Witness Name: Dr Gerard Dolan
Statement No.: WITN4031001
Exhibits: WITN4031002
Dated: 22nd April 2020

GRO-C 22/4/20

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR GERARD DOLAN

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 21 January 2020.

I, Dr Gerard Dolan, will say as follows: -

Section 1: Introduction

1. My name is Dr Gerard Dolan, GRO-C 1959, of GRO-C, London GRO-C. My professional qualifications are MBChB, FRCP, FRCPath.

2. I was appointed Consultant Haematologist to Queen's Medical Centre, Nottingham (now part of Nottingham University Hospitals) in September 1991.

3. I had responsibility for a very wide range of clinical issues including malignant haematology, red cell disorders, thrombosis, haemophilia, paediatric haematology, laboratory haematology and blood transfusion.

4. Nottingham was recognised by the United Kingdom Haemophilia Directors Organisation (UKHCDO) as a Comprehensive Care Centre for Haemophilia in 1993 and I increasingly negotiated more time in my job plan to specialise in Haemophilia. I spent a lot of time improving and developing our Haemophilia services.

5. I was elected to the executive of UKHCDO in 1993 and became Chairman for 5 years. I subsequently became Chairman of the Clinical Reference Group for Haemophilia and

Specialised Blood Disorders for a total of 9 years. The service in Nottingham benefited from my close involvement in developing guidance for improving haemophilia services. I remained Haemophilia Centre Director in Nottingham until 2015 when I took up the role of Haemophilia Centre Director at Guy's and St Thomas' NHS Trust.

Section 2: Responses to criticism of Witness W1538

Witness W1538

6. I shall, purely out of formality, refer to the patient as Witness W1538, unless directed otherwise by the Inquiry.

7. Before I address the specific questions asked of me, I shall give some background to my involvement with Witness W1538.

8. I can remember Witness W1538 but cannot remember full details of our conversations or of his clinic appointments in the 1990s.

9. I regret that my memory of events of 28 years ago may not be complete. Further to the Inquiry's Rule 9 letter, and with the consent / authority of both the Inquiry and Witness W1538, I visited Nottingham University Hospitals on 16 March 2020 and read through a photocopy of the case records; I attach a copy of an extract from the same (those I was able to discern as possibly relevant) as Exhibit WITN4031002.

10. The records do not seem complete. I do remember that there had been a significant issue with case records when I first started in Nottingham; some consultations were recorded on discrete hospital out patient paper and some of these did not get filed.

11. From memory, Witness W1538 did not live very local to Queen's Medical Centre (QMC). Much of his earlier treatment had been given at his local district general hospital, Kingsmill Hospital (KMH). Witness W1538 had been seen in Nottingham relatively infrequently. It is clear that for much of his childhood Witness W1538 was managed at Kingsmill by the paediatricians and haematologists.

12. I believe I first met Witness W1538 in 1992. At that time, I had been a Consultant for little over a year, possibly less.

13. I had no role in any aspect of his treatment during the period when he was given plasma-derived factor concentrate that was subsequently shown to transmit blood-borne pathogens. When I took up my position in 1991, I changed treatment for all patients with haemophilia B to highly purified, virucidally inactivated Factor IX (FIX) concentrate and, as soon as it was licensed and approved by NHS England, I switched all patients to recombinant FIX concentrate, with no risk of infection.

At paragraphs 12 to 14 of his statement, witness W1538 states that he was never told about, and therefore never gave consent to, his blood being regularly tested for Hepatitis B and HIV. He also claims that he was never explained why his blood was routinely taken. Please comment on this.

14. I cannot remember the exact conversation I had with witness W1538 at this time or on this issue. It was my routine practice in respect of any clinical action or investigation to explain to my patients what I intended to do and why.

15. Through my review of the medical records, I can see some evidence to demonstrate an awareness or understanding (or a likelihood of the same) on Witness W1538's part in relation to investigations or tests carried out on samples of blood taken from him.

16. There is a letter in the notes from Dr Logan at Kingsmill hospital indicating that she was aware he was due to come to Queens Medical Centre in 1992 for hepatitis C (HCV) testing. The letter indicated that Dr Logan was made aware of this during her consultation with the patient in April 1992 (page 1 of Exhibit WITN4031002). It seems likely therefore that witness W1538 was aware that he was to be assessed for HCV.

17. I cannot say for certain what testing had been performed on Witness W1538 before 1991. The case records do not seem complete. From the case records, however, Witness W1538 had been tested for evidence of hepatitis B in 1983 and for evidence of hepatitis B and HIV in 1985. At the time he was a minor and discussion would be likely to have been with his parents. In the 1990s, when patients continued to be treated with plasma derived products, continued surveillance had been undertaken by regular testing of patients to ensure the safety of the products they were treated with. I believe that it was standard practice to take formal consent for patients being tested for HIV but there were no tests for HCV until 1992, and patients had regular assessment of liver function as a surrogate.

18. Further, a newly appointed virologist, Professor Will Irving, who had a special interest in HCV, developed an early means of testing for chronic viraemia to identify those individuals with evidence of chronic HCV infection. One of the specialist registrars, Dr John Hanley – working closely with Professor Irving – had been charged with arranging the HCV screening of patients.

19. There are 2 entries in the case records, dated 11 May 1992 and 17 August 1992 (page 10 of Exhibit WITN4031002). The entry from May 1992 by Dr Hanley recorded that W1538 had been assessed and had been included in the study of the new assay that had been developed for hepatitis C. Unfortunately, the note is very brief and does not fully record the conversation but it was a clear policy that patients were informed of the background and purpose of the testing. The second entry, August 1992, states that the results were available and that they were given to Witness W1538. There is also a note to state that counselling was given.

At paragraph 10 of his statement, Witness W1538 states that he was disappointed by the way in which you told him he was infected with HCV, claiming that you launched straight into it when he had no idea what you were going to tell him. Please comment on this.

20. I am sympathetic to the shock Witness W1538 felt at receiving this news. It is in practice very difficult to cushion the blow of informing an individual that they had been infected through blood products. Witness W1538 states at least part of the conversation was a 'blur' and he felt unable to process what was being discussed.

21. I estimate that the same conversation took place between the Haemophilia team with over 60 patients – all of whom reacted in different ways. What I can say is we did try to be as kind as we could and tried to end the conversation with optimism that effective treatment would be available – this is reflected in my letter of December 1992 (pages 2 and 3 of Exhibit WITN4031002).

22. I am saddened and dismayed that Witness W1538 felt disappointed in the manner in which he was informed about hepatitis C test results. As I explained above, communicating bad news is one of the most difficult consultations to have with any patient. In my career and certainly in the 1990s, I developed much experience in informing patients of diagnoses that had major impacts on their lives, for example leukaemia and other malignant conditions, and HIV.

23. One of the major difficulties with counselling patients with HCV was that at that time much was not known. In particular, while the advice regarding sexual transmission was clear for those individuals infected by HIV, the risk of sexual transmission with HCV was not at all clear. I did advise patients that the risk of sexual transmission was not clear but that it was possible and that condoms were likely to reduce this risk. Unfortunately, I cannot remember the details of any conversation I had with Witness W1538 about this particular issue; I see a note from one of the senior staff in our team, Dr Lishel Horn, who recorded in some detail the conversation, advice and actions, all of which were appropriate (page 12 of Exhibit WITN4031002).

Section 3: Other issues

24. I am very sympathetic to the very difficult time when patients were aware of having been infected with HCV, and the often terrible side effects that they had to endure when treatment was given.

25. I am glad that Witness W1538 felt that he had not been denied any access to medical or dental services. It was something that we as a team worked hard to ensure.

Statement of Truth

26. I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 22nd April 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
10/06/1983 to 26/01/1998	Extract of Witness W1587's medical records	WITN4031002