Witness Name: Rak Nandwani
Statement No.: WITN359601
Dated: 21 Oct 2019.

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF RAK NANDWANI

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 22 August 2019.

I, Rak Nandwani, will say as follows:

Section 1: Introduction

1. My name is Rak Nandwani. My date of birth is GRO-C 1962 and I live near Glasgow. I have been a Consultant Physician in Genitourinary Medicine in NHS Greater Glasgow and Clyde since 1997, with particular expertise in HIV medicine.

2. In 1985, having trained at Middlesex Hospital Medical School, I was awarded the MB BS (Bachelor of Medicine, Bachelor of Surgery) from the University of London. I was subsequently awarded the MRCP(UK) (Membership of the Royal College of Physicians UK). I was awarded Fellowship of the Royal College of Physicians (FRCP) in 2002.

3. Whilst an undergraduate student in 1983, I spent six weeks attached to the department of genitourinary medicine at the Middlesex Hospital where I saw some of the first people in the UK diagnosed with HIV. I was trained by the first professor in this field (Professor Michael Adler). I then spent my student elective in Sydney in 1984 when I saw more people diagnosed with HIV/AIDS. As a newly qualified house officer at the Middlesex and University College Hospitals in 1986, I provided care for in-patients with AIDS conditions. I can recall that some of the patients were haemophiliacs who had received factor VIII.

4. From February to July 1987, I became a senior house officer in genitourinary medicine at James Pringle House, part of Middlesex Hospital in Charlotte Street, London W1. This coincided with the Government's 'Don't die of Ignorance' campaign to raise awareness of HIV and AIDS. This encouraged many people to come forward to get tested for the virus. I would sometimes break the news to people who had tested positive for HIV. Patients would ask me quite simply, 'How long before I become unwell? How long before I die?'

5. From 1990-91, I undertook a genitourinary medicine locum registrar post at James Pringle House. I then worked as a Medical Research Council funded research registrar from 1991 to 1993 in what is now the Chelsea and Westminster Hospital. I worked between the HIV in-patient ward, the HIV day unit and in out-patient clinics in the era before effective antiretroviral therapy.

6. I undertook clinical trials for the first HIV drugs on behalf of the Medical Research Council and the hospital. I recruited individuals to the MRC Concorde study (Zidovudine monotherapy) and also the Delta study, offering the first combination dual therapy. Chelsea and Westminster Hospital had a large cohort of HIV-positive patients. The outpatient

service had 2000-3000 attenders. Many of the patients from that period died. I can remember going to a lot of funerals.

7. From 1993-97, I was on the HIV and genitourinary medicine senior registrar rotation where I alternated between Kings College Hospital in London and Brighton. At both Kings College and the Royal Sussex County Hospital in Brighton, I worked in the HIV inpatient and outpatient departments. Since February 1997, I have worked as a consultant in HIV and genitourinary medicine in Glasgow where I have been involved in leading the HIV and sexual health services.

8. In 2000, I was one of the people who led the establishment of the Sandyford Initiative in Glasgow, which is one of the largest sexual health clinics in Europe. In January 2012, I was appointed as joint HIV clinical lead for NHS Greater Glasgow and Clyde, overseeing the delivery of HIV services in the Health Board.

9. I chair various local and national committees including the national HIV clinical leads in Scotland. I was asked to chair a short life working group in 2016 which recommended the HIV PrEP (Pre-exposure Prophylaxis) programme in NHS Scotland. In April 2019, I became joint chair of the Scottish Health Protection Network Strategic Leads which has oversight of hepatitis B and C, sexual health and HIV in Scotland and is accountable to the public health minister.

10. I have not provided any evidence nor been involved in any other inquiries or investigations, criminal or civil litigation in relation to either the human immunodeficiency virus ("HIV") nor the hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections in blood and/or blood products.

Section 2: Involvement with this particular patient

11. GRO-A was born on GRO-A 1960. She died on GRO-A 2013 from HIV related causes as a result of contracting the virus through a blood transfusion in 1981. She was 53. GRO-A was under my clinical care from 2002 until 2013 when she died.

12. I understand, as a young woman GRO-A was living with her husband, GRO-A when she became pregnant and delivered a child at GRO-A in 1981. She was aged 20. She had a blood transfusion for a post-partum haemorrhage. It is believed that it is from this transfusion that she contracted both HIV and Hepatitis C. She is not known to have engaged in any other risk behaviour to have contracted the virus. In the initial letter referring her to the Glasgow HIV service in 1996 for specialist care, it is stated that she is believed to have been infected by blood transfusion.

13. GRO-A was first diagnosed with HIV on 28 May 1987. I believe that this was done through a GP in GRO-A Glasgow. GRO-A first tested positive for hepatitis C in 1996. The hepatitis C was not investigated further at that time as GRO-A had normal liver function. When I took over her care, I arranged a liver biopsy which was done on 17 March 2003. Her liver function test and liver cancer markers were still normal and no fibrosis was found. At the time, she wasn't keen to be treated for the hepatitis C using interferon therapy.

14. Her husband, GRO-A her senior, is believed to have contracted HIV from her and died at the age of GRO-A in GRO-A I was not involved in his care. The first child, GRO-A, delivered at GRO-A Hospital in 1981, was born prior to the transfusion and is therefore HIV negative. GRO-A gave birth to her second child, GRO-A in 1984. GRO-A was infected with HIV and died at the age of 5 in 1989. The third child, GRO-A, was born on GRO-A

GRO-A 1985 with HIV. She is alive and living in Glasgow. She attends the HIV service and is under the care of Dr GRO-A who is one of my consultant colleagues. GRO-A is one of the oldest survivors of HIV mother-child transmission in the UK. She is also looked after by a member of the counselling support team in Glasgow, who have been supporting her through potential compensation. They didn't know anything about the infected blood inquiry. A fourth child, GRO-A was born in 1987, and died at the age of 2 in 1989.

15. GRO-A died in 2013 from an HIV-related lymphoma (cancer of the lymphoid system). The surviving members of her immediate family are GRO-A uninfected but affected, and GRO-A who is infected. In summary, this was a family with both parents infected, who have had 4 children, three of whom became infected and the source is believed to be a blood transfusion.

16. In August 1996, GRO-A was referred from GRO-A to Dr GRO-A, a consultant colleague in Glasgow for HIV specialist care. Up until this point, GRO-A had not received any antiretroviral therapy. The referral letter notes that GRO-A was 'frightened'. However, it is difficult for me to work out what happened to GRO-A between 1987 when she was first diagnosed with HIV and 1996 when she began treatment. I believe she had been cared for by her GP and general physicians. I can see from her records that in 1987, she had shingles. She also had enlarged lymph glands and oesophageal candida (which is an AIDS defining condition), all of which indicate that she had a significantly impaired immune system. Her weight was only 42kg.

17. On 5 April 1997, GRO-A suffered from pneumonia and became an inpatient, at what was then GRO-A in Glasgow.

18. Owing to difficulties coming to terms with her own HIV diagnosis and the impact it had on her family, GRO-A found it difficult to attend for HIV care and to take treatment consistently. After dropping out of care, in January 2005, GRO-A s HIV viral load was 16.8 million. This is very high. She wasn't taking antiretroviral medication at that time. After further missed appointments in 2008 I rung her at home to encourage her to come to clinic again. I could tell that she was suffering psychologically and socially. Her daughter was transitioning from paediatric to adolescent care which was emotionally very difficult for GRO-A.

19. I last saw GRO-A in the HIV clinic on 6 June 2013. She was taking her medication again. In September 2013, she developed a swelling on her left groin, which was linked to the development on an HIV-related lymphoma. She died on 1 November 2013. With HIV clinical nurse specialists who had known the family over the years, I attended GRO-A s funeral. This was the only patient funeral I've been to in the last 20 years as I recognised the circumstances that GRO-A and her family went through and the difficulties that she endured.

Section 5: Knowledge of risks

20. Throughout my medical training and over the course of rotating posts in a number of hospitals, I provided care and treatment for a large number of people infected with HIV through all routes of transmission. Historically and prior to my arrival in 1997, HIV-positive individuals in Glasgow were cared for by infectious diseases consultants. In the 22 years I have been an HIV consultant in Glasgow, I have not personally seen any people who have been newly infected with HIV by blood products.

21. In the early 1980s, The Middlesex Hospital had a large virology department. As a medical undergraduate student, I was told by the

senior lecturer at the time, Professor Richard Tedder, that despite the availability of HTLV3 testing, contaminated blood products were still being imported and used. I recall him saying that there would be issues in the future regarding the use of contaminated blood and that one day, those responsible would have to be held accountable. As medical students who qualified in 1985, we were taught about the high risk of blood product contamination, especially in settings such as the USA where individuals were paid for making donations.

22. In the UK, I can recall that the criteria for donating blood, in terms of who could and could not donate, had changed in light of the HIV epidemic, although I cannot recall particular dates.

Section 5. Impact

23. In September 1998, the Glasgow HIV service psychiatrist, Dr Roger Wong, wrote a letter to the GP regarding GRO-A 's psychological state, reporting social isolation and sleep disturbance. Her husband had died, she had lost two young children and her daughter was also HIV positive. This created a difficult relationship between family members.

24. In GRO-A 1998, GRO-A s daughter GRO-A was under the care of GRO-A Hospital. A letter from the paediatrician who specialised in HIV care, Dr GRO-A , notes how GRO-A finds past issues difficult to deal with'. This created tension between mother and daughter.

25. When I first became involved in GRO-A 's care in July 2002, I was informed of the psychological trauma that she had suffered. GRO-A would also speak to me about her wider circumstances but she could not give me a narrative about everything that she had been through. It was too difficult for her to talk about. Over the next few years, GRO-A

found it difficult to engage consistently with HIV care. GRO-A would come to some appointments and not others, she would take some medicines and not others. This was partly attributable to the unpleasant side-effects of treatment but mainly with the psychological impact of her condition on her well-being and the stigma to which she was subjected. I believe that GRO-A did not inject drugs. I had asked her directly about this in terms of addictions and recreational use but also to prevent interactions with other prescribed medication. GRO-A was clear that she had never taken or injected recreational drugs and there were no physical signs (such as needle marks) to suggest that she had done so. No other multidisciplinary team colleagues involved in GRO-A's care reported any circumstances related to past or present injecting equipment.

26. GRO-A and her family's circumstances were reported extensively in newspapers as a result of which, I have been told that she was named and vilified and consequently made subject to a great deal of abuse and social ostracization. Her family were known as GRO-A GRO-A She lived in a small community. There are photos of her taken by paparazzi photographers. The family circumstances were widely known and within the public domain, which exacerbated their distress.

Section 7. Financial Assistance

27. In October 1996, correspondence shows that GRO-A had applied for DS 1500 benefits, a government scheme supporting those with limited life expectancy to certain immediate payments. At that time, it was usually awarded to those with AIDS conditions. Despite the fact that she was unwell and been diagnosed with AIDS, it had been declined, to which she appealed.

28. To my knowledge, GRO-A has not had any involvement in seeking compensation or criminal injuries nor had any involvement in any inquiry or investigation.

Section 8. Other Issues

29. What strikes me is GRO-A s immense courage and her perseverance to raise a family and deal with the adversity that had been dealt to her. She did not wish to speak much about how she had acquired HIV and Hep C in the first place. She attempted to lead as normal a life as she could, despite her own diagnosis and the large impact it had on those closest to her. In some ways, trying to ignore HIV may explain why she found it so hard to engage with care and take therapy. Her difficulties were exacerbated by wide public knowledge and media reporting of her circumstances. I chose to contact the inquiry because GRO-A is no longer in a position to do so herself, but it is important that the sequence of events is addressed to learn from them and as other family members are still alive.

Statement of Truth

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

Signed GRO-C

Dated 21 Oct 2019