Witness Name: Charles MacKenzie
Statement No: WIT3939001
Exhibits: WITN3939002- WITN3939060
Dated: 15 May 2020

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF CHARLES MACKENZIE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 11th December 2019. I adopt the paragraph numbering in the Rule 9 request for ease of reference.

I, Charles Mackenzie, will say as follows: -

1. An Account of your campaigning history with Tainted Blood Product Action Group, Tainted Blood Australia and the Independent Blood Council

1. My name is Charles MacKenzie. My date of birth is GRO-C 1972 and my address is known to the Inquiry.

2. I was born in, GRO-C London. My parents divorced when I was young. My mother had a brother in Australia so, in order to start a new life, we relocated to Sydney soon after my fourth birthday in 1976 and my family have lived here ever since.

3. I moved back to England for a few years between 1981 - 85. My GRO-C was ill so I went to stay with my grandparents in East Sussex. I then returned to Sydney.

4. I went to St Andrews Cathedral School in Sydney. I left aged 16 in 1988 with the School Certificate, which is the equivalent of English GCSE's.

5. In 1992 I obtained a Diploma in Psychology, with a distinction, from the University of Sydney. I then obtained a place at Sydney University to study for a BA but had to cut short my studies due to illness.

6. In the mid 1990's I had a number of jobs in marketing and sales but again, illness curtailed my ability to work.

7. As a young child I was healthy and at the age of 15, I was given medication (tablets) for acne. Some months later, I suffered a reaction and developed Severe Aplastic Anaemia (SAA). SAA is a condition that occurs when your body stops producing enough new blood cells. SAA leaves you feeling fatigued and with a higher risk of infections and uncontrolled bleeding. It is a rare and life-threatening condition. The bone marrow and stem cells do not produce enough blood cells. It is also called bone marrow failure. SAA attracted media attention in the 1970s through the case of 'the boy in the bubble'.

8. I required a bone marrow transplant. A related bone marrow donor was thought to be the best choice, and whilst waiting on testing to see if any of my relations were a match as bone marrow donors, my doctors would not allow me to have autologous or family based blood transfusions because that would increase the risk of rejection of a transplant from a relation. As a result, I was treated with publicly donated blood, provided by the New South Wales Red Cross Blood Transfusion Service. I received red cell whole blood transfusions and platelet

transfusions. I was treated at the Royal Prince Alfred Hospital in Camperdown, Sydney.

9. As part of the management of my SAA, I was treated with an immunosuppressive therapy called ATGAM or Anti-thymocyte Globulin (ATG). I was also prescribed high dosages of the steroid Prednisone. I had to be kept away from others, and at times was placed in a special room on my own as I was so ill and prone to infections. It meant that I was unable to continue my education, work, or have normal social contact. I had to give up sports and football refereeing, which I had loved as a youth.

10. After two courses of ATGAM my bone marrow began to function again although at a reduced capacity. I was able to come out of isolation and was free from requiring blood. I was in remission for ten years.

11. In around 1989/90 I began to suffer symptoms consistent with hepatitis C (HCV). I was having terrible aches and pains. I approached my hospital Consultant about these symptoms but he was not supportive. He thought my problem was psychological.

12. I researched the issue. I knew of a boy who attended the same St. Andrews Cathedral School that I had. He was a haemophiliac who contracted HIV/AIDS from infected blood that he received for bruising when he was eleven years old. He sued the children's hospital that treated him and the case was widely publicised. As a result of his age he was a minor in law. This meant that the courts gave him the pseudonym of 'H'.

13. I began to be convinced that I too must have been given contaminated blood during the course of my treatments. H's litigation ultimately failed on a technicality. I refer to **Exhibit WITN3939002** which is an article from the Sydney Morning Herald dated 4 October 1989. The article details H's struggle with HIV and living with the diagnosis, along with its effects at the age of 16.

14. I now know that I was actually infected with hepatitis C in late 1988, from a unit of platelets that were not just contaminated, but also past their 'use by' date and therefore had no therapeutic benefit and should not have been transfused. The Australian Red Cross Blood Service ('ARCBS') discovered that my blood donor GRO-A had hepatitis C in April of 1990. A 'Look-back' interview was conducted shortly afterward. It was found that not only had my donor frequently donated blood in the 1980s, but had failed to reveal a true medical background, including a long history of illicit drug use involving using cocaine, heroin and speed, whilst also sharing needles, and had previously been a prison inmate. I refer you to **Exhibit WITN3939003**. This is an affidavit from 27 April 1997. The affidavit sets out the details of the infections the blood donor who infected me with hepatitis C was carrying.

15. Despite the ARCBS finding out about my blood donor's infected status, at no time was I contacted and warned of my potential exposure to hepatitis C. Instead, I later discovered that my donor had been encouraged to continue donating blood, even after providing false information on their donor declaration forms (which is a criminal offence under law) and after their infected status and past illicit drug use had been established.

16. Upon discovering this, I felt utterly betrayed and made a criminal complaint about the ARCBS to the New South Wales (NSW) Police, State Crime Command. **Exhibit WITN3939004** shows my letter to the Commissioner for Police, which details my complaint. **Exhibit WITN3939005** is a copy of email correspondence that details a telephone conversation between Detective Chief Superintendent Peter Dein and his colleagues, as a result of a letter they had received from myself regarding the complaint.

17. Exhibit **WITN3939005** shows that, to my dismay, rather than investigate the complaint, the NSW police actually contacted the ARCBS and offered assurances that no action would be taken. At no time was I contacted in relation to their decision not to investigate.

18. The Australian press caught wind of my desire to proceed with a criminal investigation, which resulted in Detective Chief Superintendent Peter Dein issuing a statement declaring, *"it would be simply a matter of determining whether there is any criminal investigation required"*. Exhibit **WITN3939006** is an article from the Sydney Morning Herald dated 24 February 2003. The article sets out Detective Dein's statement, and also refers to the Australian Red Cross's assertion they were confident the matter would go no further.

19. In September 1991, I finally found a GP who was willing to test me for hepatitis C, Dr Norman Walsh. He confirmed that I had hepatitis C. It affirmed to me that my suspicions had been well placed. I became resigned to it and felt that my life would be a shortened one.

20. The following year I went to study at Sydney University. Whilst studying, I started to ask questions about whether any of it was "worth it" given my long-term health prospects. I had also been worried by the attitude of the University to hepatitis C at that time so I elected to leave.

21. In 1991, the National Health and Medical Research Council in Australia ruled against issuing a public warning regarding hepatitis C, similar to the public health warnings about AIDS in the 1980s. Instead, it instigated a look-back exercise. The look-back proved to be a disastrous failure, as many victims were never contacted. I wrote a report/study with a cohort of 100 people on look-back in 2003 that exposed the contaminated blood tracing system as being flawed. I refer you to **Exhibit WITN3939007** which is a copy of the look-back report I wrote. This was published on 6 February 2003. The ARCBS published a press release in light of the criticism it received regarding the failure of the look-back service. I refer you to **Exhibit WITN3939008** which is a copy of the press release published by the ARCBS.

22. In 1991, the former Australian Minister for Community Services and Health, Brian Howe, gave a speech referring to the contaminated blood scandal. I refer to **Exhibit WITN3939009**, which is a copy of the speech. In the speech Mr Howe acknowledges the fact many individuals were infected with contaminated blood but expresses concern over the government awarding compensation to victims. The tone of the speech reflects the general attitude of the Australian government towards the scandal.

23. It was around this time, that the scale of the numbers of Australians infected began to emerge. It was believed that over 210,000 people had hepatitis C in Australia, with up to 10% of that figure being made up of people infected by Australia's contaminated blood supply. The ARCBS estimated at the time of the 2004 Senate Inquiry that between 3,500 and 8,000 Australians lived with hepatitis C infection derived from blood transfusions, including an estimated 1,350 haemophiliacs.

24. In Australia, health is devolved to the individual states. Prior to 1996, blood was collected and distributed by separate blood transfusion services in state and territory-based divisions of the Australian Red Cross Society. Following the 1995 review of the Australian blood and blood product system, steps were taken to establish a national blood service. In 1996, the blood services of the states and the territories united to form a national blood service, the ARCBS. In 2003, the National Blood Authority (NBA) was established. Its role is to enhance and manage the blood supply.

25. All blood products in Australia are processed by Commonwealth Serum Laboratories (CSL). CSL was set up by the Commonwealth Government in 1916, to assist with Australia's wartime needs for vaccines. In 1961 it was incorporated as a statutory authority. In 1991 it became a public company (CSL Ltd) while remaining publicly owned. In 1994 it was sold by means of a public float. However, in 1993 it was given an indemnity from the Government for any claims arising out of CSL products.

26. The 'H' case and my research into hepatitis C led me into a wider interest in the issue of infected blood in Australia.

27. Another high profile case, was that of GRO-A GRO-A GRO-A GRO-A was a haemophiliac and contracted AIDS due to infected blood. He died on GRO-A 1991. GRO-A attempted to write a book himself but on his deathbed, he asked GRO-A to write it for him. The best-selling book 'April Fool's Day' was published in 1993 (I believe I read it the following year). It was a scathing indictment of the infected blood scandal in Australia.

28. Around that time, I saw an advert by the large Australian law firm Slater & Gordon, about a class action for hepatitis C blood victims. I signed up with them and became part of the class action.

29. By the late 1990s the Internet was in its infancy but becoming accessible. Through it, I began to link up with other victims in Australia. There were government funded hepatitis groups; Hepatitis Australia and Hepatitis NSW (formerly Hepatitis C Council of NSW). Authorities would direct contaminated blood victims to these groups for support once their infections had been discovered. However, most people would report having difficulties with these organisations - finding that they were distinctly lacking in sympathy.

30. Hepatitis Australia and their state-based chapters like Hepatitis NSW, would lecture and discourage tainted blood victims from using terms such as "innocent" or from suggesting that they were infected "through no fault of their own" when referring to their infections or those of their loved ones. These organisations believed that the terminology often used by infected blood victims was discriminatory and therefore unacceptable to them. As a result of their attitude, the government funded hepatitis groups were a source of huge resentment amongst contaminated blood victims. The discrimination issues within the hepatitis groups even saw their own staff walking away in disgust and

joining our 'Tainted Blood' group. There was also an organisation called TRAIDS; Transfusion related AIDS. It was another government funded support group. However, it was very small, and its low profile put some people off. Its name was also confusing as it referenced AIDS alone and not hepatitis C.

31. Initially a small group of victims, led by me, established the Tainted Blood Product Action Group (TBPAG). Our aim was to try to force an Inquiry. I had been following events in Canada and the Krever Commission of Inquiry there. I became a friend of the late Canadian lawyer and tainted blood activist, a haemophiliac called GRO-A I sought his counsel over the telephone often and considered him a mentor. As part of my work for the TBPAG I drafted a submission to the Australian Senate Inquiry in 2004. The submission discusses the impact of contaminated blood in Australia. I will refer to and exhibit the submission later in my statement.

32. As a campaign group TBPAG grew rapidly. We acquired over 700 members and had proper offices and secretarial support.

33. I was the first President of the Independent Blood Council, which was a charity for victims of Australia's contaminated blood supply. Our patron was the well-known Australian Minister and national living treasure, Rev Bill Crews. We were an incorporated charity, not for profit, that advocated for special assistance for Australians affected by contaminated blood. We were able to help victims access support, counselling and legal representation. In 2004 we achieved a Senate Inquiry and an apology for blood transfusion victims who had received blood contaminated with hepatitis C from the ARCBS. However, their apology did not extend to the 1350 haemophiliacs infected with hepatitis C.

34. We deregulated and wound down in 2006 after the Senate Inquiry. The infected blood community was devastated by the Senate of Australia and the Australian government's refusal to offer victims compensation or meaningful financial support. We also had a number of deaths of key members of our group. I became affected by the on-going difficulties and injustice experienced by so

many people, and I was particularly affected by the deaths and the sense of helplessness.

35. A few years ago, I became aware of the campaigning in the UK for a full-scale Public Inquiry there. I set up a social media platform, Tainted Blood Australia. It is a small group at the moment, there are about 50 key people involved but there are literally thousands in Australia who are waiting on developments to re-join the campaign.

2. An Account of your campaigning history with Tainted Blood Product Action Group, Tainted Blood Australia and the Independent Blood Council

36. In the mid-1990s, the major political parties in Australia blocked any moves to have any sort of Committee looking at the contaminated blood scandal. Amongst the reasons given were that it might affect the share price of CSL. Exhibited before me at **Exhibit WITN3939010** is an article from News Weekly dated 6 May 2000, which outlines how CSL became such a powerful body and how it might be culpable in allowing infected blood to be given to victims. It outlines how CSL processed foreign sourced blood, right up to 1999. In 1996, CSL admitted that up until 1984, it mixed Australian blood with blood from several foreign countries.

37. Calls for an inquiry into CSL were rejected. It may be no co-incidence, that the Federal Government agreed in 1993, to indemnify CSL from any legal claims linked to infected blood, thus the Federal Government had no desire to put CSL under the microscope of any sort of inquiry. **Exhibit WITN3939010** also references the Federal Government's decision to indemnify CSL.

38. During this period, I genuinely feared for my own safety, particularly after hearing reports that Doctor Ian Young had been found dead. He was a British Doctor who, prior to his death, had been the Chair of Ethics and Law at the International Society of Blood Transfusions. He had also run the Blood Transfusion Service in Queensland in the 1980s and up until the 1990s.

39. Queensland was the first state to take effective preventative measures. It was ahead of the other states in Australia. Following the publication of the research paper 'Red Alert', there were also questions about whether the Australian Red Cross Blood Society or any of its state based chapters, including Queensland, had distributed any Factor VIII derived from the unauthorised use of foreign donated plasma which had been mixed into the Australian blood plasma supply. Doctor Young's testimony would have been of key significance to potential compensation cases to be heard in the courts. I honestly believe that Dr Young knew a lot about blood safety and indeed, the safety of Factor VIII that might have made things uncomfortable for authorities (in both Australia and the UK).

40. Doctor Young had been instrumental in implementing the use of surrogate tests such as ALT in Queensland between 1987 and 1990. The New South Wales branch of the Red Cross, and the other state branches in Australia, didn't do this. They took a "wait and see" approach, preferring to conduct further studies into the efficacy of surrogate testing rather than to implement it. It is my understanding that Doctor Young was pivotal in having Queensland take a different, far more enlightened approach. I was aware of various rumours from credible sources that his death was not the official version of suicide but that he was possibly murdered.

41. Although I am usually very sceptical of conspiracy theories, this all made me feel that I was pushing against something sinister. I became worried about my own safety. I was worried about my house being burgled and the like. I had built up a very good relationship with campaigners in Canada and was aware that the Haemophilia Association in Canada had been burgled at one time.

42. I became so concerned that I spoke to one of our campaign supporters, a retired Superintendent of Police called Niel Lake. Niel had contacts with the National Crime Authority which investigated organised crime and had extraordinary powers to do so. I met its head, Robert McDonald on a number of occasions. I can remember having lunch with Robert where I spoke about

fearing for my own safety, and he told me that at times he had thought about potential risks to his life but that you could not live life in constant fear, you had to just get on with things. I asked him if he would personally investigate if anything terrible happened to me, and he promised he would do that. I also asked the same of journalists that were covering the blood scandal in Australia.

43. One of the incentives to hold some sort of inquiry was the account of GRO-A GRO-A GRO-A was the catalyst for the expert report on hepatitis C in plasma in 1990. He'd had a motorcycle accident as a young man. He lost a leg and had to have blood transfusions. In around 1990, he contacted the blood service saying he wanted to donate blood as a way of giving something back. However, he received a letter from the Australian Red Cross saying that he had hepatitis C. Surprisingly they still suggested he continue giving blood.

44. I managed to interest one of Australia's top investigative TV programmes with a story. The program was called "Sunday". It was something of a tradition that leading politicians, Prime Ministers and state premiers would watch Sunday as a gauge to finding out what the next big issues might be. It went out on the Network Nine Australia. I refer you to **Exhibit WITN3939011.** This is a copy of the transcript from the programme.

45. An Australian Labor party Senator representing New South Wales, Steve Hutchins, got in touch with the Rev Bill Crews and myself after watching the Sunday program. We became friendly. He began asking questions of the Health Minister about the scandal.

46. He suggested that we should ask for a Senate Committee to look into the matter. He felt that given the seriousness of the contamination of Australia's blood supply, that we would be able to achieve that. Senator Hutchins was a very morally driven man. He was a GRO-C He told Rev Bill Crews and I in a meeting that getting justice for tainted blood victims would be one of the most important things he could achieve in his political career. He sadly passed away on GRO-A 2017 after a GRO-A

47. In 2003, following the revelations that centred around the whistle-blower GRO-A the tainted blood victim who was then asked to donate his infectious blood back into the blood supply, came the "Report of the Expert Advisory Group on hepatitis C and plasma in 1990" (Barraclough Report), 2003. This Expert Advisory Group was appointed to examine claims that plasma positive to HCV antibody was used in the manufacture of plasma products for several months in 1990. The report revealed that for almost three years infected blood was administered to possibly thousands of patients in hospitals Australia wide. However, it went on to say that there was no evidence that anyone who received the blood developed hepatitis C. I made a submission to this Expert Advisory Group which can be seen at **Exhibit WITN3939012.**

48. This was a finding that I wholly rejected. I appeared on media such as ABC radio. I stated that the vast majority of regular users of blood and blood products in Australia, like haemophiliacs, were positive for hepatitis C. I accused the Health Minister of stonewalling victims. It is worth pointing out that this report only had very limited terms of reference. I refer you to **Exhibit WITN3939013**. This is a copy of the report from the Expert Advisory Group on Hepatitis C and Plasma dated May 2003.

49. The demand was now growing for some sort of wider investigation into the issue of contaminated/infected blood in Australia.

50. Senator Hutchins was continuing to support us. He asked some pertinent questions in the Senate in Canberra. I refer you to **Exhibit WITN3939014.** This is a copy of the questions Senator Hutchins asked and some of the answers he received. He suggested we should seek a Senate Committee Inquiry.

51. The attraction of a Senate Inquiry was that victims could make submissions without fear of any kind of prosecution or liable actions against them. In addition, it also promised to give victims a chance to tell their side of the story,

for all to see, as Senate Inquiries routinely publish public submissions online. It also required that people tell the truth, as it is an offence to provide false or misleading information. We were also assured that Senator Hutchins would be the Chair of the committee. This was very important to us because he was clearly sympathetic and had acquired a degree of good knowledge and insight by now into the issue.

52. Senator Hutchins asked me to assist him with drawing up Terms of Reference, which during the course of 2003, I helped to prepare. Exhibited before me at **Exhibit WITN3939015** is a copy of the Senate Inquiry Report. A copy of the Terms of Reference is on page 1. All of the Terms of Reference were important, but there were some that were of primary importance. For example, the Terms of Reference that would look at when the Australian Red Cross Blood Service and Australia's plasma fractionator, CSL, first became aware of infections from blood contaminated by hepatitis C. There were Terms of Reference that would also examine why it was that Australia had such a high rate of haemophiliacs infected with hepatitis C. Then there were Terms of Reference that would investigate the importation of foreign sourced plasma in the manufacture of blood products in Australia. And crucially, the Terms looked at the number of Australians infected with hepatitis C through blood and blood products and what services could be provided or remedies made available to those affected by contaminated blood.

53. There were a number of witnesses to the Senate Inquiry; I refer you to **Exhibit WITN3939016** which lists the witnesses. I appear on the second page of the document representing the Tainted Blood Action Group.

54. At that point, I was very optimistic about the Inquiry. Senator Hutchins said that he wanted to see justice done and he was talking about potential prosecutions arising out of it.

55. However, just before the Inquiry was due to begin, the appointed Chair Senator Hutchins was moved aside and replaced by Senator Jan McLucas. Senator Hutchins became just an ordinary member of the committee.

56. Senator McLucas was an Australian Labor Party Senator representing Queensland. She was affiliated with the left faction of the Australian Labor Party, who at the time, held similar views to the government funded hepatitis groups in that they supported a 'one size fits all approach' to hepatitis C that was opposed to contaminated blood victims receiving ex gratia payments.

57. The removal of Senator Hutchins and the appointment of Senator McLucas caused immediate alarm within the TBPAG. It was noted by a number of our members that as soon as Senator McLucas was appointed, the government funded hepatitis groups were given more prominent roles in the Inquiry. We were outraged by this. Stuart Loveday, the Executive Officer of Hepatitis NSW and board member of the national organisation, Hepatitis Australia, had attended a meeting of tainted blood victims in Sydney 2002, where he made it clear that his organisation would not advocate any special assistance for tainted blood victims. However, when the Reverend Bill Crews put it to him at that meeting that victims would set up and lobby for compensation themselves, Stuart Loveday said he fully respected our right to do that.

58. Therefore, we were very angry when Mr Loveday and the other groups were included in the Inquiry for obvious reasons. They had forced us to set up on our own without sharing any of their government funding and then fought against compensation at the Inquiry. With the switch to Senator McLucas as Chair, TPBAG members felt that the whole Inquiry was over before it began. Some years later Senator McLucas was involved in an expenses scandal. I refer you to **Exhibit WITN3939017** which is a copy of an article from the Courier Mail dated 3 May 2009 which discusses the expenses scandal involving Senator McLucas.

59. A Senate Inquiry is a committee made up of Senators that sets aside time to investigate and discover the facts about a specific policy or issue. It does not have any true legal force. It makes recommendations. It does not have the power to compel witnesses.

60. There are normally several such inquiries going on at any one time and it is a relatively common occurrence. It is staffed by civil servants. The Hepatitis C and Blood Supply Senate Inquiry Report lists five members of its secretariat acting and assisting it. There are no lawyers or barristers involved. It sat for a day or two a week over a period of time in between the Senators' other duties in the Senate and dealing with government and constituency business.

61. The Sydney Morning Herald published an article 'We were given hope, and we got nothing', and reported that the estimated cost of the Senate Inquiry into hepatitis C in the Australian blood supply was $161,770 Australian dollars. Exhibited before me at **Exhibit WITN3939018** is a copy of the article dated 20 June 2005. Therefore, it is a million miles away from having the resources of a full Public Inquiry such as the one underway in the UK.

62. TBPAG made a written submission to the Senate Community Affairs References Committee which can be seen at **Exhibit WITN3939019.** As the President, I submitted evidence that focused on the devastation caused by Australia's contaminated blood scandal. It detailed the death and injury dealt to thousands of unsuspecting adults, children, accident victims, haemophiliacs, pregnant women, the anaemic and those having elective surgery who received contaminated blood or blood products.

63. I also exposed the cover-up by the ARCBS and the plasma fractionator CSL. I provided evidence that CSL had mixed freely donated Australian blood from unpaid donors with blood from foreign countries for distribution in Australia. The submission also reveals how the blood services in Australia knowingly collected blood from people they knew to be unsuitable as blood donors. They collected blood from individuals that they knew to give false statements about their health

histories, that they knew to be infectious, or were known to be IV drug users, prostitutes and prisoners.

64. I exposed the disastrous failure that was the tainted blood tracing service called 'Look-back'. I also made recommendations on behalf of those infected and affected by Australia's infected blood scandal. They were that Australia should establish a compensation tribunal for victims, where each claim would be heard and assessed individually. I also called for alternative therapies for those that could not be cured by or could not tolerate the conventional hepatitis C treatments. Home care assistance was also a stated need.

65. The Inquiry was open from 2003 to June 2004 for written submissions. It then had some hearings in April 2004. I gave an opening address on behalf of our group that lasted about ten minutes. A copy of the transcript of my evidence at the hearings is exhibited at **Exhibit WITN3939020.**

66. I started by speaking of what was a medical emergency and the total failure of the look-back tracing service to notify people potentially infected with hepatitis C through the blood supply. Hundreds, perhaps thousands of infected Australians had still not been traced. I stressed that it was imperative that this be rectified. I spoke of how through my research and experience in running the Tainted Blood Product Action Group, that I had found horrifying evidence about the number of haemophiliacs and women/expectant mothers who acquired hepatitis C from contaminated blood. I urged that all Australians who had given blood before the 1990's be tested in a responsible fashion.

67. In my evidence before the committee, I also spoke of how the Australian Red Cross Blood Service had collected blood from prisoners in jails into the 1980s and a full twelve years after other countries ceased the dangerous practice. I asked how Australia could lay claim to having one of the safest blood supplies in the world, when the majority of haemophiliacs in the country had acquired hepatitis C from bad blood. I also informed the committee that Australia had purchased blood and blood products from companies that were known to have

dealt in blood harvested from the US prison inmate population. I urged the committee to send a letter to the American Food and Drug Administration and to the US Department of Justice requesting clarification on whether any plasma sourced from US prison facilities ever arrived in Australia. Furthermore, I told the Inquiry that while this was a medical disaster, it was in essence, first and foremost, a human tragedy that had destroyed the lives of many men, women and children.

68. I gave my evidence on 6 April 2004, lasting some 2 hours. I sat in front of the full committee. I was met with a cold reception from the Deputy Chair Senator Sue Knowles. Just a few minutes before I was due to give evidence, Senator Hutchins had taken me aside. He told me that CSL had sent in lobbyists who had met with most of the Senators on the committee. He said that Sue Knowles would attack me and try to discredit me for not being a medical doctor. What did I know compared to all the medical experts? Therefore, when I gave my evidence, I tried to take the initiative by making it clear that I wasn't speaking as a medical expert and I also made reference to CSL's lobbyists in my opening address to the committee.

69. I can remember that the committee had a very full attendance. It was made up of victims, loved ones, health officials, members of the written press and an ABC TV news crew, observing that day in The Jubilee Room of NSW Parliament. It was so full that some victims and supporters had to listen from the corridor outside the room as we gave our evidence. This was a monumental occasion for us, as it was the first time an Inquiry like this had been held into how the blood supply could infect thousands of people.

70. Addressing the committee was always going to be a potentially challenging experience. However, I was already concerned with worry, as I had been previously tipped off about CSL's possible influence on the committee and about how Senator Knowles, the Deputy Chair, was essentially going to try to discredit me.

71. At that moment, it felt like I was about to be on trial in a kangaroo court, giving evidence to an Inquiry and to Senators, some of whom had clearly already made up their minds. This was made particularly clear from Senator Knowles' adversarial approach towards me and in her line of questioning. It felt like she was trying to make me slip up. Senator Knowles said that I had made serious allegations about people, saying human life was expendable. I denied saying that and asked her to show me where I had ever said that. Senator Knowles kept pressing me as to why my views were not shared by the government funded Hepatitis groups such as the Hepatitis C Council of NSW. I said it was because I was not paid by the government. That absolutely brought the house down with laughter and applauding from the audience - so much so that the Chair told everyone in the room that applause was not usually allowed. The ovation from those in attendance visibly angered Senator Knowles and other members of the committee.

72. Senator Knowles responded to my answer about the Hepatitis C Council by stating that they had made a well-considered submission. The submission of the Hepatitis C Council of NSW to the Inquiry is exhibited before me at **Exhibit WITN3939021.** This statement astounded me as according to the author of the submission, Stuart Loveday, ex gratia payments of the kind used in the UK to help contaminated blood victims, would send the wrong message to healthcare workers who acquired hepatitis C through needle stick injuries and migrants who had acquired the virus from contaminated blood transfusions overseas, such as South East Asia and Europe.

73. Additionally, he said that it would also be unfair to people who had acquired hepatitis C from blood-to-blood contact through sharing injecting equipment. We felt as though the government funded Hepatitis C groups would have literally made any argument, that it would have been unfair on the man in the moon, if it meant they could stop haemophiliacs and blood victims accessing financial assistance.

74. The government funded Hepatitis C groups received preferential treatment by the Inquiry; in contrast, our group's submission came under heavy fire from Senator Knowles for making what she considered to be serious allegations. I felt it deeply discriminatory that the Hepatitis C groups would use public funds to submit a position that warned against offering financial assistance to infected blood victims when they were funded on the basis that they would represent the best interests of all people with viral hepatitis.

75. A transcript of Stuart Loveday's evidence is exhibited before me at **Exhibit WITN3939022.** He had told the committee that morning that it was his understanding that nothing could have prevented haemophiliacs being infected from blood products in the 1970s and 1980s. When commenting on hepatitis C not being considered a serious health condition in the early 1980s, he spoke of his experience from working in a sex clinic in England in the 1980s. He also said that his understanding was that there was no knowledge, no expertise and no possibility of excluding hepatitis C from the blood supply. This was not in the best interests of haemophiliacs with hepatitis C when Mr Loveday said these things to this Inquiry. He did not have the qualifications to make such assessments. I found them to be inappropriate and so I was incredibly upset by how the Inquiry lauded his view but cast ours in a questionable light.

76. Members of my group including the Rev Bill Crews, GRO-A, GRO-A GRO-A and GRO-A also gave evidence. I have included a summary of their statements from the Senate Inquiry in 2002. I refer you again to **Exhibit WITN3939020.**

77. The above-mentioned victims were mainly people who had been featured in the Network Nine Australia program referred to above. I believe that is why they were asked to give evidence. No haemophiliacs from our group were asked to give evidence, although the Australian Haemophilia Foundation (HFA) gave written and verbal evidence. The HFA spoke of Australian haemophiliacs being like haemophiliacs the world over in that all too often they are 'canaries in the coal mineshaft', always being the first affected when a virus or pathogen has

entered the blood supply. They provided information of the devastation hepatitis C and HIV/AIDS had caused the haemophilia community in Australia. They were critical of decisions to use donations from HCV positive blood donors in the manufacture of Factor VIII in 1990. Ultimately the HFA submission called for compensation for haemophiliacs infected with hepatitis C. Some of what came out of the Inquiry was helpful. It was the first time it was admitted there was some sort of compensation scheme required.

78. It was the first time it was admitted that something like 1350 infected haemophiliacs were infected with hepatitis C from tainted blood products. This is shown above at **Exhibit WITN3939015,** paragraph 2.18. It was also the first time that the Australian Red Cross Blood Service admitted that Look-back was not working. This was in stark contrast to a media release that they issued two years earlier in which they refuted the criticisms that I and other infected blood victims had made about Look-back as being "unfounded". I refer you again to **Exhibit WITN3939008** which is a copy of the ARCBS press release.

79. I can recall sitting home one Sunday afternoon after evidence had been taken, but before the report had been published, so it must have been in about May 2004. I received a phone call from the Chair of the Inquiry, Senator Jan McLucas. She was telling me that congratulations were in order and that we were going to get everything we asked for. I said, "did that include compensation?" She said, "yes". At that moment, I felt the happiest I had ever been. I thought we had achieved everything that we had fought so hard for. However, she then came up with a caveat. She said we needed to attend a mediation meeting and that it would be in private. I said that it caused me some concern that it would have to be held in private. I took this back to the group and we reluctantly decided to go along and attend the meeting as we were led to believe that we would only get the recommendation that contaminated blood victims would be compensated if we attended.

80. More recently, I discovered on the Parliament of Australia's website, information relating to compensation the Australian government handed out as a result of

the 2004 Senate Inquiry. I refer you to **Exhibit WITN3939023**. I believe the compensation that has been awarded will never come close to healing the pain many individuals and families have endured as a result of this treatment disaster.

81. The meeting took place in Parliament House in Sydney on 27 May 2004. The facilitator was the former Chief Justice of NSW called Sir Laurence Street. A copy of a transcript of the meeting is Exhibited before me at **Exhibit WITN3939024.** This lists the attendees of the meeting. I am listed as an Administrator of the Tainted Blood Product Action Group. It can be seen there were also people present from the Hepatitis C Council of NSW (now known as Hepatitis NSW), Haemophilia Foundation Australia, TRIADS and the ARCBS. Also in attendance were three members of the Senate committee, the Chair, Deputy Chair and Senator Moore, who came along as observers. Sir Laurence Street said that the purpose of the meeting was to "*sow the seeds for an on-going interactive relationship between the ARCBS and those institutions and, ultimately individuals who have a concern with the activities of the ARCBS*".

82. At one point during the mediation there was a tea break. We were in a very large room and I can vividly recall myself and Rev Bill Crews helping ourselves to the tea and biscuits when Sir Laurence Street came by us. He was a pleasant gentleman and we chatted to him. He then said to us that, when he first started out in law, there had been the HMAS Voyager Disaster (that was a naval accident between a British ship and an Australian ship, that had cost the lives of 100 men - it was Australia's biggest peacetime disaster). Sir Laurence said that it took 40 years for the victims' families to get to the truth and to get compensation from that disaster, and he said to us "they will make you wait 40 years". I took that as a coded warning as to what we were up against, but also an encouragement not to give up. Rev Bill Crews would go on to remark on many occasions about what Sir Laurence Street had told us both in private, that the tainted blood scandal would play out very much like how HMAS Voyager did.

83. In his opening statement Doctor Benton Wylie of the Australian Red Blood Cross Service expressed sympathy for victims but said that "we do not accept liability".

84. My colleague, Rev Bill Crews, was incensed and wanted to walk out more or less there and then. We had both been led to believe by the Inquiry Chair, Senator Jan McLucas, that attending this meeting would help facilitate financial assistance being offered to victims. Instead, we discovered that we had been misled. The meeting turned out to be nothing more than a concocted opportunity for the Australian Red Cross Blood Service to deliver its qualified apology that felt so very cynical and like it had been written by a lawyer.

85. When I had the chance to speak, I tried to suggest that the Australian Red Cross should work with victims' groups and accept that compensation should be paid. I was happy to try to avoid litigation if possible. I also recommended trying to contact potential victims who might not know they were victims. At the end of the meeting, Sir Laurence said that it was just the start of a process. However, nothing further ever came of this. It turned out to be a complete and total waste of time.

86. I find it extraordinary that nothing further came of that mediation meeting. As stated above, Sir Laurence seemed to think it was merely the start of some sort of process of engagement and discussion. Nothing further though happened in that context. Exhibited before me at **Exhibit WITN3939025** is a copy of the article that was published in the Sydney Morning Herald on 1 September 2004 following the mediation. The article discusses how Australian haemophiliacs will miss out on compensation and instead the money would go into generating "recombinant blood".

87. Following this article, Rev Bill Crews penned a letter to the Sydney Morning Herald. The letter is exhibited before me at **Exhibit WITN3939026.** In the letter Rev Crews states his disappointment at the Australian Red Cross action following the Inquiry and expresses dismay after reading of the $80 million

pledge to recombinant blood in the Sydney Morning Herald. Rev Crews believes this should have been announced to those taking part in the Senate Inquiry before it was published in the Sydney Morning Herald. The newspaper subsequently published the letter on 3 September 2004. I have a copy of the article exhibited before me at **Exhibit WITN3939027.**

88. Some victims subsequently wrote to Sir Laurence asking him what was going to happen next and received responses from him, saying that he was surprised not to have been asked to be involved further and that there had been be no formal public apology, and nothing seemed to have come of any of this. Following the mediation, my confidant and retired Superintendent of Police, Neil Lake, wrote to Sir Laurence Street. Sir Laurence personally replied to this letter. I refer you to **Exhibit WITN3939028** which is a copy of the letter from Sir Laurence. Sir Laurence references the mediation meeting that took place in 2004; he states that he has not heard anything further himself in regard to any progress since the meeting. I particularly like what Sir Laurence says in the final paragraph of the letter where he states: *"I devoutly hope that a way forward may be able to be found taking due account of personal hardships that have been inflicted on so many".* Sir Laurence was a great advocate for the cause. However I do not believe his influence was enough to cause any significant change.

89. The Inquiry Report came out in very quick order in June 2004. It was actually leaked beforehand. The Inquiry Report entirely sidestepped the issue of compensation. The Committee warned that extending compensation would not be in the best interests of those people who had acquired hepatitis C through blood and blood products. Instead, it recommended the establishment of a new national body that would help deliver an apology as well as help cover out of pocket expenses for medical expenses.

90. It came up with six recommendations, which are summarised in the Report, exhibited at **Exhibit WITN3939015** above. The first five recommendations are really looking forward. It was recommendation number six which was most

relevant. This recommends a setting up of a National Post Transfusion Hepatitis C Committee. It was my understanding this was to apply across the board in respect of victims. It would include transfusion victims as well as haemophiliacs infected through contaminated blood products.

91. The other recommendations included the formulating of an apology, establishing an effective look-back program, improving service delivery and most crucially to the committee, funding expenses of victims when they have to attend for treatment. Also funding home care and home help for victims and alternative medical treatment. Those last suggestions were something I had personally been pushing for, as we had victims in our group that were bed bound and also others that were not successful in treating their hepatitis C infections with the conventional treatments. I thought that the establishment of this National Post Transfusion Committee and the financial funding referred to were good ideas and very positive ones. However, absolutely nothing came of this.

92. One of the big things about the Senate Inquiry in 2004, was that blood victims' accounts would be made public if their evidence/submissions met with the Terms of Reference and if they were marked by the individual as public. In the Senate's report, it states there were 60 confidential submissions, however from my knowledge, I am aware of 60 public submissions. Many victims sacrificed their rights to privacy and made those submissions so that other Australians could see what went on. Fellow campaigner GRO-A wrote to the President of the Senate, the Honourable Paul Calvert on the 5 October 2004. Exhibited before me at **Exhibit WITN3939029** is a copy of the letter. In the letter GRO-A remarks that an Inquiry called the "Children in Institutions Inquiry" which was running alongside the Senate's Inquiry into hepatitis C, had all of its submissions posted to the internet. GRO-A makes a point in the letter of stating there are different rules for transfused hepatitis C victims.

93. GRO-A's letter sets out that victims' submissions from the Senate's 2004 Inquiry were withheld from the public domain. Exhibited before me at

Exhibit WITN3939030 is a list of public submissions from organisations and individuals from the Senate's Inquiry.

94. An article was published in the Sydney Morning Herald on 20 June 2005, I refer you back to **Exhibit WITN3939018.** I believe the general tone of the article perfectly sums up the average Australian's opinion of State led Inquiries. My dear friend Rev Bill Crews sums matters up perfectly when he states in the article "the end result of it all is disappointment, extreme disappointment".

95. The only apology that had ever been offered, was the extremely qualified and legalistic one spoken, in the "mediation" which mentioned transfused victims but completely ignored Australia's 1350 haemophiliacs infected with hepatitis C from contaminated blood products.

96. There is a formal timescale for responding to Senate Inquiry recommendations. I had some correspondence at the time with Tony Abbott who later became Prime Minister of Australia, but at that time was a Health Minister.

97. On 30 August 2004, Tony Abbott drafted a press release regarding the government's response to the Senate Inquiry. At the time, Tony Abbott was the Minister for Health and Ageing. I refer you to **Exhibit WITN3939031.** This is a copy of the press release by Tony Abbott. The press release sets out the amount of compensation that will be provided for victims by the government between 2004-2008.

98. Following this, the Australian government formally released its recommendations to the Inquiry in April 2005. I refer you to **Exhibit WITN3939032.** This is a copy of the recommendations from the government and covering letter from Tony Abbott to the President of the Senate Paul Calvert.

99. Currently, the federal and territorial governments of Australia are providing very little in terms of contingency payments. I refer you to **Exhibit WITN3939033.** This document is from the Australian Department of Health website. On page 66 of the document, there is reference to the "Hepatitis C Settlement Fund". The document shows how only the State of New South Wales has set aside funds to compensate victims between 2018- 2023. The other states do not allocate any funds.

100. I was resigned to the fact that things would take some time, and that there would be some posturing and political deliberation by the relevant authorities and government but eventually, the National Post Transfusion Committee would be set up. I had hoped that, once that was up and running, it would inevitably begin to address the matter of compensation. In 2015, I wrote a letter to Sussan Ley, the then Federal Health Minister. In the letter I set out the harsh reality for many victims and I also questioned Ms Ley's moral standing, considering her repeated refusals to meet with myself or any other campaigners to discuss the scandal. My letter received attention from the press. An article was published in the Newcastle Herald newspaper dated 10 January 2017. The article is exhibited before me at **Exhibit WITN3939034.** The article provides a short but accurate summary of Sussan Ley's actions and the content of my letter.

101. However, the forces that reigned against this were too strong. The government funded hepatitis groups opposed anything being done. This also included the Haemophilia Foundation of Australia. It is my personal opinion that these organisations were fearful of having funds diverted away from them to the new committee proposed. They were acting in their vested interests.

102. Recently, when Stuart Loveday, the founding member of Hepatitis Australia and Head of the government funded Hepatitis NSW, was asked about what he did to see that the Inquiry's recommendations were carried out and what steps he had taken, he said, "no significant ones". It's not that these organisations don't lobby and pressurise for things, they have done that on

many occasions for enhanced, health services for prison inmates, and for others infected or at risk of infection to hepatitis C. I refer you to **Exhibit WITN3535035**. This is a copy of an article from the Newcastle Herald dated 3 October 2019. In the article Stuart Loveday denies any connection between Sir Brian Langstaff's comments about the treatment of tainted blood victims in the UK with their counterparts in Australia.

103. By the end of 2006, it was clear to me that nothing was going to come of the Senate Inquiry. Also, a number of key campaigners were dying. I found myself caught up in the grief and having last conversations with people. I developed a sense of guilt. I thought that I personally had failed and let down all the infected blood victims. I had gotten their hopes up, only to see them dashed by the refusal of the Australian government to offer meaningful help. I believed myself and our campaign to be an abject failure.

104. As a result, I stepped aside from running the group. There were still the urgent needs of contaminated blood victims to consider, however. This is where the Sydney based charity, the Medical Error Action Group (MEAG) came in. They are an organisation with the most incredible track record of fighting for victims of clinical negligence scandals. They had their own contact over the years dealing with hospital patients who had been infected with viruses as a result of tainted blood transfusions. They had also given evidence to the Senate Inquiry into hepatitis C and blood supply in Australia. This meant that they had the background knowledge and required sensitivities to be able to continue to challenge the government for answers. They made numerous representations to the government on behalf of Australia's tainted blood victims. I assisted MEAG with that and other work. Most importantly, I was able to learn from MEAG and had one of the privileges of my life, in being able to know their founder, Lorraine Long.

105. Lorraine Long had brought down the infamous Australian Obstetrician whom the media dubbed the 'Butcher of Bega' because he had assaulted and mutilated hundreds of female patients. Long was rightly hailed over that and is

also renowned for many other investigations and exposes that have led to changes in our country. This influence helped me greatly. It helped me see that while public health failures and criminal conduct can occur in healthcare, there are still those watchdogs and heroes that want to protect patients. I was inspired by the MEAG ethos and I vowed to continue their guiding principles and help other patients so that they did not have their lives ruined unnecessarily by failures from health authorities.

106. It was the sight of the valedictory speech of Andy Burnham MP, on 25 April 2017, which reinvigorated me and greatly inspired me to take up the fight again on behalf of Australian infected blood victims. Andy Burnham talked about institutional cover up, about criminal activity, about the problems he had faced in trying to get answers. I realised at that moment, that Burnham had experienced exactly what I had, and that if an actual Health Minister was met with such resistance then what chance did an ordinary medical patient like myself have? It made me feel for the first time in the thirteen years since our failed Senate Inquiry a sense of relief from my feelings of guilt and I started seeing that I was not entirely to blame for failing to achieve financial assistance and help for victims. That this fight was bigger than me. And it would need something more than just me to fight it. Victims and their loved ones would have to reform and try again.

107. Our incorporated association and charity, the Independent Blood Council was deregulated in 2006 and with myself taking up other fights and challenges in the clinical negligence sphere, the campaign wound down. Following the Andy Burnham speech, I established Tainted Blood Australia. It is not yet registered as a charity, although it is something I aim to do in due course.

108. I set up a very limited presence of Tainted Blood Australia on social media and through that I established contact with Michael Imperato of Watkins and Gunn Solicitors in Wales, UK. I checked out Michael and Watkins and Gunn and saw they had been one of the main legal firms fighting for victims of the

Infected Blood Scandal in the UK. I had some preliminary discussions with Michael over Skype and was very impressed with his commitment to the cause of victims both in the UK and indeed around the world.

109. It is important to remember this scandal was actually, a global scandal. It touched people and killed people around the world. Such a disaster knows no international boundaries. It's all about a failure of processes, a failure of accountability and a failure to place concerns over protecting patients above considerations such as costs of tests, and concerns over drops in yield of blood plasma due to the kind of heat sterilization required to kill viruses. It is important that the UK Inquiry realises this global scope and the influence that UK protocols have had on the Australian blood supply.

110. Furthermore, I believe that the UK Inquiry can be assisted by myself and fellow campaigners in Australia. I will go into this in detail further in my statement where I look at issues of Australian blood being supplied to the UK and links between the two countries in respect of what was known at what time.

111. I also hope that my involvement and possibly that of other key Australian campaigners, will be a springboard to an equivalent Public Inquiry in Australia. It's well known, that Australians have a great rivalry with England. Therefore, I believe it's fair to say, if Australians see English victims getting to the truth, getting justice, and getting fair and proper compensation, they – and indeed the people of Australia, may say, "If the English can have it, why can't we in Australia?"

3. <u>Your knowledge of interaction between the UK Government and Australian Government on issues relevant to the Infected Blood Inquiry's Terms of Reference</u>

112. The Haemophilia Society in the UK was founded in 1950 and has close links to its equivalent in Australia, the Australian Haemophilia Foundation (HFA) that was established in 1954. HFA is a National Body that represents people

with haemophilia and other bleeding disorders in Australia. It is a National Member Organisation of the World Federation of Haemophilia and along with the UK they joined in the 1960s.

113. After the HFA was formed in Victoria, other societies sprang up in neighbouring Australian states and in 1979 they joined together to form the Federation of Haemophilia Societies and the Haemophilia Foundation was established to represent the Haemophilia Community nationally and with one voice. The Haemophilia Foundation was registered as an Incorporated Association in 1986. Its head office is still based in Victoria.

114. Just as in the UK, the HFA were remarkably silent about the scandal in the 1980's and 1990's. They also failed to lobby for the recommendations of the Senate Inquiry (2004) to be taken up and failed to defend the discrimination levelled at haemophiliacs by state funded Hepatitis groups.

115. I am aware there are similar criticisms made against the Haemophilia Society in the UK. I am also aware that both these organisations have historically worked closely together over the years and I consider it to be instructive for the UK Inquiry to examine any such communication.

116. My close friend GRO-A a haemophiliac who contracted hepatitis C from contaminated blood products, wrote to the Executive Director of the HFA, Sharon Caris on many occasions GRO- initially wrote to Ms Caris in February 2013. I refer to **Exhibit WITN3939036**, which is email correspondence from GRO-A to Ms Caris. At that point in time GRO-A was desperate, not just for himself but for his brother GRO-A GRO-A is also a haemophiliac who contracted hepatitis C through contaminated blood. Contained in the correspondence are Ms Caris' unhelpful responses to GRO-A's pleas for assistance. In email correspondence dated 28 February 2013, it is clear from her tone and language that as Executive Director of the HFA, she cannot provide reassurance that any

changes will be implemented in terms of compensation or acknowledgement of wrong-doing.

117. I would like to draw your attention again to **Exhibit WITN3939036** and the correspondence dated Tuesday 10 September 2019. **GRO-A** emails Sharon Caris, reminding her that he has not heard from her for six years, despite the fact that Ms Caris promised to keep in contact. In the correspondence **GRO-A** makes it apparent he has emailed on a couple of occasions chasing up on what, if anything, was being done. However, his emails appear to fall on deaf ears, without a response. **GRO-A** pleads that Ms Caris lends her support to Australian haemophiliacs in their bid to call for a Royal Commission to be established. Eventually, following a number of chaser emails **GRO-A** receives a reply from Ms Caris. The reply is dated Thursday 14 November 2019. In the email Ms Caris provides a generic and lacklustre response. Ms Caris sets out "*we want to understand more about the impact of things like arthritis, reduced mobility, and financial issues, work related matters... and the on-going impact of hepatitis C and/or HIV*".

118. This type of response will be familiar to the Infected Blood Inquiry as we have seen similar in the communications between numerous victims and the UK Haemophilia Society.

119. It is important to understand, that the United Kingdom was the architect of modern haemophilia treatment for Australia. Haemophilia Centres in Australia were modelled on those operated in the UK with leading medical professionals in the field being trained in the UK before moving to Australia to set up Haemophilia Centres. It would be fair to say, that the relationship between Australia and the UK in respect of haemophilia treatment was exceptionally close. It is important to recognise that unlike North America, Australia had a volunteer blood donation program as did the UK during the time leading up to and during the contaminated blood scandal.

120. A further similarity between the UK and Australia can be seen by the way the medical profession responded to concerns raised about blood safety, particularly in respect of its reluctance to introduce surrogate testing, and the delay in the introduction of heat treatment due to concerns relating to the drop in yield and associated costs. It is reasonable to state that the UK and Australia responded in similar ways to the same issue.

121. I refer to **Exhibit WITN3939037**. This is a report of a meeting of the Working Party on Factor VIII and IX Concentrates. The meeting was held by the Australian Red Cross Society at Commonwealth Serum Laboratories (CSL) on 29 June 1984. This document links the Australian Red Cross Society with the Scottish National Blood Transfusion Service (SNBTS) where at paragraph 2.3 the evaluation of heat treatment methods is explored. Particularly concerning in this report is the statement that:

"both Doctor Ekert and Doctor Rickard agreed they had no problem with liver disease, hence they would prefer to have sufficient concentrate for all cases rather than be short of concentrate because of heat treatment."

122. It is now known that authorities in Australia were using high risk blood donors, and that some of those donors were using the blood service as a way to obtain free and discreet testing for hepatitis. That donated blood was then sent to CSL to be made into treatment for people with haemophilia, with CSL then refusing to heat treat due to costs and a reduction in yield.

123. I am aware of a report of a meeting of the BTS Executive Sub Committee held in Canberra on 23 and 24 February 1984 which stated; *"Doctor Schiff reported that the heat sterilisation currently being evaluated at Commonwealth Serum Laboratories resulted in a fall in yield of factor 8 of about 40%. As oversees manufacturers claimed losses of only 15% Commonwealth Serum*

Laboratories was investigating other methods in an effort to find a more satisfactory process. He said that at present, pressure from interested groups for a heat treated Factor VIII concentrate was not at a level where an immediate solution was required although haemophiliacs would like to have a product available in Australia as soon as possible. The committee urged that no decision be taken hurriedly on a matter which would have such far reaching consequences for the Blood Transfusion Services, such as markedly decreasing the amount of Factor VIII available for treatment while at the same time increasing the cost of both plasma collection and processing."

124. Unfortunately I no longer have this original document in my possession, but it is held in my legal file held by Marsden's Law Group, Campbelltown, New South Wales.

125. The relationship between the UK and Australian Blood Services gives rise to the obvious concern that if Australia was exporting products to the UK, then the recipients of such products would be at considerable risk of infection.

126. I now refer to **Exhibit WITN3939038.** This is a letter dated 12 March 1986 from LG Stubbings, Secretary General of the Red Cross to Doctor NJ McCarthy, Director of CSL. In this letter, LG Stubbings states;

"as plasma from the Australian Red Cross Blood Transfusion Service is currently pooled for processing with plasma from New Zealand and South East Asian sources the society could already be compromised for the same reasons which had been advanced should it agree to pooling of its plasma with that of the private blood bank and to distributing any finish product."

127. I think this letter would be of significant interest to the Infected Blood Inquiry, because if plasma was sent from Australia to patients in the UK, this letter is further evidence that the recipients would have been exposed to a highly dangerous medicine indeed.

128. I now refer to **Exhibit WITN3939039**. This is a letter dated 25 September 1989 from Professor John D Cash, National Medical Director of the Scottish National Blood Transfusion Service to Doctor Harold Gunson, who was then the National Director of the National Blood Transfusion Service. The letter states;

"whilst in Australia recently I was asked to pop in and see [redacted].

It became apparent that the Red Cross in Australia are in the midst of briefing lawyers for impending HIV/Haemophilia litigation and they would very much appreciate our assistance."

129. The implications of this letter for infected blood victims in Australia cannot be underestimated. I personally believe that the individual referred to in this letter is the name of "H", the young boy infected with HIV and referred to above. At the time of this letter, H's case was high profile in Australia as it pertained to a child who had to seek legal redress because his parents couldn't afford his medical care and had to sell their home following his infection with HIV through contaminated blood.

130. H's parents took the case to Court and it was widely reported that sadly, in the days before H's death, that H's family had difficulty accessing pain relief for him, due to the fact that the nursing staff believed he was exaggerating symptoms. The story created rage in Australia as it is one thing for a little boy to have been inadvertently infected with HIV but another for him to be dying and denied pain relief. Many people, including myself, believe this to be criminal behaviour.

131. On discovery of this letter, I was appalled to find out that Australian blood authorities were at the time, writing to their British counterparts, not to ask for

advice or information on how to help this poor little boy, but instead were asking for assistance with defending the litigation associated with the little boy's claim.

132. In my opinion, this letter further evidences the close relationship between the blood authorities in the UK and in Australia. Why would a foreign body randomly write to another country to ask about dealing with a specific piece of litigation, if that country was not already involved in their own similar domestic legal problem? Did the National Blood Transfusion Service assist? And in what capacity?

133. We already know that the UK set the protocols for blood services in Australia, but this letter is evidence of the further extent of the collaboration between the two nations in direct response to the contaminated blood crisis. The Infected Blood Inquiry should investigate the correspondence between the UK and Australian Red Cross within the relevant period. Was assistance provided as requested, by the UK Transfusion service to the Australian Red Cross in respect of the litigation? Did the National Blood Transfusion Service's assistance aid the Australian Red Cross in their successful attempt to avoid compensating this family (and consequentially so many other families similarly affected)?

134. **Exhibit WITN3939040** is a report entitled "Red Alert!" by Katherine Beauchamp, published in 1994. The report looked at whether or not, regulation was working for imported and CSL blood products in Australia. This report is essential reading for anyone trying to understand the background and context of the contaminated blood scandal in Australia.

135. Prior to the publication of Red Alert there was an independent review of CSL ordered by the then Prime Minister, Malcolm Fraser in 1978, over concerns regarding CSL's financial mismanagement. This was the only major independent review of CSL's conduct ever conducted. The major recommendation was that CSL should adhere to the code of GMP (good manufacturing process). At page 70 of Red Alert, it can be seen that an

Inspector from the UK described CSL's manufacturing processes in the late 80's as "god awfull."

136. On page 72 of Red Alert, a Senior Official from NBSL asked, what were the main problems in the blood processing area, cited 'worn out equipment' and 'CSL did not know enough about viruses in the blood'.

137. Another Senior NBSL Informant said that CSL had not been inspected adequately in the 1980's when they were inactivating HIV in the blood and blood products. In 1984 there was a meeting at CSL over Factor VIII and HIV. He said CSL's process was a compromise between killing the virus and maintaining potency. The process was weighted in favour of potency and thus increased the risk of live virus ending up in the final product. This informant outlined research and action to show CSL how to increase the temperature and improve safety without greatly reducing yield. It is unknown if CSL accepted this advice. Evidence from the HFA shows that CSL told a Senior Executive in 1989 that they would raise the heating temperature for some clotting factors to better destroy the virus but that CSL had still not done so at the time of the interview (in 1992).

138. Exhibited at **Exhibit WITN3939041** is Report of the Chairman of the NBTC to the National Executive dated November 1989. The report clarifies that "*whilst 60 degrees for 72 hours is effective against HIV, it is not considered sufficient to reliably destroy Non A and Non B virus*". The report confirms the point in time at which CSL began effective heat treatment of its products as January 1990.

139. We also know from page 138 and 139 of Red Alert that CSL was unlawfully mixing blood from numerous countries with high infection rates. On page 205, we can see that CSL sent Australian blood products overseas without clearance. This was alleged to have happened across a number of years for a number of products.

140. During the course of the Senate Inquiry, I had a conversation with the Author of Red Alert, Kate Beauchamp. At **Exhibit WITN3939042** is a letter I received from Kate Beauchamp which I interpreted as a warning in so far as it states; "*anyone who tried to push on this, use this inquiry to force other data onto the public record, would be risking their life, because first they would not succeed, and then would instead be left exposed as trying to bring to light data that would not get up. Therefore they would identify themselves as a target.*"

141. I now refer to **Exhibit WITN3939043** which is an article from the Sydney Herald Sun published in 2013. Here it can be seen the Australian scandal has all the hallmarks of the British situation. In particular, the crisis of confidence in blood supplies, victims being ostracized, the failure of the government to compensate and public money being spent defending lawsuits rather than supporting victims.

142. I now refer to **Exhibit WITN3939044** which is an article entitled; 'Factor VIII patterns of usage in New South Wales' by Doctor Kevin A. Rickard of the Haematology Department and Haemophilia Treatment Centre at the Royal Prince Alfred Hospital in Sydney. The article compares haemophilia care in the UK with Australia and states:

"*This unfavourable state of affairs has to be contrasted with the benefits accruing from the definitive organisation of haemophilia care that have occurred in the UK in National Health Service Hospitals throughout the country. Their concepts, which date back to 1954, currently incorporate these types of centres; haemophilia reference centres, haemophilia centres and associate haemophilia centres as defined in a 1976 DHSS memorandum to regional health authorities. An exactly similar system could be readily introduced to haemophilia care as has developed in the UK.*"

143. Doctor Rickard was from the UK and was instrumental in starting the Haemophilia Centres in Australia and held key roles in those centres. For example, he was the International Haemophilia Training Centre (IHTC)

Secretary for Australia from 1982 to 1986. He was the Chairperson for the IHTC for Australia from 1986 to 1996. He wrote a number of articles about haemophilia, and in particular hepatitis and haemophilia in Australia.

144. **Exhibit WITN3939045** is the second page of a letter retrieved from the National Archives dated 28 December 1977. Unfortunately, I don't have the first page. This letter will be of interest to the Infected Blood Inquiry in the UK as it mentions the infamous tainted blood supplier company 'Cutter' being in Australia in 1977;

"*when I last spoke to Mr Hjorth in July 1977 he told me that Cutter had appointed someone to London to study the match between their product line and European market requirements. This study seems to have made some progress and Mr Hjorth said that they had pretty well decided that they should manufacture blood bags and plasma produced by the phoresis process in Europe (they are at present supplying the European market from their Australian plant).*"

145. This information has potential implications for victims of infected blood in the UK. I refer to the case of Core Participant Thomas Griffiths, who gave evidence to the Inquiry. He mentioned in his evidence seeing blood products that were produced in Australia. He did not mention to my knowledge seeing "Commonwealth Serum Laboratories" but the assumption would have been that as they were Australia's sole blood fractionator, any Australian blood products would have come via them. However, this letter suggests that it could have been the firm Cutter that sent the contaminated products to Scotland. We need further investigation, as without it, we won't be able to know exactly what was coming out of the Australian plant that is mentioned in this letter.

146. **Exhibit WITN3939046** is a study carried out in 1988 called 'Surrogate testing for non A, non B hepatitis in Queensland, Australia; an ALT micro titre method for screening blood donors.'

147. One of the authors of the article is Doctor Ian Young, the Doctor referred to above who was instrumental in implanting the use of surrogate tests in Queensland. Doctor Young had a colleague called Catherine A. Hyland. The study exhibited was referred to in Scotland's Penrose Inquiry. Catherine Hyland also worked closely with Doctor Young throughout his career. If Doctor Hyland is still alive, I believe it would be of great insight to the Infected Blood Inquiry to speak to her, as she would be likely to have significant information relating to Doctor Young and his work.

148. It is important to understand that in my experience, and the experience of the other campaigners, literally everyone involved in the Blood and Haemophilia Services in Australia seems to be British. Even my own Doctor who gave me the contaminated blood was Scottish. Our whole system was modelled on those in operation in the UK. Doctor Rickard was a key figure and extremely influential in the treatment of haemophilia and subsequently, the identification and treatment of infected blood. **Exhibit WITN3939047** is an abstract of àn article called 'Hepatitis and haemophilia therapy in Australia' published in 1982 in the Lancet. This article demonstrates Doctor Rickard's standing as the leading authority on hepatitis treatment in Australia.

149. **Exhibit WITN3939048** is an article entitled 'The International Haemophilia Training Centres of the World Federation of Haemophilia; 30 year review" written by Doctor Rickard in January 2001. This article sets out how the United Kingdom was the leader in the implementation of special Haemophilia Centres and that the UK demonstrated leadership at the international level and had profound influence on the advancement of understanding of haemophilia and its clinic management.

150. The link between the UK and Australia in respect of haemophilia treatment is further evidenced by **Exhibit WITN3939049** which is a printout of a presentation on the History of Comprehensive care to the Haemophilia Foundation in Australia and Haemophilia Foundation New Zealand.

151. **Exhibit WITN3939050** contains a quote from the Royal College of Physicians in London from 1971 and it is stated that:

> *"the need to develop a broadly based service at Royal Prince Alfred Hospital [Sydney] became apparent about 10 years ago when it was realised that haemophiliacs were using the hospital staff as their sole source of advice and guidance on every conceivable person on a social matter… having constant source of support and guidance in the hospital clinic appeared to be the most helpful factor to the patients and relatives. Accordingly, fulltime services of social worker and nurse were made available to the clinic."*

152. **Exhibit WITN3939051** is an article from the Australian Press entitled "Women Only Ruling May Halve Queensland Blood Supply." This was published in the Age Newspaper on 21 November 1984. This article is an example of the horribly lax standards that the Australian authorities have held in producing medicines via CSL in the 1980s.

153. The comments by the spokesperson, Mr Brian Day, from the Brisbane Gay Action Group are a good insight into the reality of the day back then. With blood donation serving as a free and discreet test for those who may feel at risk or having engaged in risky behaviour. Many gay men were using blood donation as a testing method for diseases.

154. We know now that CSL were not heat-treating blood products at the time in 1984 or beyond, at a level sufficient to kill non A, non B hepatitis (hepatitis C). We also now know from the documents exhibited here from that era, that the British and Australian medical experts (Doctor Ekert and Doctor Rickard) state that they have "no problem with liver disease" and would rather avoid seeing fewer products being made available because of heat sterilisation.

155. My key concern about any blood products produced or exported from Australia, would be the standards by which they were manufactured here. The Australian Red Cross Blood Service and CSL tore up one of the biggest components of blood safety – donor screening and appropriate donor selection.

156. On the one hand, the Red Cross appeared to acknowledge the risks associated with viruses in blood by ruling in 1984 that female donated blood would be used in preference to male donated blood for regular patients and procedures requiring the whole blood transfusion. Male donated blood would instead be only used in emergency cases because of its risk, or sent to the Commonwealth Serum Laboratories to be made into medicines for haemophiliacs.

157. Haemophiliacs were put at risk as a result, and 90% of them treated with blood products in Australia became the recipients of viruses such as HIV and hepatitis C. Any potential British user of these Australian blood products would have been at the same level of risk.

158. A further connection between the United Kingdom and the Australian infected blood crisis, is the role played by the CEO of Hepatitis New South Wales and the founder of Hepatitis Australia, Stuart Loveday. Stuart Loveday came from the United Kingdom to found the government funded national hepatitis body, the Australian Hepatitis Council (now known as Hepatitis Australia) in 1994, and he subsequently became the Executive Officer of Hepatitis NSW.

159. Exhibit **WITN3939052** is a timeline compiled by Tainted Blood Australia of government funded hepatitis C group's discrimination against infected blood victims before and during the Senate Inquiry into Hepatitis C and Blood Supply in Australia (2004). Campaigners in Australia felt completely betrayed by Stuart Loveday's representations to the Senate Inquiry. As a Government funded organisation, the Hepatitis C Council NSW, were expected to represent the best

interests of all people with viral hepatitis but instead began to lobby against the interests of haemophiliacs who were predominately infected with hepatitis C.

160. For example, in their submissions, the Hepatitis C Council NSW stated that, "*in terms of ex gratia payments, as have happened in some Countries abroad where the situation maybe very different from the Australian context, we would also be very concerned about the perceived inequality if payments were made to some but not to other people with hepatitis C.*"

161. Unfortunately for the victims, this recommendation was accepted by the Senate Inquiry and compensation was refused on the grounds that it would appear discriminatory to people infected with hepatitis C who received it through other means such as through the use of illicit drugs and the sharing of needles.

162. In 1991 the New South Wales Parliament held its own Inquiry into Medically Acquired HIV. **Exhibit WITN3939053** is the Report of the Inquiry. The Inquiry included evidence from the GRO-A family, the parents of the little boy 'H' referred to above (page 11 of the Report). The Report sets out the cost the government spent on defending H's case (page 37 of the Appendix). This is a disgraceful amount of money that could have been better spent taking care of the child.

163. The Inquiry will note page 6 of the Introduction to the Report states:

"*The Committee contacted the Haemophilia Foundation of Australia and wrote to the Departments of Health in the United Kingdom, France, Canada and New Zealand for advice on how people with medically acquired HIV had been dealt with in other countries.*"

I would expect that the UK government's response to that request (which I have not been able to obtain) would be of great significance to the Infected Blood Inquiry.

164. In this Part 3, I have described and provided evidence of the influence that the UK had over the treatment of haemophilia in Australia and the similarities between the Australian Haemophilia Foundation and the UK Haemophilia Society, both in their establishment and their response to the contaminated blood crisis and its victims. I have described and evidenced the extent to which the UK was the leading influence over modern haemophilia treatment in Australia and the links between the two nations and the leading professionals of both. I have gone on to demonstrate the close connection between the Scottish National Blood Transfusion Service and the Australian Red Cross Society, both working together at a time when we can see Dr Rickard and Dr Ekert agreeing that they had "no problem with liver disease".

165. It is clear from the evidence exhibited in this Part 3, that the Infected Blood Inquiry ought to examine closely the relationship between the UK Blood Transfusion Services, the UK Government, the Australian Government and the Australian Red Cross and CSL.

166. Firstly, the Inquiry must assess whether or not, blood and blood products were imported from Australia into the UK and if so, who were the recipients.

167. Secondly, the Inquiry must obtain and examine the correspondence between the Red Cross in Australia and the Blood Transfusion Services in the UK in order to assess what information was shared and to what extent and in what capacity the UK was involved in the litigation commenced in Australia.

168. There must be extensive documentation surrounding the events set out above, much of which will be located here in Australia and which would be of

great interest to the Inquiry, as it would shed light on what the shared ideas and common understandings were between the UK and Australia in the relevant time period and the extent to which the UK and Australian governments co-operated with each other as the contaminated blood scandal unfolded in both nations. I would be happy to assist the Inquiry from Australia with any further lines of inquiry that require exploration.

4. Your knowledge of how the Common Wealth Serum Laboratories, under ownership of the Australian Government, produced blood products and exported them to the UK.

169. **Exhibit WITN3939054** is a letter dated 4 March 1991 from Doctor R J Kimber, the Chairman of the National Blood Transfusion Committee in Australia to Mr Stewart Hamilton the Secretary of the Department of Community Services and Health. The letter states: -

"As you would be aware Australia has the privilege of observer status on the Council of Europe Committee of experts on blood transfusion and immunohematology.
The Red Cross National Blood Transfusion Committee believes that Australia's observer should be a person whose professional work is principally concerned at a practical level with the committee's area of interest. The expectation is therefore that Australia's observer would normally be the director of a state or territory Red Cross blood bank or senior scientist from the Common Wealth Serum Laboratories.
Doctor Schiff of the Common Wealth Serum Laboratories is about to compete his three year term as Australia's observer. He will attend the 1991 meeting in June. The National Blood Transfusion Committee suggests Doctor A Keller, Director of the Western Australian Blood Transfusion Service, would be a suitable nominee for the next three years".

170. The reason this letter is important, is that it confirms the presence of a representative of CSL on the Council of Europe Committee of Experts on Blood

Transfusion and Immunohematology. I would suggest, that the Infected Blood Inquiry should obtain the minutes of the meetings of the Council of Europe Committee for the time period referred to in the Inquiry's Terms of Reference in order to ascertain the reason for a CSL presence on that committee, the UK's involvement with that committee and the response of that committee to the contaminated blood crisis.

171. Doctor Peter Schiff was the Chairman of CSL during the relevant period and as set out above, was responsible for the decision in 1984, not to make a heat treated Factor VIII product available to the Australian market. He was also at the meeting of the Working Party on Factor VIII and IX concentrates (referred to above) at which heat treatment methods were explored and dismissed. At this meeting Doctor Schiff said: -

"CSL was currently a evaluating a heat treatment method obtained from the Scottish BTS with a 30 – 40% loss of activity."

172. It appears essential that the Infected Blood Inquiry explores the relationship that Doctor Schiff of CSL had with the Scottish National Blood Transfusion Service and potentially with other Blood Transfusion Services across the UK. There is a clear indication from the evidence that there was a relationship between CSL and the Scottish National Blood Transfusion Service in 1983, which is a key date in the Inquiry's Terms of Reference.

173. **Exhibit WITN3939055** contains the minutes of the National Blood Transfusion Committee of the Australian Red Cross Society held in Melbourne on 21 October 1983. It can be seen, that Doctor Cash, the Director of the Scottish National Blood Transfusion Service was in attendance, by invitation, at this meeting.

174. It is important to note, that here we are discussing a period of time, the early 80s, when travel to and from Australia was slow and expensive. Why was

Doctor Cash in attendance at this meeting? What was his particular relationship with the Australian Red Cross, and with CSL? We can conclude from the evidence that the Australian Red Cross Society and the Scottish National Blood Transfusion Service were closely linked, and that steps being taken in Australia were being informed by the state of knowledge in Scotland.

175. Documentation from Australia and witness evidence could shed more light on this. The Inquiry must also consider the fact that documents lost or missing from the UK archives might be retained in Australia.

176. Given that we know from the evidence set out above, and the testimony of Thomas Griffiths to the Inquiry, that Australian blood products were used in Scotland and that CSL was the only manufacturer of Australian blood products, we can draw the conclusion that the relationship was one of mutual trade, most likely the import and export of blood products. The Inquiry must consider the possibility that the Scottish National Blood Transfusion Service was importing Australian blood and blood products at a time when it was known to be unsafe, potentially introducing infected blood to Scotland.

177. Further support for the contention that Australia was exporting infected blood products from CSL to the UK can be found in the "Red Alert" report referred to above and exhibited at Exhibit **WITN3939040.** At page 70 of Red Alert it is stated:

"CSL generally perceived outsider expertise not as a help but as a threat. NBSL Officials would have to wait upon a Foreign Government with an interest in a CSL product to ask NBSL to inspect CSL on their behalf. Or if CSL was bringing in a foreign product for packaging and sale here, NBSL would rely on CSL's product responsibility as an excuse to see if CSL's specifications were up to standard. An Inspector from the United Kingdom, which, according to informants, does not have particularly good procedures itself, yet said of CSL's manufacturing processes during an inspection in the late 80's; "god, its awful."

178. The Infected Blood Inquiry must examine the circumstances under which an Inspector from the United Kingdom came to be inspecting CSL's laboratories and particularly the fractionation facility during this period. The implication from this paragraph is that the UK was either a Foreign Government with an interest in a CSL product or that CSL was bringing in a UK product for packaging and sale in Australia.

179. The presence of a UK inspector in CSL's laboratories is a clear indication of a contractual arrangement between the UK and CSL. This was an inspector, not a visitor or an observer. The Infected Blood Inquiry must explore what that arrangement was, and what its consequences were for victims of contaminated blood in the UK. Further investigation of this is required, in order for the Inquiry to ascertain exactly what contractual arrangements were in place between the UK and CSL and what blood and products came into the UK as a result of those arrangements.

180. Further, it will be essential for the Inquiry to ascertain what the UK state of knowledge was of the way that CSL sourced and produced blood products. Clearly, there was sufficient awareness to send an Inspector all the way to Australia. The Inquiry must look to find answers to the questions raised by that inspection: what was the remit; what was its outcome; who in the UK knew about this; and why did the UK continue to take blood from CSL in these circumstances? I believe that I could assist the Inquiry further in examining those critical questions.

181. The Inquiry will already be aware of a Report to the Penrose Inquiry titled "Events Concerning the Safety of Blood and Blood Products with Special Reference to the Treatment of Haemophilia" dated October 2009. I draw the Inquiry's particular attention, to page 14 of that Report which states:

"Page 14. Manufacturing know-how

A chance encounter in 1966 between John Watt, Director of PFC and Dr Alan Johnson, an academic expert from the USA, led to a collaboration from which the SNBTS introduced new intermediate-purity concentrates of Factor VIII (in 1974) and Factor IX (in 1972). This knowledge was shared with PFL & BPL and the Commonwealth Serum Laboratories (CSL) in Australia, enabling these centres and PFC to be the first plasma fractionators in the not-for-profit sector to be capable of manufacturing these products".

This paragraph reinforces the close collaboration between CSL and the SNBTS and the influence the SNBTS had over production techniques in Australia.

182. In 1989, the National Blood Transfusion Committee (NBTC) held a meeting in Melbourne. Following analysis of the minutes of this meeting, it can be seen that the NBTC had considered using Baxter packaging for its blood products. I would like to refer you to **Exhibit WITN3939056**, this is a copy of the minutes from the meeting held on 6 October 1989. At para 8.2 you will note that Baxter had approached the Divisional Blood Transfusion Services to offer plastic packaging for Australian blood products. The close relationship between NBTC and Baxter is apparent from viewing these minutes.

183. The Inquiry will recall that Core participant Thomas Griffiths believed that his infection happened in the early 1980s. He recalled seeing that his blood came from laboratories in Australia and the USA. He recalled the name Baxter. At 8.2 of this Exhibit we may see the reason why Australian blood might have been packaged in Baxter packaging.

184. **Exhibit WITN3939057** is an article from the Age newspaper dated 12 October 1994 mentioning the research carried out by Katherine Beauchamp. The article states, "*CSL last night categorically denied that its sterilisation procedures had allowed contamination of its blood products. The organisations general manager (bio plasma), Mr Jack Wood, said the virus had not been*

identified until the late 1980's and the hepatitis C blood test did not become available until 1990.

The Democrats Science spokesman, Senator John Coulter, said foreign plasma contaminated with the virus may have been mixed with Australian plasma to produce blood products.

But Mr Wood said foreign plasma had not been mixed with Australian plasma since the mid 1980s."

185. We have seen above at **Exhibit WITN39390038** that foreign plasma had indeed been mixed with Australian plasma and that practice continued beyond 1986. If the UK was importing blood obtained from CSL, it would be crucial for the Infected Blood Inquiry to identify where that blood was sent, which hospitals it was used in and which patients received it.

186. **Exhibit WITN3939058** is a document entitled 'Privatisation of CSL' by Clive Hamilton and John Kriging published in June 1995. This paper provides a useful summary about the privatisation of CSL in 1994. CSL was privatised at a loss to the taxpayer. The report states;

"However, when all of the relevant financial details are taken into account, it is shown that the sale of CSL will result in an additional expenditure by the Commonwealth of $45 million. The proceeds of the sale, $292.4 million will thus be forgone soon after the first 6 years after sale and each year thereafter tax payers will be $45 million worse off as a result of the sale."

187. The report goes onto state;

"CSL was sold as a bundle of assets, rights, and obligations. The company has a 10 year contract to manufacture blood products for the Commonwealth. The new owners have been indemnified against claims arising from the use of some blood products manufactured by CSL in the past. This was important to the sale

because CSL is subject to compensation claims arising from previous practices, including claims relating to aids related illnesses, hepatitis, CJD and pertussis vaccine intolerances."

188. Whilst it is not for this Inquiry to investigate the privatisation of CSL, it is clear, that it was not to the benefit of the taxpayer. We know that liability for contaminated blood related claims were shifted away from CSL back onto the government as a result of the sale. This shift is likely to have informed the extent to which the Government has resisted any thorough investigation into the Blood Service or CSL or its own failings as the regulator.

189. While 90% of haemophiliacs who used CSL plasma derived Factor VIII or Factor IX became infected with hepatitis C not one haemophiliac victim has been offered financial assistance following the Senate Inquiry in 2004. Incredibly the public servants that were responsible for the management decisions at the Commonwealth Serum Laboratories at the time haemophiliacs were infected in the1970s, 1980s and 1990s have gone on to become leading figures of global health with vast personal fortunes. This stands in stark contrast to the horrifying and life destroying outcomes for the estimated 1750 recipients of their HIV and hepatitis C contaminated plasma product in Australia.

190. Exhibited before me at **Exhibit WITN3939059** is an article published by Bloomberg.com on 4 March 2020, which is entitled "Blood Beats Banking with CSL Becoming Australia's Biggest Firm". The article describes how CSL is now Australia's leader on its benchmark stock index. This firm now has a market value of 142 billion dollars whilst infected victims are struggling to survive financially.

191. In Part 3 above, I have exhibited evidence at **Exhibit WITN3939045** of Cutter Laboratories (at the time, a wholly owned subsidiary of A.G.Cutter International) supplying the European market from their Australian plant. We know that CSL was Australia's sole blood fractionator at this time, and the Inquiry must therefore look into what the relationship was between Cutter

Laboratories and CSL and consequentially, what impact that relationship had on the UK blood product market.

192. In this Part 4 I have provided evidence of the presence of a representative of CSL on the Council of Europe Committee of Experts on Blood Transfusion and Immunohematology. I have provided evidence of the relationship that Doctor Schiff of CSL had with the Scottish National Blood Transfusion Service and evidence that Dr Cash attended meetings with the National Blood Transfusion Committee of the Australian Red Cross Society. I have further shown the presence of a UK Inspector at CSL's fractionation facility.

193. Further investigation is required in order for the Inquiry to explore further the contractual and other arrangements that were in place between the UK and CSL, what blood and products came into the UK as a result of those arrangements, and who were the recipients of those products which we now know to have been extremely dangerous.

194. Given the relationship between these services, there must be further evidence that relates to the exchange of ideas and knowledge between the services' key individuals that would shed further light on the practices adopted by the services during the relevant time period. I would be happy to assist the Inquiry in further investigating these links.

5. Your knowledge of correspondence and communication between UK Blood Transfusion Services and their counterparts in Australia.

195. I have exhibited above and commented on, all of the evidence I have in my possession, in respect of the correspondence and communication between the UK Blood Transfusion Services and their counterparts in Australia. However, it is important to understand that whilst I have very few documents, the indication from the documents I have exhibited is that there was extensive

correspondence and communication between the UK Blood Transfusion Services and their counterparts in Australia.

196. It may interest the Inquiry that a Centenary Gala Dinner was held in Melbourne in 2016. Current CSL Chair Brian McNamee spoke of what he found at CSL when he started as a public servant with them in 1990:

> "*All during that time, during the early 90s leading up to 1994 to 2000, we had to reinvent our entire plasma product portfolio. CSL had suffered from competition internationally and we'd become a technologically dependent company. Our IVOG was licensed from Bayer. Our factor VIII was licensed from BPL, the British laboratory. And so it's really through the incredible efforts of Peter Turner, Geoff Davies and a lot of remarkable people, that we completely re-built the plasma protein portfolio of products over that seven or eight year period that enabled us to, um, to consider an expansion".*

A 'YouTube link to a video of that speech is here: https://www.youtube.com/watch?v=a3QDUYE0ixM&feature=youtu.be

197. The Inquiry will undoubtedly wish to establish what the terms were of that licensing arrangement, and whether or not CSL was importing contaminated blood products into the UK blood supply throughout the 1980s. Could this licensing arrangement be the reason why a UK inspector visited CSL? If documents relating to this arrangement have been lost or destroyed in the UK, there is a good chance that the evidence will have been retained by CSL.

198. The Infected Blood Inquiry must investigate the extent of this collaboration and the related correspondence and communication, as it is clear that there are close links between the UK and Australia in respect of both Haemophilia Services and Blood Services in general, but also in respect of the

packaging and supply of blood and blood products from CSL to the European market and in particular to the Scottish National Blood Transfusion Service.

6. Conclusion

199. **Exhibit WITN3939060** is the discovery list of the documents held on my full legal file by my former lawyers Marsdens Law Group, Campbelltown, Sydney. I am providing this to the Infected Blood Inquiry as there maybe documents on this list that the Inquiry may wish to see and can be requisitioned directly from Marsdens Law Group.

200. **Exhibit WITN3939019** is my submission on behalf of the Tainted Blood Product Action Group to the Senate Community Affairs References Committee Inquiry into Hepatitis C and Blood Supply in Australia. This is essential reading for the Infected Blood Inquiry, as it sets out the position here in Australia and the Inquiry will note the striking similarities between the suffering of the victims in Australia and those in the UK.

201. Here in Australia, we see the Infected Blood Inquiry as if we are peering over a fence watching our British friends being liberated while we remain in a state of grief, barely surviving under the exact same public health scandal. Thousands of Australians have acquired deadly hepatitis C and HIV from blood transfusions and blood products. What happened to victims and their families in the UK also happened to victims here. But our accounts, and in particular, those of haemophiliacs remain untold.

202. Health chiefs have been dismissive of the need for legal investigation. The former Chairman of the Australian Council for Safety and Quality in Health Care, Professor Bruce Barraclough, himself having investigated infected blood, told ABC radio in 2003:

"My personal view is that to spend the millions that would be necessary for a significant judicial inquiry over a long period of time, are unlikely to produce benefit to current patients or people with Hepatitis C."

We feel that attitude lies at the heart of the problem, the long held belief that justice would be of no benefit to thousands of Australian infected blood victims and their families.

203. The government's response has always been about diminishing the scale and severity of the problem. They have distorted critical data sets, which have led to a lack of reporting from media and complete disbelief from our fellow Australians that something as horrifying as this could ever have happened. We believe the net effect of that explains why, unlike the BBC, our national broadcaster, the Australian Broadcasting Corporation, despite pleas from victims, has never once, conducted an investigation into Australia's infected blood scandal. In 2017 victims were even denied a right of reply after the broadcaster read out on air a statement from Australian blood products manufacturer CSL, which stated that for over 100 years they had been driven by a promise to improve the quality of life for people with rare and serious diseases.

204. It is the hope of all Australian victims of contaminated blood that the acceptance of my evidence into the UK Infected Blood Inquiry will inform and encourage a recommendation that a similar statutory Inquiry take place in Australia.

205. I am, for the first time, telling my own personal story to the Infected Blood Inquiry, in the hope that my evidence will be persuasive in obtaining such a recommendation from Sir Brian Langstaff but also, that the public nature of the Infected Blood Inquiry in the UK will raise awareness and promote a wider understanding of how appallingly its closely connected neighbours in Australia have been treated.

206. One of the key issues that I ask for the Infected Blood Inquiry to consider, is where all of this began in terms of the relationship between the UK and Australia. Going back to the case of the poor little boy known as 'H' who was infected with HIV, it is sickening to me to consider that the authorities couldn't safeguard a child of his age. Rather than turning to the rest of the Commonwealth such as the UK for assistance on how to support H and his family, instead the Commonwealth came together, not to help him, but instead to weaken his case for assistance.

207. The type of psychological, financial and medical support already available to victims in the UK has never been made available to victims in Australia. In fact, the way that Australian victims have been treated by their Government actually, has had the effect of frightening them and deterring them from protesting against their treatment, campaigning for an inquiry or pursuing proceedings against the Government or CSL.

208. There were many frustrations experiencing life with bone marrow failure and as a contaminated blood victim, but It was around 1999 – 2000 that I realised that the government was waging a war on contaminated blood victims and that there was a serious battle to be fought. In 2000, medical professionals denied me storage of my stem cells due to my infection with hepatitis C. For someone with my health condition (Severe Aplastic Anaemia), the storage of my stem cells may have one day been the difference between life and death. They denied me the dream I had fought for since the age of sixteen and the confidence that I could live and plan a long-term future. I was also pressured to take the drug Interferon which I was worried would have devastating side effects, possibly even killing me, given the precarious nature of my bone marrow, but doctors dismissed my concerns. As a result, even though I have life threatening conditions, I have never returned to them.

209. **Exhibit WITN3939042** is the letter I received from Katherine Beauchamp, author of the Red Alert report. In her letter she expressed her

concerns about the way that CSL would be likely to behave if anyone tried to go up against them or properly investigate their activities stating:

"*You should expect CSL to hire PR's to prowl around in case something adverse gets dropped into the public arena and to watch people like yourselves and try to infiltrate your ranks offering stuff. All this has happened before and common sense tells you it will happen again, as the truth could utterly ruin CSL and possibly bankrupt the Common Wealth as well. They will not allow this to happen and will deal coldly and ruthlessly with anyone who looks like exposing them.*"

Despite the dangers, I have dedicated my life to fighting and campaigning on behalf of the victims of contaminated blood in Australia. Back in the 90's and 2000's, haemophiliacs were terrified - to put it mildly. There was no recombinant product on offer. That was only given to those who didn't have HIV or hepatitis C. This meant that none of the haemophiliacs I knew received recombinant because they were all infected. As a result, haemophiliacs were afraid to attach their names to public campaigning for fear of being denied supply of blood products. They also feared cold shoulder treatment at the Haemophilia Clinics.

210. Because of this, I took up the cause on their behalf and asked the tougher questions for them and it has been my honour and privilege to do so.

211. It is our contention, that had authorities in the UK accurately reported the established risks of Factor VIII to the Commonwealth then in 1978, Australia would not have started switching otherwise healthy haemophiliacs treated with the blood product cryoprecipitate to Factor VIII. Little boys like 'H' would never have been given an injection in 1983, five years after Factor VIII was introduced, for superficial bruising, that transmitted HIV/AIDS to him and created the most appalling outcome imaginable.

212. GRO-A a campaigner in our group has told me that since the commencement of the UK Inquiry "everyday has felt like a year", because we know that the UK Inquiry is our last chance. We are in bad shape here. Victims have been totally abandoned. There has been no counselling at all. GRO-A was recently called over the telephone by a liver specialist to tell him he had developed liver cancer. Two weeks later he was being asked about whether he was an IV drug user who shared needles by his new doctor, a liver transplant specialist GRO-A like his haemophiliac brother GRO-A who had a liver transplant three years before him, now faces the most uncertain of futures. Will he be eligible for transplant? What guarantee is there that he will even survive one?

213. The experience of the GRO-A family is typical of what has happened to haemophilia families in Australia. GRO-A has gone from supervising a hundred plus workforce with a young family and a mortgage to being forced to live in public housing and on a disability support pension. GRO-A has had three gruelling rounds of treatment for his hepatitis C infection. Two of those treatments took six months and had side effects equivalent of chemotherapy. He, like so many victims, also has to experience the highs and lows of waiting every six months on tests and hoping for good news.

214. The horrifying consequences and mistreatment of thousands of haemophilia families is not just the UK's worst treatment scandal but also that of the Commonwealth's. What blood went where and to whom? We know that haemophiliacs in Australia were infected en masse by Australian blood products but there has been no investigation into where exactly these high-risk Australian blood products were exported to. What happened to potential recipients in New Zealand, across South East Asia, to Europe and to the UK?

215. The conundrum for the Commonwealth is, now that British infected blood victims are likely to access to support and justice, what will be done about victims of the exact same scandal in Australia? Are we to be forever left in the cycle of suffering and dying at the hands of the worst of injustices, so much of which was influenced by leading British experts and British blood protocols?

216. I want to thank Sir Brian Langstaff for accepting my evidence into the Infected Blood Inquiry. I hope that I have demonstrated the close links between highly placed individuals in Blood Services in the UK and Australia, that there was much sharing of information, that infected blood was taken from Australia back to the UK and that the UK is culpable in exporting its culture of secrecy and cover up into Australia. I hope that I have demonstrated the strong parallels between the UK Haemophilia Society and the Haemophilia Foundation Australia both in their culpability and their treatment of victims of contaminated blood. This is hugely important in obtaining the full picture of what actually happened in the UK, assisting the Inquiry in its pursuit to find out the truth about how many thousands were infected and killed.

217. Finally, I wish to ask Sir Brian, on behalf of all of the victims in Australia who have suffered so horrifically, to make a recommendation to the Australian Government that an Independent Judge-led statutory Inquiry takes place in Australia with the power to properly investigate CSL and the Australian Red Cross. Victims in Australia deserve the opportunity to be heard, to find out the truth about what happened to them, and for reparations to be made to the fullest possible extent.

Statement of Truth

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

Signed... GRO-C: Charles Mackenzie

Dated.......15/5/2020.......

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