the news
6 media concerning our activities in Edgware and the
7 following notes are relevant."

8 Paragraph 2, there was a question of:

9 "Towards the end of 1973, following reports by BPL
10 of HBAG in three of our five-litre packs, our honorary
11 consultant adviser in virology, Dr Dane, initiated
12 testing by RIA of all such packs before dispatch.
13 Within one week, two were found RIA-positive and in each
14 instance, tests on repeat samples from the contributors
15 identified the culprit as a TA donor.

16 "3. This led to review of our figures ..."

17 Essentially it became apparent that there was
18 a higher incidence of Hepatitis B antigen in donors from
19 what was termed "tropical areas". Beneath the figures
20 in paragraph 3 it stated:

21 "Thus, 25 per cent of carriers detected by IEOP were
22 located in less than 2 per cent of the donor panel."

23 In paragraph 4 it states:

24 "The detection efficiency of IEOP is probably not
25 much better than 50 per cent, so that even after

1 elimination from the panels of all HBag positives to
2 IEOP, an equal number of carriers almost certainly
3 remains and the TA donors must represent comparatively
4 a high risk group."

5 Then the end of paragraph 5:

6 "I decided, therefore, to suspend issue of all TA
7 donations until a policy decision could be made."

8 I think that's the matter which caused interest from
9 the media. Do you, professor, have any recollection of
10 this topic?

11 A. None at all. Not the documents you have shown, no.

12 Q. Then over the page, paragraph 7 states:

13 "It is also proposed to test current and future TA
14 donations by both HA and RIA and to store the serum
15 samples for future reference."

16 Essentially I think the RIA test was more sensitive
17 than the IEOP test. Then paragraph 8:

18 "The desirability of taking a more detailed history
19 from coloured donors than has previously been considered
20 socially acceptable is being discussed."

21 That all forms part of a letter we are going to come
22 to shortly but to go back to page 2494, back to
23 Dr Lewis's note of the meeting in London, the last
24 paragraph states:

25 "Geoffrey Tovey said that they were still taking

1 donations at prisons, and he suggested that initially
2 the most sensitive tests for Australia antigen should be
3 used for testing donations from high risk groups."

4 I take it, professor, from what you have said that
5 you have no recollection of that note from Dr Lewis?

6 A. No.

7 Q. Thank you. The next document is number [\[SGH0030187\]](#).

8 This is Dr Yellowlees's letter of 1 May 1975 to all
9 regional medical officers. We have looked at this
10 before in the Inquiry and it is headed "blood donation
11 and hepatitis" and it commences:

12 "The department ..."

13 This is the Department of Health and Social
14 Security:

15 "... has recently received advice from a group of
16 experts on the use of blood donations from certain
17 categories of donors."

18 We see that the footnote at the bottom of the page
19 explains the group of experts was a subgroup of the
20 advisory group on testing for Australia antigen. The
21 letter then deals with the question of geographical
22 factors, in particular the question of donors from
23 tropical areas. Then over the page, the second page of
24 the letter deals with the question of prisons and
25 states:

1 "There is a relatively high risk of Hepatitis B
2 being transmitted by the blood of prisoners, but there
3 is probably an equally high risk in other groups of the
4 population, eg drug addicts, who are not so easily
5 identified in advance as prisoners, if they can be
6 identified at all. The advice we have received is that
7 it is not necessary to discontinue the collection of
8 blood at prisons and similar institutions provided all
9 donations are subjected to one of the more sensitive
10 tests referred to above."

11 I think more sensitive tests is a reference to
12 either the RPHA or the RIA testing.

13 Just to continue this particular chain, professor,
14 we can see that this letter did make its way to
15 Scotland. If we can look, please, at [\[SNB0025017\]](#) and
16 this is a letter from Dr McIntyre of the SHHD dated
17 16 May 1975, I think your predecessor, professor. Is
18 that correct?

19 A. That's correct.

20 Q. To Major General Jeffrey who was then the national
21 medical director of the SNBTS. And the letter from
22 Dr McIntyre is headed "Blood donations in hepatitis":

23 "Further to our conversation, I enclose a copy of
24 the circular letter sent out by the chief medical
25 officer, DHSS, to all regional medical officers and

1 regional transfusion directors in England and Wales."

2 And the letter concludes:

3 "We would be interested to have your comments on
4 this matter once you have had an opportunity to discuss
5 it with the Scottish transfusion directors."

6 I think we can see from the text of that letter that
7 reference is being made to the question of donors from
8 tropical areas, as it was termed, rather than the
9 question of express reference to prisons?

10 A. Yes.

11 Q. If we then, please, go to reference [\[SNB0025016\]](#), we can
12 see this is a letter dated 21 May 1975 from
13 General Jeffrey to Mr John Watt at the PFC and
14 Major General Geoffrey states:

15 "I attach copies of Dr Yellowlees's letter which
16 will be on the agenda for discussion at our next meeting
17 on 11 June 1975."

18 If we then next go to the minutes after that
19 meeting, the reference being [\[SNB0024995\]](#), we can see
20 these are the minutes of a meeting of the Scottish
21 directors on 11 June 1975. Major General Geoffrey
22 chaired the meeting. I think, professor, you were also
23 present at this meeting along with Dr Wallace and
24 Dr McIntyre among others. I think we can see in the
25 introduction apologies intimated from Dr Cameron and

1 Dr Maycock. When looking at these minutes, it does seem
2 to be quite a common theme that the English director
3 quite often sent his apologies rather than himself?

4 A. True.

5 Q. Yes. For what that is worth.

6 Then if we can look, please, at page 5 of the
7 minutes, which is court book reference 4999, and
8 paragraph 9 sets out the discussion of Dr Yellowlees's
9 letter. I think we can see that the discussion appeared
10 to have been confined to the question of donors from
11 tropical areas rather than there being any express
12 reference to prisoners. In particular, the minute
13 records that General Jeffrey explained that SHHD would
14 welcome directors' comments on DHSS letter from
15 Dr Yellowlees:

16 "This stated that in the opinion of a subgroup of
17 the advisory group on testing for Australia antigen, the
18 red cells of donors who are born or had resided in
19 endemic malarious areas should not be used. Dr Wallace
20 explained that his first knowledge of the recommendation
21 as a member of the advisory group was when it was
22 circulated as a proposed appendix to the group's draft
23 report. It has not been incorporated in the final
24 report. Directors agreed to continue with their present
25 practice, which was to ask donors if they had suffered

1 from malaria at any time not whether they were from
2 endemic malarious areas. It was not a major problem in
3 Scotland. Dr McIntyre noted directors' views for
4 transmission to DHSS."

5 That, perhaps, professor may be consistent with what
6 you have told us in your statement and today, that you
7 essentially didn't give any consideration to the
8 question of the practice of collection of blood from
9 prisons at the time in, say, the mid to late 1970s?

10 A. Yes, that's correct, sir.

11 Q. Thank you, professor. That completes that chain of
12 correspondence.

13 Could I now, please, revert to your witness
14 statement. I think we had reached question 10 at
15 page 4. Question 10 asks:

16 "Why the SNBTS continued to collect blood from penal
17 institutions following the Medicines Inspectorate's
18 adverse comment on that practice in March/May 1982."

19 You answered:

20 "As far as I recall there were four reasons.

21 "1. There was bemusement that no mention of this
22 difficulty had been made in the MI reports for Aberdeen,
23 Glasgow and Inverness.

24 "2. There was a strong view that this could have
25 significant adverse effects on red cell supplies at

1 certain times of the year, notably in the West."

2 When you say there was a strong view, professor, who
3 or whom held that view in particular?

4 A. It is notably the West, my good friend, Dr Mitchell.

5 Q. Yes. Before we leave that, do you recall at the time,
6 so in 1982 or 1938, which of the individual Scottish
7 directors supported the continued collection from
8 prisons and which of the Scottish directors thought that
9 practice should stop?

10 A. I don't recall, to be absolutely honest. The only thing
11 I can recall is I tended to be on the side, as I have
12 said before, that we should pull out, but I don't
13 recall. I don't think my old friend, Dr Mitchell, was
14 totally opposed. I think the notion he felt of suddenly
15 stopping when his donor programme had been planned for
16 12 months ahead and he foresaw major problems with
17 shortages -- we didn't second guess that, we accepted
18 his point of view and it is very interesting that even
19 by 1984 it had dropped from 2,500 down to about 400.

20 So they were clearly, in 1983, as the others
21 switched off finally, the West team were making
22 strenuous efforts to detach at the same time. So
23 I think you need to go and find as many of the directors
24 as you can to get their views but I don't recall, other
25 than Ruthven Mitchell found himself, he felt, in a very

1 difficult position.

2 Q. I see. Returning to this statement, please, professor,
3 the third point you make is that:

4 "Without SNBTS directors' consensus there was no
5 national management process for considering issues
6 related to the location of blood collection sessions in
7 the regions. Throughout the UK this issue was strictly
8 left to the RTDs and their teams and their priority was
9 maintenance of supply. This management practice and the
10 operational priorities enjoyed SHHD/DOH support."

11 By management practice and operational priorities,
12 do you essentially mean by "management practice" the
13 question of regional autonomy?

14 A. Yes, indeed.

15 Q. And by "operational priorities", you mean the
16 maintenance of supplies?

17 A. Yes, absolutely right, thank you.

18 Q. The fourth point you make was that there was uncertainty
19 at the time with regard to the locus of the medicines
20 inspectors regarding donor sessions issues, a view
21 shared by SHHD. We have already discussed that this
22 morning.

23 Question 11. We have covered. Question 12 we have
24 covered as well, professor. Question 13 asks a question
25 in relation to a July 1984 report by doctors Follett and

1 Dow on their research project entitled "Non-A non-B
2 hepatitis in the West of Scotland". If we can go over
3 the page, please, to page 6 of your statement. You
4 answer:

5 "As far as I can recall, the SNBTS directors had
6 first site of Dr Dow's studies in May 1986. Thus the
7 presentation of this work to the directors was not
8 related to prison donor sessions but rather surrogate
9 testing."

10 We will come on to look at the question of surrogate
11 testing after the summer, as a separate topic.

12 Question 14:

13 "The extent to which, if at all, between 1975 and
14 1984 the SNBTS discussed with officials from the SHHD
15 the practice of collecting blood from prisons and any
16 increased risks of hepatitis."

17 You answer:

18 "The SHHD officials were present on all occasions
19 the SNBTS directors discussed this topic. This included
20 the initial verbal briefing immediately after the
21 inspections at the Dundee and Edinburgh centres, every
22 occasion when it was discussed at the SNBTS directors'
23 meetings. SHHD were also aware that we had sought
24 advice/guidance from the DHSS."

25 We have already covered the interplay between these

1 organisations.

2 Before I leave the question of prisons, professor,
3 and turn on to the second question of donors with
4 a history of jaundice, I think I would like to put
5 a number of documents to you, really with a view to
6 asking the question: do these documents suggest that
7 either in the early 1970s or in the later half of the
8 1970s consideration should have been given to stopping
9 the practice of collecting blood in prisons in Scotland.

10 So if I may, professor, the first document I would
11 like to take you to is [\[PEN0020407\]](#). We can see,
12 professor, this is a report of proceedings at the Royal
13 society of Edinburgh in 1972, the topic having been
14 transfusion practice or transfusion medicine.

15 In particular, if we can, please, go to
16 [\[PEN0020559\]](#). Professor, this is a copy of a talk you
17 gave at those proceedings. I have to say, when 40 years
18 ago you were down the road At the Royal Society giving
19 this paper, I'm quite sure you never thought that you
20 would be 40 years later having to go over and answer
21 questions on it. But be that as it may, professor, we
22 do have the paper and I would like to put it to you. We
23 can see the paper is headed "Principles of effective and
24 safe transfusion". At that time you were deputy
25 director of the Edinburgh and Southeast Scotland BTS.

1 At page 0564, at the bottom under the subheading
2 "Laboratories' contribution, Australia antigen testing."

3 I should perhaps say, of course, that Australia
4 antigen was the initial, original name given for
5 Hepatitis B. So you start a discuss of that. If
6 I could then please fast forward to -- well, slow
7 forward to the next page, please, page 53. It's
8 original reference S53, court reference 0565. At the
9 very bottom of the page, second to last line, it starts:

10 "Although the recent introduction of total donor
11 screening throughout the length and breadth of Scotland
12 must be regarded as a major step forward, there is still
13 much to be done."

14 Over the page, please:

15 "This concerns the quality of the existing
16 facilities and development of more sensitive screening
17 procedures for future use. While it is accepted that
18 the CIEOP technique is basically simple, it is full of
19 pitfalls and liable to give false positive and negative
20 results. Both these events could have serious
21 consequences for the donor and recipient respectively."

22 Then in the next paragraph I think you make the
23 argument for the institution of a national reference
24 laboratory in Scotland but then a few lines beneath
25 that, so it is seven lines above "Miscellaneous

1 contributions", we can see:

2 "In short, the Blood Transfusion Service must be up
3 in front rather than behind for we must not assume that
4 the elimination of all antigen positive units will solve
5 the post-transfusion hepatitis dilemma. Current
6 evidence strongly suggests that the present limitations,
7 which have been calculated to represent a detection rate
8 as low as 25 per cent, cannot be entirely explained on
9 insufficient sensitivity of existing methods, and that
10 other agents are responsible for a significant
11 proportion of the problem."

12 You make a reference in particular to a paper, 1970,
13 by Gocke, which I think suggested -- or do you recall,
14 professor, what you were getting at in that statement?

15 A. In that last sentence?

16 Q. Yes.

17 A. It sounds pretty prophetic about non-A non-B. I really
18 can't claim any cleverness. One was very conscious, as
19 I was associated with the fractionation side, that
20 Hepatitis B surface antigen was still getting through,
21 despite the testing, and if you in fact then looked at
22 that, you were left, as other people were aware -- there
23 seems to be another area that doesn't relate to
24 hepatitis B.

25 Q. So two concerns at that time. Firstly, the existing

1 screening methods weren't sensitive enough to detect all
2 Hepatitis B antigen-positive donors, and secondly, in
3 addition to that, there appeared to be another agent or
4 agents which appeared to transmit post-transfusion
5 hepatitis.

6 A. Might I just add, there is a third. We had several
7 episodes in which it was quite clear that the test was
8 sensitive enough. The good manufacturing practices, the
9 whole system, had failed, and that raised whole stories
10 about inspection and audit and so on and so forth.

11 Q. And presumably, professor, in particular, once RIA
12 testing was available for Hepatitis B, then RIA is
13 a sufficiently sensitive test to be able to exclude
14 Hepatitis B as the cause of a case of post-transfusion
15 hepatitis, which would then point to other possible
16 hepatitis agents?

17 A. I would only add the slight rider -- and there is data
18 in your database, which showed that the RIA produced and
19 available widely in the UK at one point, that was
20 manufactured in the blood products laboratory, was shown
21 by the team in the West of Scotland to be much less
22 sensitive than the commercial kit, RIA kit, supplied by
23 an American company, Abbott. So just using the word
24 "RIA" -- and this takes us into the whole area of NIBCS
25 and producing standards which we eventually did. Just

1 saying "RIA will totally remove it", is just a little
2 bit simplistic.

3 Q. Yes, so different RIA kits, made by different
4 manufacturers will have different sensitivities and
5 specificities?

6 A. Absolutely right.

7 Q. I understand.

8 Perhaps the next main chain in this document, if we
9 can just go to a paper I'm sure you will be familiar
10 with, [\[LIT0010363\]](#). We are starting to trace now the
11 developing knowledge of non-A non-B hepatitis. This is
12 a paper by Prince and others, reported in the Lancet in
13 1974. The title is "Long incubation post-transfusion
14 hepatitis without serological evidence of exposure to
15 the Hepatitis B virus". Do you recall seeing this paper
16 at the time, professor?

17 A. I don't. But I don't think -- I don't recall but
18 I wouldn't put much store on that.

19 Q. But would you agree it is one of the important papers --

20 A. No question.

21 Q. -- charting the history of non-A non-B hepatitis?

22 A. I see Alfred Prince in my 1969 visit to the States, he
23 gave me a small vial of Australia antigen in New York
24 and I brought it back, and that was the first beginnings
25 of testing for Australia antigen, certainly in Scotland.

1 This was an outstanding group.

2 Q. From that vial you received from Dr Prince you were then
3 able to initiate the development of Hepatitis B
4 screening in conjunction with --

5 A. I was, and most importantly for me in that area is
6 that -- and there has been no mention of it in the
7 Inquiry so far -- that one of the colossally impressive
8 things upon me was the death of my close friend, a
9 surgeon in Edinburgh, in relation to the kidney dialysis
10 transplant, viral hepatitis outbreak. And I mention
11 that because it was related to transfusion. A
12 multi-transfusion. The patient had a kidney transplant
13 which was hugely multitransfused.

14 I mention it because the guys, the virologists who
15 we worked with, with Alfred Prince's stuff,
16 Professor Barry Marmion, they published all this. They
17 said the reason why this attack, this Edinburgh episode
18 is so lethal -- and it took out two surgeons, a nurse,
19 my technician -- bless her, Pamela -- and about four
20 others. It was a disaster. The reason they said it was
21 so lethal was that they postulated it was a simultaneous
22 double virus infection.

23 A few years later, when they got the Hepatitis C
24 testing, they showed that this was a Hepatitis B and C
25 and they had reason to believe because of problems in

1 dialysis units of cleanliness, there might have been E
2 in it.

3 So the notion that double infections can be
4 particularly dangerous got into my head. If you ask how
5 can you get a double infection? The only way is large
6 pooled blood products.

7 Q. That's very interesting, professor. The outbreak in the
8 Edinburgh dialysis centre, was that in the late 1960s?

9 A. My friend died in February 1970. Yes, 1969.

10 Q. And subsequent testing indicated that outbreak was not
11 solely Hepatitis B but also --

12 A. That is correct.

13 Q. -- but also Hepatitis C?

14 A. That is correct. This is published.

15 Q. I'm grateful. So going back to the Prince paper in
16 1974, certainly you were on the lookout really as far
17 back as at least 1972, about the possible existence of
18 other hepatitis post-transfusion viruses, but I think
19 Prince in 1974 was perhaps important in establishing, at
20 least in America, that there was a likelihood of non-A
21 non-B virus or viruses. Is that a fair way to put it or
22 does that put it too highly, that the Prince paper
23 established that the existence of non-A non-B hepatitis
24 viruses was not only a possibility but a likelihood?

25 A. Hm-mm. Yes, yes.

1 Q. Is that a fair way of putting it?

2 A. Absolutely right, sir, yes.

3 Q. What I'm interested in exploring, professor, is whether,
4 in particular from this point onwards, from 1974
5 onwards, the possible or likely existence of non-A non-B
6 hepatitis viruses should have pointed away from the
7 collection of blood in prisons in Scotland and whether
8 there should have come a time when that practice should
9 have stopped.

10 So just to develop this question of knowledge of
11 hepatitis non-A non-B a little, if I could then refer to
12 two further papers, the next is [\[LIT0013657\]](#).

13 We have looked at this in the Inquiry previously,
14 professor. It is a paper by Hoofnagle and others from
15 America, the Bureau of Biologics in the National
16 Institutes of Health, on the question of transmission of
17 non-A non-B hepatitis published in the Annuals of
18 Internal Medicine in July 1977. On page 3662, which is
19 original page reference 19, on the right-hand column,
20 several observation are set out. Have you seen this
21 paper before, professor?

22 A. Oh, yes. I don't recall seeing it now, but, yes, sure,
23 in the work-up for the Inquiry?

24 Q. Yes.

25 A. Yes, indeed, sir.

1 Q. I won't go back over the observations because I think we
2 did that yesterday. But I think we can see there
3 various points are made by those at least working in
4 America on this likely agent or agents, non-A non-B
5 hepatitis.

6 Then to complete this passage, the next document is
7 [\[LIT0010189\]](#). Again, professor, we have looked at this
8 before. Again, it's a paper from America, from Berman,
9 Harvey Alter and others at the National Institutes of
10 Health on the question of the chronic sequelae of non-A
11 non-B hepatitis, again published in the Annuals of
12 Internal Medicine. I should perhaps ask, professor, in
13 the mid to late 1970s, is this a publication that you
14 would have been aware of, the Annuals of Internal
15 Medicine? Is that a periodical that you would have
16 read?

17 A. Yes, this is -- and I think I'm right and
18 Professor Oliver can confirm this, but we didn't have
19 the big databases to do the searching but what we did
20 have at this time was a thing called Current Contents,
21 which was a small thing about this size and it simply
22 put together all the journals in the -- the ones
23 I looked at -- the biological sciences, the medical
24 sciences. All the contents pages of every journal that
25 fitted in this thing. My wife will recall that I spent

1 three to four hours every weekend going through my
2 Current Contents, and on Monday morning arrived with my
3 PA with a list five miles long of papers, and I'm pretty
4 sure it was going at 1979 and I would have certainly
5 picked this up. There is no question about that.

6 Q. I understand.

7 A. But we didn't take that journal but we would have had
8 access, no problem.

9 Q. Thank you. At page 0192 in the left-hand column, last
10 paragraph, the authors state:

11 "Several interesting features of non-A non-B
12 hepatitis and its relation to chronic liver disease
13 derived from this study."

14 And five observations are set out. I don't propose
15 to go through them now. Really, the question is this,
16 professor: at some point in the 1970s ought the
17 following to have been thought: firstly, that initially
18 Hepatitis B screening tests were relatively insensitive,
19 in the sense that they did not catch all, or perhaps
20 even most, positive donors but secondly, there did then
21 come a point, perhaps around the mid 70s, when
22 Hepatitis B screening tests were such that they probably
23 did catch most of the positive Hepatitis B donors.

24 Thirdly, there appeared to be a blood-borne non-A
25 non-B hepatitis agent or agents. Fourthly that there

1 was an increased prevalence of Hepatitis B among
2 prisoners; and fifthly Hepatitis B is a blood-borne
3 virus. And this is the big leap, or not: so therefore,
4 sixthly, there may also be an increased prevalence of
5 non-A non-B hepatitis among prisoners.

6 I have set out six propositions, perhaps not very
7 eloquently, but do you essentially agree or do you agree
8 with any or all of these propositions?

9 A. I'm not sure I can remember all six at the moment but
10 I intended to say, "Yes, I agree with them" as you went
11 along, yes.

12 Q. Yes. So --

13 A. Do you want to repeat one to make sure --

14 Q. I possibly should just go through them, professor. We
15 have the handy transcript to enable that to be done.
16 I think I have probably forgotten myself what I said.
17 We can pause the transcript and I'll just read them
18 back.

19 Yes, I think the first proposition was: initially
20 Hepatitis B screening tests were relatively
21 insensitive --

22 A. Yes.

23 Q. -- in the sense that they did not catch all or perhaps
24 even most positive donors.

25 A. Yes.

1 Q. The second proposition was that there did come a point,
2 perhaps around the mid 1970s, when Hepatitis B screening
3 tests were such that they probably did catch most of the
4 positive Hepatitis B donors.
5 A. I agree.
6 Q. But thirdly, there appeared to be a blood-borne non-A
7 non-B hepatitis agent or agents.
8 A. I agree.
9 Q. Fourthly, that there was a increased prevalence of
10 Hepatitis B among prisoners.
11 A. Yes.
12 Q. Fifthly, Hepatitis B is a blood-borne virus.
13 A. Yes.
14 Q. So you have agreed with the first five propositions.
15 Does it follow from those five proposition that sixthly,
16 there may also have been an increased prevalence of
17 non-A non-B hepatitis among prisoners?
18 A. I agree there may have been, yes.
19 Q. Certainly, should the first five propositions have given
20 pause for thought in the mid to late 70s, as to whether
21 blood should continue to be collected from prisons?
22 A. Yes. I agree with that, sir.
23 Q. If one had regard to those five propositions and had
24 paused for thought in the mid to late 1970s to consider
25 whether blood should continue to be collected from

1 prisons, can you say what the likely conclusion ought to
2 have been?

3 A. I find that very difficult to answer. Can I postulate
4 what the likely conclusion -- I really don't honestly
5 know to be absolutely -- in 2011. Again, with the power
6 of the retrospectoscope I would say they should have got
7 out of that and the whole of the transfusion world
8 should have moved, including the commercial people,
9 collecting plasma. But that's a very retrospective view
10 and in our country, in the United Kingdom, I have always
11 argued that we did have problems that went on and on, as
12 to who had the duty of care in this area, particularly
13 when one of the departments of health was playing a very
14 lead position.

15 That doesn't absolve us, certainly from the point of
16 view of viral hepatitis in relation to transfusion. The
17 biggest tragedy for me personally was the disbandment of
18 the MRC research committee because there Harold Gunson,
19 Dr Harold Gunson and our own Brian McClelland were
20 developing a whole major programme on
21 transfusion-transmitted hepatitis, and the whole thing
22 collapsed when it was disbanded. So opportunities were
23 there and we just didn't pick them up.

24 Q. I think, that committee was disbanded in 1982, I think?

25 A. That is correct.

1 Q. We will come to look at that in the topic of surrogate
2 testing, I think, in due course. One final document
3 I should perhaps put to you on this matter for
4 completeness, professor, is an international document.
5 It is reference [\[DHF0012672\]](#).

6 Professor, this is a 1976 document from the
7 International Society of Blood Transfusion, entitled
8 "Criteria for the selection of blood donors". If we go
9 over the page, please, to 2673, we saw yesterday this
10 was a fairly international body. Do you recall,
11 professor, whether you saw this document at around the
12 time it was published in 1976?

13 A. I don't. But I suspect I was -- is this an
14 international conference in Paris, is it?

15 Q. I think it is professor, yes.

16 A. It looks like it. I very much suspect I was there.

17 Q. In particular if we can, please, go to page 2683,
18 paragraph 9 "Viral hepatitis". Again we looked at this
19 yesterday. About half way down the recommendation was
20 that:

21 "Prospective donors should be excluded if it is
22 known that they ..."

23 Over the page, please, page 2684, number 7:

24 "... are inmates of a correctional institution."

25 Again, if one had paused to consider the question of

1 collection from prisons in the late 1970s in Scotland,
2 if one had looked at this guide, presumably that is
3 something else which would have pointed away from the
4 practice.

5 A. Yes, I think that's correct, although 1976 was probably
6 six months after the CMO in England said "March on".

7 Q. Indeed.

8 A. I suspect -- that did -- I can't recall in detail but
9 I'm pretty sure that must have had an influence on
10 whether this was really seriously picked up.

11 Q. Yes, although in the CMO's letter in May 1975, there was
12 no discussion of non-A non-B hepatitis in that letter at
13 least.

14 A. No, but he had the access -- or should I say his
15 experts -- he was surrounded with a vast number of
16 virological experts, were no less expert, in fact a good
17 deal more expert than John Cash in 1971 saying, "I think
18 there might be -- " and the other papers you have
19 referred to.

20 So the fascinating thing would be to ask the
21 question: what really led Sir Henry Yellowlees to issue
22 that roundelay. And it is fascinating and I certainly
23 don't know. But he had access -- regular access to --
24 I happen to know the director of NIBSC was a virologist
25 at that time. That was Smith that we have picked up

1 today. Director of PHLS. These people would have been
2 closely advising. I cannot imagine the CMO in London
3 interfacing with his Scottish counterparts and they in
4 turn would have consulted their senior top -- there were
5 some very top virological experts.

6 So I think the game was there to be played and a lot
7 of us didn't pick up the ball and run.

8 Q. I see. Professor, thank you for that.

9 I think I can now leave the question of prisons.

10 Can I then, please, return to your statement, to
11 page 6, question 15. We move on in question 15 to the
12 question of accepting as donors those with a history of
13 jaundice or hepatitis. Question 15 refers to the
14 recommendation in the second Maycock report to the
15 effect that blood from donors with a history of jaundice
16 or hepatitis could be accepted if the donor tested
17 negative for Hepatitis B surface antigen. I think in
18 addition, if the jaundice episode was more than 12
19 months previously. Then in your answer to this question
20 you state, on next page:

21 "I do not recall this topic being discussed by the
22 SNBTS directors in 1975 but I do recall soon after I was
23 appointed NMD expressing my concern to Dr Ed Harris,
24 deputy chief medical officer London, that the criteria
25 for the selection of blood donors in the UK was left in

1 the hands of junior DHSS civil servants who had little
2 knowledge of blood transfusion practice nor were they in
3 touch with international experts."

4 I would like to explore this answer a little,
5 professor. Is there a particular document you have in
6 mind in that answer? You state that your concern was
7 that the criteria for the selection of blood donors in
8 the UK was left in the hands of junior DHSS civil
9 servants. Is there a particular document or manual --
10 A. I'm sure there will be but nothing springs to mind, but
11 we have already talked about Dr Entwistle's committee
12 that generates views on the selection of donors. Those
13 views are transmitted. They had to be transmitted into
14 DHSS, and DHSS then consulted widely -- it was a very
15 slow process -- and then issued, as I recall, guidelines
16 and the idea was they kept them updated.

17 Q. If I can go, please, professor --

18 A. Jack Gillon --

19 Q. If I can go to, please, to three particular documents by
20 which of example. If we can start, please with document
21 [\[DHF0012039\]](#), this is a 1973 "Notes on transfusion",
22 which, I think we heard from Dr McClelland, provides
23 guidance on the clinical use of blood. It's that end of
24 the transfusion spectrum.

25 A. I agree.

1 Q. Over the next page, please, we see at the top the insert
2 page states:

3 "Notes on transfusion. Issued by the Department of
4 Health and Social Security with the Scottish Home and
5 Health Department and Welsh Office for the National
6 Blood Transfusion Service and the Scottish Blood
7 Transfusion Association."

8 Simply taking those words at face value, professor,
9 the impression one is left with is that the DHSS
10 essentially publish these notes on behalf of the Blood
11 Transfusion Services, who primarily at least -- or
12 perhaps exclusively are responsible for the content of
13 the notes. Is that an accurate impression or not?

14 A. No, I don't think it is and I really -- it is such
15 a long time ago but I mean, the issue that arose was
16 a fundamental issue, which I completely understood, that
17 if the DHSS and the Scottish Office and so on, were
18 publishing something they were responsible as publishers
19 for publishing it. And in this area and in another
20 area, which the haemophilia directors will advise you
21 on, the people responsible to ministers for publishing
22 and releasing this stuff understandably consulted very
23 widely, outside the Blood Transfusion Service, wherever
24 they wished to.

25 Certainly, an impression developed which -- as

1 I have said, come the AIDS, we decided we had to move --
2 the impression developed that, as I have said in this
3 statement, is fairly junior -- and I'm not going to name
4 them because they were not that junior. DHSS doctors,
5 because they had to cover their own backs, were
6 suggesting modifications, coming backwards and forwards
7 and backwards and forwards and there were long delays.

8 So I took the view, and I know my colleague
9 Harold Gunson took the view and he eventually moved with
10 us on the AIDS episode, that the documents that were
11 issued were regarded as DHSS property, and SHHD -- it
12 was a joint -- but DHSS actually did all the work in the
13 context of publishing and consulting.

14 Q. I understand. Just for completeness, if we could go to
15 the next page in this document as well, please, this
16 states:

17 "This edition of notes on transfusion, like the four
18 previous editions, has been prepared by the committee of
19 regional transfusion directors of the Department of
20 Health and Social Security and Welsh Office."

21 What's that a reference to, "the committee of
22 regional transfusion directors of the Department of
23 Health and Social Security and Welsh Office"?

24 A. I very much regret I have no idea. That's absolutely
25 fascinating. I didn't know the department had its own

1 little committee of regional transfusion directors,
2 I genuinely didn't. What is for sure is that
3 Colin Entwistle, Dr Entwistle's committee, the idea was
4 that they generated guidelines, these are not notes on
5 transfusion -- I'm thinking of donor selection and so on
6 and so forth -- they generated guidelines and I'm
7 absolutely certain that they would have let the
8 directors have sight of these before they handed them on
9 in to the department. I'm not absolutely certain but
10 I can't imagine they wouldn't do that.

11 Q. If this is speculation please say so but is it possible
12 that the committee of regional transfusion directors of
13 the DHSS may have comprised some of the regional
14 transfusion directors of the NBTS in England and Wales
15 with perhaps DHSS membership as well?

16 A. Possible, sir, yes.

17 Q. Essentially speculation at this stage.

18 A. I honestly don't know.

19 Q. Thank you. We can put that document to one side.

20 Another example of guidance documents is found at
21 [\[SNB0025348\]](#). Professor, I think this is the 1977
22 version of the "NBTS memorandum on the selection,
23 medical examination and care of blood donors", and is
24 this the guidance which Dr Entwistle was involved in,
25 I think in the mid 1980s or early to mid 1980s?

1 A. I would have thought that's right, sir. And I don't
2 know who his predecessor was, I can't remember.

3 Q. We see there are different versions of this memorandum.
4 We looked at references yesterday and identified at
5 least the references. But this memorandum on the
6 selection, medical examination and care of blood donors,
7 who drafted that and who revised it?

8 A. My understanding -- I honestly don't know, but I do know
9 who will know if anybody knows, and that's
10 Dr Jack Gillon, and he has produced a superb review
11 paper on this whole area, in my view, and I really --
12 I feel I may be wasting your time giving an opinion
13 because I don't really know.

14 Q. I understand, professor. We will come back to that with
15 Dr Gillon.

16 The last example of a guidance document, please, is
17 [\[PEN0020249\]](#). We can see this document is dated 1979
18 and is entitled "Standards for the collection and
19 processing of blood and blood components and the
20 manufacture of associated sterile fluids".

21 If we can go to page 0251, please. Subparagraph 1
22 in the introduction states:

23 "These standards were compiled by the Department of
24 Health and Social Security in consultation with the
25 regional transfusion directors of England, Wales and

1 Scotland, the directors of the blood products
2 laboratory, Elstree, the protein fractionation centre,
3 Liberton and the Scottish Home and Health Department."

4 Are you familiar with this document, professor?

5 A. To be honest, I'm not, but again, I may have just
6 forgotten. If you can keep going, I might sort of catch
7 up.

8 Q. In short, professor, I was interested in who was
9 responsible for drafting the guidance. Certainly the
10 document states that the standards were compiled by the
11 DHSS, albeit in consultation with the NBTS directors.

12 A. I mean -- I do realise I have been seeing some
13 correspondence about Diana Wolford in terms of access to
14 her expertise in this Inquiry. But, I mean, the name
15 that springs to mind in DHSS at that time is
16 Dr Alison Smithies, a charming lady. And I have
17 a certain feelings that Alison bore the brunt of this
18 whole area during that period.

19 Q. Yes. Professor, going back to your answer 15, where you
20 say that the criteria for the selection of blood donors
21 in the UK was left in the hands of junior DHSS civil
22 servants, it is quite a wide statement and I wonder
23 really if one has to look at particular documents and
24 really ask oneself how were they compiled and by whom.
25 And certainly the 1977 guidance on the selection of

1 blood donors, my impression, rightly or wrongly, was
2 that that was largely compiled and revised by the BTS
3 services in England and in Scotland. Is that fair?

4 A. I think the typed one we saw -- I'm not sure -- is
5 probably correct. But the published ones came out of
6 the DHSS. And again I think Jack Gillon -- I apologise
7 for not having enough detail in this area but Dr Gillon,
8 I'm sure would be immensely helpful in clarifying that.

9 Q. And we can check that with Dr Gillon, professor, but
10 I think your point is that anything published by the
11 DHSS, there is likely to have been some DHSS involvement
12 in the content of the document?

13 A. Yes, they made this very clear. There is a letter on
14 file, for instance, if you take the haemophilia
15 directors, in which they produce guidelines for the
16 management of patients and they submitted this, for
17 reasons that I don't understand, to the department for
18 publication and distribution. And there is a letter on
19 file from a senior medical officer in the DHSS saying
20 they are not prepared to be involved because the
21 clinicians, coming from Newcastle in particular, were
22 looking to develop prophylactic therapy and the
23 Department of Health was not prepared to agree to the
24 whole notion of prophylactic therapy, for funding
25 reasons no doubt, and therefore would not publish the

1 thing. So there is understandably there is an editorial
2 involvement.

3 Q. I understand. Thank you.

4 Question 16 asks:

5 "The consideration given by the SNBTS between 1975
6 and 1991 to the exclusion of donors at a higher risk of
7 transmitting non-A non-B hepatitis including the
8 exclusion of donors with a history of jaundice or
9 hepatitis."

10 You regret you do not recall specific occasions and
11 advise consultation with Dr Gillon. I think, perhaps,
12 professor, I will explore that a little more with
13 Dr Gillon and Dr Dow.

14 A. Superb, he has got a superb knowledge.

15 Q. We all look forward to that, professor. You have set
16 Dr Gillon up for a good performance.

17 A. No, no, no, it really is -- he has done a lot of
18 research.

19 Q. And we are grateful to him.

20 Question 17. Again, procedures. You refer to your
21 previous answer. Question 18 asks about the question of
22 whether there were national policies or whether each
23 SNBTS region had its own practice and policies. You
24 state:

25 "One of the features in this aspect of blood

1 transfusion practice throughout the 1980s, 1990s, was
2 the development and maintenance of UK, later SNBTS,
3 guidelines. As far as I'm aware, these guidelines were
4 adopted by each SNBTS RTC. I'm reasonably certain that
5 an independent audit of compliance did not take place
6 during the period I was with the SNBTS."

7 Paragraph 19 you are asked a question about:

8 "If donors with a history of jaundice ... had been
9 excluded ... is that likely to have caused ...
10 difficulties in maintaining a sufficient supply of blood
11 ... the extent of which post-transfusion Hepatitis C in
12 Scotland is likely to have reduced."

13 I think Dr Gillon will speak to that so I think we
14 can pass over that. There is a footnote at page 8 to
15 your statement. If I could take you to that, please.
16 And I think you were asked further questions, one of
17 which was 3, selection of donors. I think you were
18 asked a question in relation to a letter by Dr Brookes
19 to yourself, dated 5 July 1983.

20 Could we have that on the screen, please? The
21 reference is [\[SNB0025920\]](#).

22 I think we can see this is a letter dated
23 5 July 1982 by yourself to Dr Brookes in Dundee saying;

24 "One of the general points made by the
25 Medicines Inspectorate was that in the SNBTS the

1 acceptance of a donor was largely a matter of chance.
2 Clearly a gross exaggeration but it has been well-known
3 for many years that the consistency between centres is
4 less than desirable.

5 "You represent the SNBTS on the UK working party
6 dealing with the selection of donors. I would be most
7 grateful for a note on what is happening in this area
8 and whether you would agree to study the position in
9 Scotland with a view to our having a more consistent
10 policy in the future."

11 Then in your statement, professor, you give a reply
12 to the query in respect of that letter, basically what
13 you were meaning. On page 8 of your statement you say:

14 "In 1982/83, the selection of blood donors was the
15 final responsibility of the doctor in a donor session
16 team. In 1977 the DHSS published a memorandum on the
17 selection, medical examination and care of blood donors
18 ..."

19 Which we looked at shortly before:

20 "... which no doubt was intended to operate as
21 a guideline for these doctors. The point I was making
22 to Dr Brookes in 1983 was that as sessions doctors we
23 are finally responsible for making these selection
24 decisions and as they were operating from guidelines, it
25 was certain that there would be some differences in

1 interpretation between different RTCs but also probably
2 between doctors working in the same centres. The
3 question I posed: was there scope for more consistency?"

4 Again, I think we come back to Dr Gillon's paper
5 which we will look at later.

6 The final question you are looking at: was there any
7 documentary evidence of blood shortages in the West of
8 Scotland?

9 You say there:

10 "I can advise that there are several such documents
11 in the papers you have already received from SNBTS."

12 You refer to a letter you wrote to Dr Mitchell on
13 this topic dated 15 January 1990. We will come back to
14 that very shortly, professor. But you have no
15 recollection of ever communicating on this topic with
16 any other SNBTS RTC director between 1974 and 1991.

17 On this question of blood shortages, professor, I
18 think you produced a helpful supplementary paper, which
19 we could also look at. This is reference [\[PEN0110066\]](#).

20 Professor, could you perhaps read this paper to us?

21 A. You would like me to read?

22 Q. Yes.

23 A. "The provision of sufficient blood and blood components
24 within each region of Scotland throughout this period
25 [that we are thinking of, 1980 to 1997] was the

1 responsibility of the local regional blood transfusion
2 centre team. As I recall, up until the early 1990s, the
3 concept of regional self-sufficiency was part of the
4 strong independent/regional culture within the SNBTS.

5 "This culture had existed since the creation of the
6 SNBTS in 1939, and was not modified when the SNBTS
7 became incorporated into the NHS in 1974 or when the
8 first NMD was appointed. Some (including myself)
9 believed that this fierce regional self-sufficiency
10 contributed much to the development of national
11 self-sufficiency in plasma products in Scotland and
12 I must confess I was at some pains not to promote change
13 unless really necessary.

14 "But change began in the late 1980s, partly as
15 a consequence of the nature of PFC's contributions but
16 perhaps most important of all was the movement of
17 surplus red cells from SNBTS [down to England]. This
18 latter development revealed that there were rare
19 occasions when as one SNBTS region was short of blood
20 others [in Scotland] were shipping their surpluses to
21 England -- wholly unaware of their SNBTS neighbour's
22 needs.

23 "As I recall, in the late 1980s we established an IT
24 system in which information on RTC blood stocks
25 throughout Scotland was available each day and centres

1 were encouraged to use those data ..."

2 I think initially it went on faxes actually:

3 "... to obtain support from other regions when
4 necessary.

5 "My recollections of significant blood shortages are
6 that they were rare, that they occurred only in the West
7 and that on file are communications between myself and
8 Drs Mitchell and Crawford [both in the West], on this
9 topic. In addition there are innumerable documents on
10 file which provide an insight into the programme [for]
11 the movement of red cells from Scotland to England.

12 I have always believed that there were never significant
13 blood/blood component shortages in Scotland during this
14 period. The key problems [we had] were fierce local
15 pride and communication glitches. As anticipated, when
16 understood change occurred."

17 Q. Perhaps the key sentence, professor, is that at the very
18 bottom of the previous page, running into that page:

19 "I have always believed that there were never
20 significant blood/blood component shortages in Scotland
21 during this period."

22 I think that is perhaps consistent with
23 Dr Mitchell's evidence that while there were
24 difficulties, they were not insurmountable.

25 A. Well, I think we have to bear in mind that surgery was

1 postponed. I don't know what we mean by "serious" but
2 for the patient that's not terribly good news.

3 Q. If we could, perhaps, professor -- I have almost
4 finished my questioning -- look at three last documents
5 on this question of blood shortages?

6 Firstly [\[SNB0037020\]](#). This is a letter dated
7 30 December 1982 by yourself to Dr Mitchell on the
8 question of blood supplies in cardiac surgery. You say:

9 "I had cause to be discussing matters with
10 colleagues in SHHD recently and mention was made of
11 a letter you wrote to David Wheatley, which was copied
12 to several colleagues ..."

13 You say:

14 "Whilst we must hope that additional funds will be
15 made available in due course, I'm particularly anxious
16 that every possible effort is made to ensure that
17 patients requiring cardiac surgery in the West are
18 managed in the optimal way and that surgery is not
19 delayed because of lack of blood."

20 You also say:

21 "I would suggest to you that there may be another
22 option: the provision of red cell concentrates and even
23 whole blood from other SNBTS regional centres."

24 That's the point you are suggesting, that there
25 should be cooperation and communication between the

1 centres. So if one region has an excess and another
2 region has a deficit, then that deficit can be made good
3 by the transfer of blood and its components between
4 regions. Is that the point?

5 A. Yes, absolutely.

6 Q. I think, to complete this, if we go to document
7 [\[SNB0036988\]](#).

8 These are the minutes of a meeting of the BTS
9 co-ordinating group, held in the HQ unit on
10 22 February 1983. We will see those present include
11 yourself, professor, in the chair and also Dr Mitchell.
12 If we then, please, go to page 6990, paragraph 7:

13 "Blood supplies, cardiac surgery":

14 "Dr Mitchell had notified Professor David Wheatley
15 that he might be unable to support the latter's cardiac
16 surgery programme because of lack of sufficient funding.
17 Dr Cash had sent to Dr Mitchell a letter, (which had
18 been circulated) drawing attention to the Scottish
19 statistics of expired red cell concentrates. He had
20 suggested to Dr Mitchell that the latter might obtain
21 red cells from other transfusion centres. Dr Mitchell
22 indicated that he preferred to cope from within his own
23 region."

24 Do you remember this meeting, professor?

25 A. I don't. But that reported comment of Ruthven fits very

1 well. It is all about the fierce independence. But
2 I don't recall the meeting as such.

3 Q. But that reported comment by Dr Mitchell perhaps
4 illustrates two things. Firstly, back to the question
5 of regional autonomy. But secondly, Dr Mitchell told us
6 yesterday that while there were difficulties in the
7 blood supply in Glasgow at particular periods, they
8 weren't insurmountable, which is consistent with him
9 saying he preferred to cope from within his own region?

10 A. I think the long-term planning is one thing but if you
11 are short for next Monday, these are different issues
12 and problems.

13 Q. Yes. I think the suggestion I made was that the comment
14 by Dr Mitchell in these minutes, that he preferred to
15 cope from within his own region, was consistent with
16 what he told us yesterday, that there were no
17 insurmountable difficulties in this region.

18 A. I agree with that, sir.

19 Q. I have no further question, thank you.

20 THE CHAIRMAN: Mr Di Rollo?

21 Questions by MR DI ROLLO

22 MR DI ROLLO: Sir, yes.

23 Professor Cash, one question I would like to ask you
24 is: do you remember the World in Action broadcast in
25 1975? Your colleague John Watts appeared in that and

1 I just wondered whether you recall that programme being
2 broadcast.

3 A. I don't honestly but if you say "World in Action, I
4 think, "Oh, my God, yeah"; that's about as far as I get.
5 I'm sorry, do you want to remind me what he or I said.

6 Q. You didn't appear in the programme as far as I recall.

7 A. That was lucky.

8 Q. But your colleague John Watt does appear in it. The
9 reason for asking you the question is that there is
10 extensive reference to Garrot Allan's letter which you
11 were asked about in your statement. That is actually
12 referred to in detail, including the proposition that
13 paid donors and prison donors -- I'm paraphrasing --
14 could be a problem and that there was an agent other
15 than Hepatitis A or B at work. That's just something
16 about that was contemporary -- the letter is
17 dated January 1975 but the programme was broadcast
18 in November, I think, of 1975. And it's really to do
19 with the question of what your awareness of matters was
20 at the time. But you don't recall the World in Action
21 broadcast?

22 A. I don't recall the details, no, but I do recall -- and
23 it is a fact -- that I think -- we can check it
24 easily -- that in around 1975 I wrote a letter in the
25 BMJ which caused some consternation, in which I advised

1 people that paid donors are highly dangerous. And we
2 are importing, I said, an increasing amount of virus
3 from the US of A. This was published and I sometimes
4 wondered -- and I have no idea whether the
5 World in Action thing sprang from that.

6 Q. The context of that is it sounds as though a lot of the
7 effort that goes into self-sufficiency seems to have
8 perhaps lost the emphasis on another problem which may
9 be there, which is the problem within the population
10 here, including the high risk prison donor. Is that
11 a possibility?

12 A. Of course it must be, but I'm very uncertain that we can
13 explain it on that basis. I don't really know.
14 Certainly in the area of hepatitis, I quite formally
15 delegated that functional sort of area of our work to
16 Brian McClelland, knowing he would be working with
17 Harold Gunson, as I have said, on this MRC committee,
18 and left them to get on with it. Whereas, there is no
19 doubt, my personal time and energy was directed towards
20 self-sufficiency at that time, that's true.

21 Q. And in 1975 you would have been the Southeast Scotland
22 director at the time?

23 A. That's correct but if we ever get round to it, what we
24 were doing in Edinburgh at that time is unbelievable in
25 the context of self-sufficiency.

1 Q. No doubt we will come to that in another context later
2 on.

3 Another matter I wanted to ask you about was the
4 Medicines Inspectorate report in 1982. I'm not entirely
5 clear that is the first external audit, as it were, or
6 inspection of the service at that time? Had there been
7 an inspection of that kind before that?

8 A. Yes, I think we need to be careful -- and I think I have
9 got it right -- to divide the service into the
10 regional transfusion centres, who were the people who
11 collected the blood, the red supplies, the local
12 hospitals, (inaudible), and the plasma, the PFC, and
13 then the PFC. And my understanding is PFC was inspected
14 early on in the 1970s. The Department of Health issued
15 this letter to the CSA on July 25th, I think, 1975,
16 saying that the SNBTS had to function as though they
17 were a pharmaceutical company in terms of safety and so
18 on and so forth, and as a consequence of that, PFC,
19 I think, was inspected, because that was the nature of
20 it, soon thereafter. The regional centres were much
21 later, largely because the inspectors didn't know how
22 to, you know, inspect a regional transfusion centre.

23 Q. So it was the first --

24 A. It was, in fact, for the regional centres. I make the
25 point that late in the 70s, there was a second, I think,

1 inspection of PFC. So it was not the first. But the
2 regional centres, yes, absolutely.

3 Q. In relation to that, as I understand it, the criticisms
4 that were made included the fact that prison medical
5 officers are not involved in assessing the suitability
6 of donors, the increased risk of infection associated
7 with prison populations, the increased risk of
8 transmitting disease through such donations, and the
9 unreliable answers to the pre-donation questionnaire
10 that can occur in such environments. Those were the
11 three matters that were criticised.

12 Is it right to think that none of those would have
13 occurred for the first time in 1982? All of those three
14 things would have been in existence since the early
15 1970s -- and obviously before -- but the period that we
16 are concerned with. They weren't new in 1982 is the
17 point I'm making.

18 A. Yes.

19 Q. You have told us that you introduced the red book, or
20 the red book was signed off by you initially, the first
21 version of it?

22 A. No, no, no.

23 Q. Sorry.

24 A. The idea of a red book, I have to confess, was mine,
25 after hours with David Haythornthwaite, the medicines

1 inspector, wrestling with the problem in our own midden
2 in Scotland. There were centres who were making
3 platelet concentrates differently from another centre.
4 And the question arose: was this difference of clinical
5 significance in terms of we were not standardising
6 properly and so on and so forth?

7 The whole question of donation testing. We have
8 talked about RIA and all of those things. The real
9 thing that cracked all that was the provision by
10 NIBSC -- and this was our idea -- of a standard that was
11 put into every test run that was done every day, and it
12 is still happening today. What we call "go, no go
13 standards".

14 So the red book was: this should be your
15 specification for a platelet concentrate or a red cell,
16 and these should be the standard operating procedures
17 with ranges, making them and so on, and the provision of
18 standards. That was the red book. And I'm sorry it has
19 been very confusing.

20 Q. Yes. I must also apologise for confusing matters.

21 What I'm I am really wanting to ask you is: there
22 must have come a point at which there was a standard
23 introduced whereby prison donors would not be
24 acceptable. We can see from the material that we have
25 been shown today that you stopped going to prisons

1 but --

2 A. It was a spontaneous, "Let's get out of here".

3 Q. But is there something now that was there which says --

4 A. I do not know. If you asked me to bet, I don't think

5 ever in the red book -- donor selection was not my --

6 Dr Gillon will for sure tell you, but I don't think it

7 ever actually was elevated into the red book.

8 Q. Right.

9 A. Bear in mind, I think, the first red book is 1987/1988

10 and I suspect by then the whole thing of prisons was

11 passe; it had gone.

12 Q. It didn't need to be included, it just wouldn't be even

13 thought about?

14 A. Nobody was doing it by 1988. That's my assumption.

15 Q. One other thing that you have mentioned, a theme that

16 has come over from your evidence, is that the

17 regionalisation, the regional nature of the organisation

18 meant that you had these autonomous bodies. Clearly

19 what we have seen is that Glasgow perhaps had

20 a particular view, perhaps because it had a particular

21 problem in relation to collection of blood at particular

22 times of the year. The fact that there was

23 regionalisation of that kind, was a function of that an

24 inability to share blood between one region and another?

25 In other words, Edinburgh couldn't help Glasgow out if

1 Glasgow needed help. Was that because of
2 regionalisation?

3 A. Yes. If Glasgow had asked, they would have moved blood
4 from all corners. And the problem was, as Dr Mitchell
5 was saying, they wished to crack these problems
6 themselves. So there is no doubt that that in my
7 view -- and some of the letters that have not been up
8 today that I wrote, were saying, "Look guys, come on".
9 And eventually they did come and it worked extremely
10 well.

11 So, yes, there was a period in which the West of
12 Scotland ran into very temporary blood shortages and
13 I made it very clear to them that, "What you should have
14 done, lads, was --" I heard this on the radio as I was
15 shaving in the morning -- "What you could have done is
16 got some blood from Edinburgh or Aberdeen," and that
17 eventually developed and was very successful.

18 Q. But you weren't in a position to tell them what to do as
19 the national director.

20 A. No, no, no. It is a consensus game.

21 Q. So if any particular regional director wanted to do
22 a particular thing or go a particular direction, that
23 was a matter for that person.

24 A. Yes. I think we need to be a little careful because on
25 the whole these guys were really fantastically

1 collaborative and we hunted in a pack most of the time.

2 Q. But not entirely with this particular issue, it would

3 appear?

4 A. Absolutely right.

5 Q. Thank you.

6 Thank you, sir.

7 THE CHAIRMAN: Mr Anderson?

8 Questions by MR ANDERSON

9 MR ANDERSON: Just one matter if I may.

10 Good afternoon, Professor Cash. Can I return to
11 this question my friend Mr Mackenzie put to you after
12 his five propositions. You will no doubt remember the
13 five propositions and the question concerned the
14 appropriateness or otherwise of continuing to take blood
15 from prisoners in the mid to late 1970s. Do you
16 remember that?

17 A. Hm-mm.

18 Q. Can I just make sure that I understand your position in
19 relation to that? Do you say that in the mid to late
20 1970s we knew enough then to know that it was
21 inappropriate to continue to collect blood from
22 prisoners and so the decision to continue to do so was
23 somehow wrong or an error of judgment or, alternatively,
24 do you say that it is with the benefit of hindsight,
25 looking back some 35/40 years, knowing all we now know

1 about what turned out to be Hepatitis C, that we are
2 able to say, "Well, we could have done things
3 differently"? Which is it? The first or the second?
4 A. I'm very grateful, and it is the latter. Thank you very
5 much, sir.
6 Q. I'm obliged to you. No further questions, thank you.
7 THE CHAIRMAN: Have you taken account of the known unknowns
8 in answering that question and in particular that, as
9 a result of the epidemiological studies in the early to
10 mid 1970s, it might reasonably have been inferred that
11 there was a hepatitis infective agent that would not
12 have been disclosed by Hepatitis A serology or by
13 Hepatitis B screening?
14 A. Yes, I agree, sir, but I see all these things very much
15 more clearly, having retired, with no responsibility,
16 and with a very large evidence base.
17 THE CHAIRMAN: I think we all see things more clearly when
18 we have no responsibility, professor, but I wouldn't
19 like you to leave this point without having in mind --
20 and I'm sure it is going to come back again in dealing
21 with the history of NANBH particularly, but I do have an
22 interest in whether those who had responsibility at the
23 time and couldn't hide from it may have failed fully to
24 take account of the knowledge that there was something
25 that was not known but was contributing significantly to

1 the pool of infection.

2 A. I wouldn't deny that. I'm simply saying to my colleague
3 there that it is much clearer and much more positive 20,
4 30 or 10 years later. That's all. When we get to non-A
5 non-B and so on, if you look at the immense pressure
6 from DHSS from the METAS(?) committee, to turn their
7 backs on all this, the bizarre collapse of the MRC
8 research working party that was in there at it -- you
9 know, as I said, I think we missed some tricks and
10 I very much regret that and it is very much clearer now
11 than even then it was.

12 THE CHAIRMAN: I hope it will become very clear by the end.

13 Mr Anderson, I don't know whether you wish to follow
14 that or not. I'm really putting down a marker that it
15 seems to me that there is quite a significant area here
16 to look at in detail.

17 MR ANDERSON: I understand that, sir. I would only comment
18 that as our American cousins say, hindsight is always
19 20/20 vision.

20 THE CHAIRMAN: We will see in due course. Mr Sheldon?

21 MR SHELDON: I do have a number of questions for
22 Professor Cash. I am conscious that the stenographer
23 may require a break. I'm happy to continue or take
24 a break.

25 (3.37 pm)

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(Short break)

(3.58 pm)

Questions by MR SHELDON

MR SHELDON: Thank you, sir.

Professor, earlier today you were shown some guidance documents from the 1970s. For example, the notes on transfusion by Mr Mackenzie, and I think you expressed some reservations about, for example, the time taken in the preparation of such documents. Do you recall that?

A. Yes, I do.

Q. I think you said yourself that in preparing documentation of that sort, the DHSS would consult pretty widely and certainly beyond the Blood Transfusion Service. Is that correct?

A. Yes.

Q. Would it be fair to say that, in preparing guidance documentation for clinicians, government officials, both at that time and no doubt now to some extent, are heavily reliant on the views of independent clinicians?

A. Yes.

Q. Just thinking about the meeting, the SNBTS directors' meeting of 29 March, would it be fair to say that at least some of the heat generated at that meeting was the result of disagreement among independent clinicians?

1 A. You mean, the directors?

2 Q. I do, yes, indeed.

3 A. Yes, indeed.

4 Q. The directors being clinicians in their own right?

5 A. Yes, indeed, absolutely right.

6 Q. And really the difficulty was that it proved impossible

7 for the directors to reach a common view as to really

8 the balance of risk and advantage --

9 A. Risk and benefit.

10 Q. -- in taking donations from prisoners?

11 A. Indeed.

12 Q. Now, perhaps some other questions arising from that, but

13 first of all, in view of the sort of difficulties which

14 arose at that meeting, would you agree that it is

15 perhaps unsurprising that civil servants might

16 experience some difficulty in collating responses in

17 relation to guidance documents and reaching an agreed

18 common position for inclusion in guidance documents?

19 A. Yes, I can imagine the civil servants had all sorts of

20 difficulties, yes.

21 THE CHAIRMAN: Sorry, I didn't pick that up.

22 A. I beg your pardon.

23 THE CHAIRMAN: I have to ask to you speak through the --

24 A. Yes. I said I could imagine civil servants had all

25 sorts of difficulties in this regard. It is a tough

1 job.

2 MR SHELDON: And indeed they might require also to consider
3 issues relating to the public purse and public policy of
4 various sorts.

5 A. Indeed, absolutely right. I agree, sir.

6 Q. Moving on then to a slightly different topic, I think
7 you said in evidence that at this time your feeling was
8 that the DHSS dictated the whole business of donor
9 selection from London and to that you added, I think,
10 that Scotland eventually broke away, as I think you put
11 it, in about 1985.

12 A. Yes.

13 Q. But that was related to the AIDS issue?

14 A. It was.

15 Q. But at least in 1983 -- and we have seen documentation
16 this morning, I think, that London, if I may put it that
17 way, was really saying it was a matter for individual
18 regional transfusion directors.

19 A. Sorry, which matter?

20 Q. This was the matter of donor selection.

21 A. Donor selection?

22 Q. Do you recall seeing the documentation I'm talking
23 about?

24 A. No, I said the individual directors was a matter in
25 relation to the prisons but in terms of the care and

1 selection of donors guidelines, these were produced
2 under the aegis, as I recall -- but Dr Gillon will
3 (inaudible) -- of the DHSS.

4 Q. All right. So, thinking just for the moment purely
5 about the issue of prison donors, what did you take to
6 be the position about, as it were, guidance from London?
7 Did you regard yourself as being free to take a decision
8 on your own account, or your own accounts, or did you
9 regard that as a matter which was or would be dictated
10 from London?

11 A. I think initially we asked for guidance from London and
12 we did that through Dr Entwistle's committee for donor
13 selection and we assumed that it would come back quite
14 quickly, if it was going to come back. As far as
15 I recall, nothing came back, as far as we were
16 concerned, from the departments. There clearly were
17 lots of communications going on between the departments
18 but I don't recall that we received -- if you then say,
19 were we in a position to get on and act without waiting
20 for London, the answer is yes, and the evidence of this
21 is actually self-evident, that spontaneously the
22 Scottish directors got out of the park.

23 Q. Yes, indeed. What is your view about the process, as it
24 were, of breaking away? You said that Scotland
25 eventually did break away in 1985 and created guidelines

1 of its own. Presumably, if you regarded yourself as
2 free to do so in 1985, you would have been free to do so
3 at an earlier stage.

4 A. I think that's absolutely right. We just grew up
5 a little.

6 Q. Returning, if I may, briefly, to the question of the
7 guidance that you sought, after the meeting of
8 29 March 1983 do we take it that there was a feeling
9 that there was a need for guidance, or at least
10 moderation or adjudication, as between the views of
11 individual directors?

12 A. Yes, that's right, sir. I think that's minuted.

13 Q. And this may be an obvious question but why was it
14 thought appropriate to approach Dr Entwistle's
15 committee, or the working party, I think I should call
16 it, rather than, for example, approaching the Scottish
17 Home and Health Department direct for guidance of some
18 sort?

19 A. Two things. One is, two members of the Scottish Home
20 and Health Department witnessed the whole exercise of
21 the meeting on 29 March.

22 Q. This was Mr Wastle and Dr Bell. Is that right?

23 A. Dr Bell, yes. Excellent colleagues. I had anticipated
24 that, as I think I said earlier, there may well be
25 a phone call a few days later calming us all down and

1 saying he is consulting the department, we should move
2 in that direction. That didn't come and in fact the
3 proper port of call, we felt at the time, was to go to
4 the committee that Dr Entwistle -- this was a committee
5 on behalf of all the transfusion services, that
6 considered the problem of donor selection, and we
7 thought it would be courteous and appropriate that we
8 consulted with them. I think no more than that, to be
9 honest.

10 Q. Do I take it from that answer that you regarded them as
11 in some sense more expert than the views or the
12 expertise available within SNBTS, or that this was, as
13 it were, simply a process of moderation or adjudication?

14 A. No, I would have thought we felt -- forgive me, it is
15 many years ago.

16 Q. I understand.

17 A. I would have thought we felt that there was a group that
18 had been established, a joint group, by the UK Blood
19 Transfusion Services. We were aware that the Home
20 Office had a card to play in this matter and we felt in
21 the first instance we should go to that committee, and
22 we went, and in due course that committee then asked the
23 DHSS for guidance. As I understand it, the DHSS said,
24 "We will come back to you but we need to consult with
25 the Home Office because they have a role to play in

1 this."

2 Q. Yes. I wonder if you would look briefly with me,
3 please, at one document. It is [\[SGH0010572\]](#). While
4 that's coming up, perhaps I can just ask, was it at that
5 time fairly common, as indeed it may be now, to set up
6 various working parties and advisory committees to
7 advise on particular issues relating to public health
8 matters?

9 A. Indeed, sir.

10 Q. So, for example, there would be committees on the
11 selection and care of blood donors and
12 transfusion-associated hepatitis and so on?

13 A. I'm not sure about transfusion hepatitis. One of our
14 problems was, as I said earlier, that if you take
15 transfusion hepatitis, there were at least three or
16 four committees going on at one time and Dr McClelland
17 was involved with them all, and indeed the DHSS set up
18 its own advisory committee on transfusion-transmitted
19 hepatitis, but then the expert advisory group on AIDS
20 set up another committee that actually was touching on
21 hepatitis. So, yes, there was a plethora of advisory
22 committees on this particular topic.

23 Q. These were committees, do we understand, which were
24 co-ordinated by the DHSS but independent of it?

25 A. Gosh, I honestly do not know.

1 Q. That's perhaps a question for others.

2 A. If that's a pejorative question, I would say they were
3 not co-ordinated but that's another matter.

4 Q. All right. If we look at this handwritten memo -- we
5 looked at it briefly earlier today. I wonder if we can
6 look, please, at paragraph 2. I think it is further
7 down the page. This is a note of a discussion with
8 Mr Winstanley of the DHSS and there is really
9 a narration, I think, of the regional directors' meeting
10 of 29 March and the disagreement. It said that:

11 "[The writer] outlined to Mr Winstanley what was
12 said then and referred to the general position. He was
13 interested in the reference to Dr Brookes approaching
14 the working party on selection and care of blood donors
15 and will try to explore that avenue."

16 So, just focusing on that passage, does it appear
17 that Mr Winstanley and the DHSS were themselves perhaps
18 looking for advice or guidance from the working party?

19 A. I honestly do not know, is the answer. I would have
20 thought the main advice they should have been getting
21 is -- the context -- the transfusion people will offer
22 advice, but the main advice, I would have thought, would
23 be coming from the virologists community across the UK.

24 Q. We saw, again, I think, earlier this morning, that
25 eventually advice was forthcoming from a working party

1 chaired by Dr Gunson on 27 September that prisoners were
2 a high risk population and should not be used as donors.

3 The reference, for the record, sir, is [\[SNB0143030\]](#).

4 Do you recall that advice being reported to the
5 SNBTS directors?

6 A. No, I don't. Actually I'm lost in terms of documents.
7 My understanding was that we received a message that our
8 counterparts in England directors were going to discuss
9 it, and I have looked at old minutes, as I think
10 Mr Mackenzie has done, and found no evidence that they
11 discussed it at all. So I'm interested in your
12 Dr Gunson comment. I discussed this on more occasions
13 than I care to remember with Harold Gunson and we didn't
14 get very far.

15 So I'm at a loss with the document you are quoting
16 there. I'm sorry.

17 Q. Perhaps we can just look briefly at that document then.

18 I'm sorry, it's --

19 A. Yes.

20 Q. I think I may have got the order of the documents wrong.
21 It is [\[SNB0143030\]](#) first of all. This is the UK working
22 party on transfusion-associated hepatitis.

23 A. Yes, that's a DHSS one, yes.

24 Q. Chair, Dr Gunson. Can we look at page 3037, please?

25 Towards the foot I think there is a section on donor

1 sessions in prisons and I think the third sentence
2 there:

3 "The working party felt that prisons should be
4 considered in the context of a high-risk population in
5 terms of several of the transfusion-transmitted
6 infections and as such should be avoided as a donor
7 source."

8 A. Yes, avoided. I'm drawing attention to that and I found
9 that pretty disappointing. I discussed this with
10 Harold.

11 Q. That's interesting. Why do you find the use of the word
12 "avoided" disappointing?

13 A. For me there is a big difference between abandoning
14 a practice and avoiding it.

15 Q. Okay.

16 A. I see a big difference, and I made this clear to Harold
17 and, "Would it be possible to switch, to up that a bit?"
18 Sadly, Harold Gunson is not with us any more and that's
19 been a big bugbear for me. But my understanding at this
20 period was the Home Office were unhappy. I have no
21 record of that but it is just chatting with Harold and
22 so on.

23 Q. So, so far as the DHSS were concerned, you felt there
24 was an additional factor in the balance, which was not
25 only the balance of risk and advantage in the prison

1 donor sessions but also the social responsibility
2 aspect. Is that --

3 A. Yes, I felt that if at one stage the chief medical
4 officer of the DHSS had issued an edict saying prisons
5 are okay providing you use high quality Hepatitis B
6 surface antigen testing, against that background, when
7 we reconsidered the matter in relation to what we are
8 now talking about, he would have come out equally
9 strongly on reflection, 1983, not only the possibility
10 of AIDS but non-A non-B.

11 I have to say I imagined, when we referred it to
12 this committee, it would quickly come back to us that we
13 needed to get out of there. This is from a government
14 point of view. I recognise that they have to consult
15 very carefully and so on. I understand that.

16 Q. I appreciate that. Do we take it from your previous
17 answers that whatever the CMO may have said in 1975, you
18 didn't regard that as, as it were, a requirement on you
19 to collect blood from prisons? You weren't bound to
20 collect blood from prisons?

21 A. No, no, absolutely right, sir. No, you are quite right.

22 Q. Perhaps if I can just tie this section off, we see
23 Dr Gunson's committee's advice. Can we now go to
24 [\[SNF0010178\]](#), please?

25 A. As we do, could I mention they are advising Gunson, the

1 Department of Health.

2 Q. Understood. This is the minute of the meeting of
3 8 December. Could we look at page 4 of that document,
4 please? At paragraph (h) there do we see that there's
5 a minute that Dr Brookes had circulated to her
6 colleagues -- that is presumably the directors --

7 A. Yes.

8 Q. -- Dr Entwistle's final version of the above. Is that
9 a different thing from the document we have just looked
10 at?

11 A. Yes, as far as I can recall, sir, yes, and the document
12 we just looked at was the minute of a meeting of this
13 advisory committee on hepatitis that Harold Gunson
14 chaired. This is yet another activity that's going on
15 of Dr Entwistle's.

16 Q. At all events, we see a little later on in that
17 paragraph that Dr Brookes then explains that only one of
18 English regions is still collecting from prisons.
19 Looking at all this together -- the working party
20 advice, the information that this had become rare in
21 England and the discussions that you had had previously
22 amongst yourselves -- really what it was that influenced
23 you to cease prison sessions altogether in early 1984,
24 as Dr Mitchell then did, I think -- was there any
25 particular factor which persuaded -- I think it is

1 really Dr Mitchell at this stage -- was there any
2 particular factor that persuaded him to cease?

3 A. Yes, as I think I said in my statement, we had that
4 meeting in which we all fell out a little. The air
5 was -- we couldn't get consensus but I had the
6 impression, when it was all over, that my colleagues
7 would go back to their regions and quietly do as quickly
8 as they could getting out of the prison set-up.

9 You could argue that's actually what happened.
10 There was no policy decision. Actually what's happened
11 is that professionals had to go back and talk to the
12 people who were organising their donor session, very
13 complex planning and so on, and they moved inexorably,
14 and the last to come to stream was Ruthven Mitchell, and
15 I think the reason why was because he had a bigger
16 problem than most of them in terms of supply. But the
17 difference between -- all the others packed in in 1983.
18 If you look at Ruthven in 1983, he had fallen from the
19 year before from 2,500 to 400, so clearly the data
20 demonstrates that the Glasgow gang were on track; they
21 were moving. The smaller regions, as always, could move
22 quicker and were nipper than big supply reserves. But
23 he was doing this.

24 So I think the answer to your question is the splat
25 took place, people went home and began to talk to their

1 staff, thinking sooner or later we are going to have to
2 get out of here, and they in fact took the appropriate
3 action. It was never a policy decision.

4 THE CHAIRMAN: Before we leave the particular document,
5 SNF0010181, what Dr Brookes reported back from her
6 work in England was that she had spoken to 12
7 English/Welsh transfusion directors. Do you have any
8 information about what sort of sample that would be of
9 the total number of directors or areas?

10 A. Well, as I recall, sir, I think there were 15 English
11 regional centres. I would have to say, I'm sure I have
12 seen a document subsequent to Ewa Brookes's report that
13 in fact there was considerably more than in fact one,
14 and indeed I discussed at great length this particular
15 topic with my good friend Dr Wagstaff from Sheffield,
16 and the situation in England and Wales down on the
17 ground was a little less clear than Ewa genuinely was
18 reporting. But I can't speak with any authority.

19 THE CHAIRMAN: At the moment I'm just concerned that this is
20 not a complete account of the picture.

21 A. I actually think that's pretty well right. I have
22 a very good friend who was director of the Bristol
23 centre and he -- it wasn't as clear as we thought it
24 was.

25 THE CHAIRMAN: Mr Sheldon, do you wish to follow up?

1 MR SHELDON: Thank you, sir, I have nothing further.

2 THE CHAIRMAN: Mr Mackenzie, is there anything that you

3 would wish to clarify arising out of the other

4 questions?

5 A. No, sir.

6 THE CHAIRMAN: Professor Cash, for the time being, thank you

7 very much.

8 A. Thank you, sir.

9 THE CHAIRMAN: Now, Mr Mackenzie?

10 MR MACKENZIE: Sir, there are three further witnesses on

11 this topic C1, which we should be able to get through

12 tomorrow. Dr Gillon sat all through today but he has

13 also kindly agreed to come back tomorrow at 9.30. We

14 also have Dr Perry of the PFC and Dr Scott, formerly of

15 SHHD, which should then, subject to Dr Dow coming back

16 in due course, allow us to finish the topic of C1,

17 hopefully, tomorrow, sir.

18 THE CHAIRMAN: Thank you very much. Until tomorrow.

19 (4.21 pm)

20 (The Inquiry adjourned until 9.30 am the following day)

21

22 I N D E X

23

24 PROFESSOR JOHN DAVID CASH (sworn)1

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