Witness Name: Dr Barry Linaker
Statement No.: WITN4437001
Exhibits: WITN4437002 -
WTIN4437023
Dated: 10 September 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF BARRY LINAKER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 May 2020.

I, Barry Linaker, will say as follows: -

Section 1: Introduction

1. I am Barry David Linaker. My date of birth and address are known to the Inquiry My qualifications are as follows:

    - MB BS 1970 KCH Medical School University of London
    - MD 1983 University of London
    - FRCP 1990 Royal College of Physicians of London
    - Full Accreditation with J.C.H.M.T in General Internal Medicine and General Gastroenterology

2. I was a Consultant Physician in Internal Medicine and Gastroenterology at North Cheshire Hospitals Trust (now Warrington and Halton Hospitals NHS Foundation Trust) from March 1981 to April 2007 when I retired at age 60. I was also a Consultant Physician at what is now called Spire North Cheshire Hospital from late 1980's to April 2013.

3. My responsibilities were both acute and elective. I was responsible for Internal Medical and General Gastroenterology patients both emergency and elective as inpatients and outpatients. I developed an endoscopy service (both upper and lower) and ERCP diagnostic and therapeutic. I arranged appropriate investigations including blood tests, various imaging techniques, endoscopy procedures and biopsies as well as starting a Nutrition team.

4. I was a member of various local, regional, and national specialist committees including:

- Warrington Trust Drugs and Therapeutics Committee.
- Royal College of Physicians Tutor and Regional Speciality Advisor for RCP in general medicine.
- Program Director GIM Mersey STEC Member of Endoscopy sub-committee British Society of Gastroenterology (BSG).
- Paces examiner and invigilator Part 1 and Part 2 for Royal College of Physicians London exams.
- Teaching both medical students and my junior colleagues in all aspects of general medicine and gastroenterology including practical procedures.

Section 2: Responses to criticism of W1889

5. In order to respond to the question in the Rule 9 request, I have reviewed the patient's medical records from Warrington Hospital. These records have been provided to me by the Inquiry but these are incomplete, which compromises my ability to reply, for example there are no liver biopsy results, no ultrasound results and a number of blood test results missing. I refer to the records that I have been supplied with as the "Disclosed Medical Records". Further my replies are solely based on the Disclosed Medical Records as I cannot recall any details for this case after 22 years. Similarly I have been asked questions concerning when I became aware of certain information, policies and testing were available. Again due to the considerable passage of time, I cannot recall any specific material and dates beyond that which I refer to in this statement.

6. It is important to note that the only test for Hepatitis C which was conducted was part of a hepatitis screen carried out by Liverpool Public Health Laboratories. It was done because the patient was still symptomatic and Hepatitis B needed to be excluded, which was known to cause severe liver disease. The results were negative for Hepatitis A and B, but a positive result for Hepatitis C antibody. The Disclosed Medical Records indicate that there was no request for a HIV test and none was carried out. The initial result did not give an answer for the Hepatitis C antibody test. This appears to have been received some time later (WITN4437002 to WITN4437004). There would have been no reason to withhold the result from the patient and if the patient was not given the result this would have been an error. If it was my error then I apologise. In those circumstances one explanation could be that the result could have been filed without me seeing it. The Patient had a good history and had findings for liver disease related to alcohol, namely a high alcohol intake for at least 10 years and micronodular cirrhosis on Liver Bx (biopsy).

7. In respect of his alcohol consumption, it is reported that the patient started drinking at age 14 (WITN4437006) and by the time he was seen in clinic he had been drinking heavily for at least 10 years. A GP referral letter mentions that a friend who attended the initial consultation with him said he was drinking 8 to 9 pints per day (WITN4437005). An intake of 6 pints of beer is recorded in the notes by various different doctors at different times during his care (WITN4437007, WITN4437008, WITN4437009, WITN4437010). At a conservative estimate of 6 pints per day of normal strength beer this amounts to 84 units of alcohol per week. This far exceeds the safe limit for alcohol intake of 28 units per week. The Disclosed Medical Records suggest that the patient stopped drinking shortly after his first consultation in 1991 as he was advised that to continue would exacerbate his liver problem.

8. From the Disclosed Medical Records neither myself nor any member of my team has referred to him as an alcoholic, Although he was advised that he was drinking too

much. If the patient did suddenly cease alcohol intake in 1991 this would be inconsistent with being an alcoholic as in general alcoholics find it very difficult to stop.

9. Referring to the text book by Sheila Sherlock and James Dooley "Diseases of the Liver and Biliary System" edition 9 published 1993 Hepatitis C was only discovered in 1989. The initial antibody test was relatively insensitive but indicated exposure to the Hepatitis C virus. The significance of this was not immediately apparent in the 1990's and the connection to severity and chronicity of liver disease was not established. The PCR test to detect RNA for presence of the virus in liver and serum was not routinely available for some time and was difficult to perform even in research institutes. The authors state that the disease is insidious and that no treatment was available at that time and in addition there were no licensed trials of antiviral agents for use outside research units.

10. In respect of the allegations about his liver biopsy, I deny these totally. Both Biopsies were conducted after consent had been obtained (WITN4437011, WITN4437016) and according to the records the initial bx was conducted with no untoward problems. He required minimal analgesia after the procedure, which was not unusual, and discharged after 24 hours of observation (WITN4437012, WITN4437013, WITN4437014, WITN4437015).

11. The second bx was done to assess the liver as he was still symptomatic and to see if his disease had progressed. There were no indirect ways of doing this at this time and experts of the time (see above text book) said that biopsy was the best way of assessing the disease's progress. There is nothing in the Disclosed Medical Records to suggest that the initial bx was not carried out correctly. From these records the doctor concerned stopped after 2 unsuccessful attempts and I was informed (WITN4437017). The Disclosed Medical Records indicate that I carried out a straight forward Bx using a Surecut needle and obtained a good sample (WITN4437018). The criticism is that I then gave the needle to the other doctors and told them to have a go. Although I have no recollection of this, I would not have said or done what has been described and so the suggestion that I did say or do this is untrue. Further I cannot see anything in the Disclosed Medical Records from either myself or the nurse attending to suggest that this was anything other than a straight forward procedure (WITN4437019, WITN4437020, WITN4437021, WITN4437022, WITN4437023). The patient was discharged after 24 hours observation and only required minimal analgesia for pain around the Bx site. Again although I have said that I cannot recall any of the details of this case, if the patient had mentioned to me that I had suggested that others "have a go" or words to that effect I would have been very concerned to hear this from the patient and I would have remembered the suggestion. I do not and so I can say that this Inquiry is the first time that this suggestion has been made to me and it is untrue.

12. The patient was discharged in 1998 as he seemed to be well and his liver function tests had improved. His diagnosis was Alcoholic Cirrhosis and Post Herpetic Neuralgia following an attack of Shingles several years previously thought to be the cause of his sudden attacks of mild upper abdominal pain. It was explained to the patient that there was no link between the 2 diagnoses. His GP was advised to do regular Liver function tests as well as alpha feto protein levels and to refer back if there were any concerns

Section 3: Other Issues

I confirm that I have never had any membership of any committee or group relevant to the Inquiries Terms of Reference

Statement of Truth

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

Signed: Dr Barry Linaker

Dated: 10 September 2020

Table of exhibits:

Notes/ Description	**Exhibit number**
Liverpool Public Health Laboratory Reports	WITN4437002 to WITN4437004
Letter from GP	WITN4437005
Initial outpatient consultation	WITN4437006
Initial outpatient consultation	WITN4437007
Letter to GP	WITN4437008
Admission notes – 20/11/91	WITN 4437009
Admission notes – 12/01/95	WITN 4437010
Consent forms liver biopsy - 1991 and 1995	WITN 4437011, WITN 4437016
Notes re first liver biopsy	WITN 4437012
Nursing notes	WITN 4437013, WITN 4437014
Discharge letter	WITN 4437015
Note re second liver biopsy on 12/1/1995	WITN 4437017
Note of liver biopsy by Dr Linaker - 13/1/1995	WITN 4437018
Nursing notes from admission to discharge and discharge letter to GP	WITN 4437019 to WITN 4437023