Witness Name: Judith Byers

Statement No.: WITN0983001

Dated: Friday, December 20th 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JUDITH BYERS

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

I, Judith Byers, will say as follows:

Section 1: Introduction

1. My name is Judith Byers. My date of birth is GRO-C 1957 and my address is known to the Inquiry. I am a widow with two grown up children. I am a fully qualified nurse. I suffer from Borderline Personality Disorder (BPD), which developed when I was 9 years old but was only recently diagnosed. The reasons behind this disorder developing are not relevant to the purpose of this statement, nevertheless BPD has had a lasting and permanent impact on my life.

Section 2: University of South Wales

2. I was a student nurse from 1976 to 1979 at the University of South Wales (USW). I practiced in medicine, surgery, theatre, paediatrics, obstetrics, gynaecology, neurology, and psychiatry. I worked in the Cardiff Royal Infirmary (CRI) and the University Hospital of Wales (UHW).

3. During my third year of training I worked in the Haematology Ward at the UHW for 10 weeks. I administered blood products to haemophiliacs and people with leukaemia, all of whom were over the age of 16. I only actually remember administering Factor 8 approximately three or four times but I must have done this more often as it was a dedicated ward to haemophiliacs.

4. When blood products were needed, a doctor would ask a nurse to order Factor 8 then one of us would collect it from the laboratories and administer it to the patient. Factor 8 was given via an IV cannula into the arm, the bag would hang on a drip stand next to the patient and it would last up to half an hour. The patient would be checked by the doctor and they would advise whether the bleed had stopped and whether another bag was needed.

5. In 1979 whilst I was working on the Haematology ward, a 16 year old boy came in with an injury. He had fallen from a height, off some scaffolding or a flag pole, and the injury was deemed serious enough for an ambulance to be called. It came about that he was a haemophiliac and he would need Factor 8, due to the internal bleed into his spine. I cannot remember who I was having a conversation with (I believe either a nurse or a sister) but we were rushing to his bed with the bag of Factor 8. At this time, I was inquisitive and learning as much as I could. This was the first time I had dealt with Factor 8. She replied that it was from America, that we were having to outsource it from drug addicts and prisons because we were running low. I immediately stopped walking and asked whether it was safe. With great assurance, she told me that it was perfectly safe because it had been heat-treated. The senior gave me the impression that she herself was convinced the blood was uncontaminated and free from infection. With hindsight, I believe she must have received that information from higher up in management because she seemed to believe this information as fact.

6. My knowledge of infections in blood and blood products was limited at this time. I remember in theory classes learning about blood diseases and blood borne

infections, but HIV and Hepatitis C had not entered the sphere then. I have never heard of Non-A, Non-B Hepatitis. I was aware of Hepatitis B, which I knew would result in liver failure if untreated.

7. At that point in my career I was incredibly naive. I had been told the blood was heat-treated and safe, and that is what I believed because the person who informed me had been more senior. At that time, I thought that if we did not have enough blood in the UK it was completely acceptable and necessary to outsource it from other countries. This would stop children and adults from dying from bleeds. I was not aware of the risks. From then on, I believed the blood and blood products we received from the Blood Transfusion Service were safe. I do not remember hearing any rumours about the blood being infected with viruses.

8. I graduated in general nurse training in June 1979. Due to a back injury not related to the focus of this statement, I was off work for about 18 months after my graduation. After I healed from the injury to my back, I got a job in the special care baby unit at UHW. I was involved with blood again, specifically in exchange transfusions. Exchange transfusions are when a baby's blood is removed very slowly in small amounts and then it is gradually replaced by 'new' donor blood. Usually 5 millilitres are taken out, and then 5 millilitres are transferred in, this whole process take a few hours. Whereas standard transfusions are when blood is added to a patient's body. I worked there for approximately one year before taking up a course in Manchester for special and intensive neonatal care. I gave maybe two exchange transfusions in the unit at St Mary's Hospital, this was in the early to mid-1980s. I do not know where the blood came from, perhaps America. I just assumed that if we were giving something to our patients, we were giving them something to help, not to harm.

9. Due to my previous injury, my back started to collapse and I was hospitalised twice over the next two years to have spinal surgery. I managed to finish the course and received the certification but due to my health I did not move back to Wales as expected.

10. In Manchester, a post was created for me in Infection Control. I was based in the Manchester Royal Infirmary (MRI) and St Mary's Hospital.

Section 3: Knowledge of risk

11. If I had had the conversation I referred to earlier (paragraph 5), regarding the source and safety of the blood and blood products we were administering, during my Infection Control career (in the 1980's) rather than while I was training, I would have made more of a fuss or at least raised some questions. But, at that early stage in my career I was too junior, without enough confidence in my knowledge and capabilities to say anything.

12. I moved from the Manchester area to Carlisle for a year and then to Burnley for a year, as an Infection Control Nursing Officer. Throughout this period, we were aware of Hepatitis and later of HIV, although it was then known as GRID. I remember the Terrence Higgins Trust being set up in 1982 and knew that HIV was a death sentence. As time progressed we knew how it was transmitted, and in my advisory role I produced practices which ensured that the disease could not be transferred between patients and staff. For example, I introduced a policy on the choice of disinfectant to use for cleaning instruments and blood spills. I also helped with trying to battle the stigma of the disease, specifically with how it was transmitted.

13. With the benefit of hindsight, I believe I was misled during the period of time I was an Infection Control Officer. Notifications of any sort of infection risk came from the Infection Control Centre. The consultants received memorandums whenever there was an outbreak or new virus to look out for, and then the consultants would pass these on to us. I wonder if information was withheld, and memos were not passed on. I believe there was more information out there than that which I had access to.

14. As an Infection Control Officer, I should have been made aware of the risk of infection in the blood supply. During my time in Carlisle and Burnley I was the only staff in this post and I never saw any literature relating to any risk from the blood that we used in our hospitals. Somebody must have known that the heat treatment was

not sufficient, or even that the blood was not being heat treated. I do not want to throw sticks but I find it unlikely that the consultants (specifically the bacteriologists and pathologists) did not know. At least on some level, management would have been aware and at the very least the senior consultants would have knowledge on the subject.

15. The consultants did not give myself or the other nurses all the information they received. I know this because as and Infection Control Officer and as a nurse, I would request to come to their medical meetings, but I was told no. Yet at the nursing meetings, there was never any medical input. I worked with three consultants who I believe would have known something about the infection, but I have no direct evidence of this. GRO-D was based in Manchester, GRO-D was a microbiologist at the Manchester Royal Infirmary, and GRO-D (now deceased) was a microbiologist in Burnley.

16. It is my belief that the information about the imported, infected blood was known on a certain level of management but kept from those 'below' a particular rung of the ladder, such as the nurses. The nurses would have stopped the infected blood from being used because it was our vocation to help and there is no way on earth that we would have chosen to hurt people - it was not an option. I only now have knowledge on the subject, and that is due to the Inquiry and the interest and publicity generated.

17. I retired from nursing in 2001 after I lost my husband. At the point of finishing my career I still did not know about infections being transmitted in the blood and blood products used during my nursing life. It was only in recent years, when the Inquiry was televised and brought up on the news, that I realised the risks of the products we had been using. I started looking into it and I was horrified. I could not believe that it had happened without the nurses knowledge. This was when I got in touch with the Inquiry. I had been unwittingly responsible for putting this blood into young people, old people, and into babies.

Section 6: Other Issues

18. I want this Inquiry to find those who are culpable for misleading the patients and the medical staff, to pay some sort of price. I want them to admit they did something wrong and to understand the damage they have done. We need to ensure that nothing like this ever happens again.

Statement of Truth

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

Signed GRO-C: Judith Byers

Dated ~~Friday, December~~ 20th 2019.