Witness Name: Dr Emrys Evans
Statement No.: WITN4467001
Exhibits: WITN4467002 – WITN4467007
Dated: June 10th 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR EMRYS EVANS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 26 May 2020.

I, Dr Emrys Evans, will say as follows: -

Section 1: Introduction

1. My name is Dr Emrys Neil Evans and my address is GRO-C GRO-C. My date of birth is GRO-C 1966. I hold the following Professional Qualifications: MB BCh MD FRCP.

2. From August 1999 and 2002 I was a Consultant in General (Internal) and Respiratory Medicine, at Darlington Memorial Hospital, Darlington, County Durham. Since April 2002 I have been a Consultant in General (Internal) and Respiratory Medicine, Morriston Hospital, Morriston, Swansea. SA6 6NL.

3. I have not been a member, past or present, of any committee or group relevant to the Inquiry's Terms of Reference

Section 2: Responses to criticism of W3691

4. I attach as Exhibit WITN4467002 letters detailing Mr GRO-B treatment in so far as they are relevant to my statement. Mr GRO-B (GRO-B 1929) was seen in the lung cancer clinic on 4/1/2010 by Dr NK Harrison (Senior Lecturer and Honorary Consultant

Chest Physician) for review of his recurrent non-small cell lung cancer. Dr Harrison noted that Mr GRO-B was wheezy and on clinical examination was noted to have a high-pitched inspiratory and expiratory wheeze over the right lung field. This raised concern regarding bronchial narrowing as a result of the recurrent tumour.

5. To investigate this further Dr Harrison arranged for a bronchoscopy. I note that I had performed a bronchoscopy on Mr GRO-B for a similar indication on 13/6/2007 and there was no obvious tumour within the airway at that time. Tumour narrowing a major airway can be investigated by CT scanning and/or bronchoscopy. Bronchoscopy can assess airway narrowing and give information regarding possible treatment options to reduce any obstruction. If the bronchoscopy is satisfactory then no further investigations are usually required. A CT scan is also useful (especially if it does not suggest any airway narrowing), but if the scan suggests that an airway is compromised a bronchoscopy may then be indicated for further assessment.

6. Dr Harrison was aware that Mr GRO-B had haemophilia and hepatitis C, but there is no comment regarding any possible risk of variant Creutzfeldt-Jacob Disease (vCJD). I believe that if Dr Harrison had any concerns regarding any risk of vCJD that he would not have suggested a bronchoscopy as the initial investigation.

7. Mr GRO-B attended for the bronchoscopy (to be performed by myself) on 6/1/2010, 2 days after his clinic appointment. He would have been asked to fast for 4 hours prior to the procedure (not for 1 day as stated by Mr GRO-B family). As noted in the bronchoscopy report, during the pre-procedure check a letter dated February 2009 from Dr Saad Ismail, Consultant Haematologist, was highlighted. The letter discussed a potential risk of Mr GRO-B having vCJD, following receiving contaminated blood products to treat his haemophilia in the 1980's. This is also thought to be the cause of Mr GRO-B contracting Hepatitis C.

8. There were (and remain) strict protocols regarding the risks of contamination of medical instruments with vCJD. Examples of these protocols are exhibited at WITN4467003 to WITN4467007. Standard sterilisation procedures are not sufficient to clean any bronchoscope suspected of being contaminated with vCJD. This would have resulted in the bronchoscope being placed in quarantine for an undisclosed period of time (maybe indefinitely). I felt that I could not justify proceeding with the bronchoscopy, for fear of decommissioning a bronchoscope. This would have had a detrimental effect on our ability to investigate patients with suspected lung cancer and

other lung conditions. In keeping with the protocols at the time, if we were planning a routine bronchoscopy for any patient with possible vCJD we could have requested the loan of equipment from the National Creutzfeldt-Jakob disease Surveillance Unit in the Western General Hospital, Edinburgh.

9. Unfortunately, I do not recall the events at the time of the proposed bronchoscopy or subsequent conversation with Mr GRO-B and his family, as it took place over 10 years ago. I note in my bronchoscopy report that I fully explained why we had to cancel the bronchoscopy, due to the mention of risk of vCJD in the letter from Dr Ismail. It is likely that I would have explained that without knowing the degree of risk I might be jeopardising an expensive piece of medical equipment, which would have significant effects on our lung cancer service.

10. Mr GRO-B and his family are recorded as understandably being very upset by this late cancellation, but after my explanation (which is likely to have included me stating the cost of the equipment for clarity and perspective) they are noted to have understood the rationale. I also recorded that I would endeavour to try and clarify the risk of vCJD with Dr Ismail, in case any future bronchoscopy (or any other intervention) was required.

11. I fully appreciate the frustration and disappointment experienced by Mr GRO-B and his family for cancelling the procedure at such a late stage, but I am upset by the implication that this was handled in any way that was neither honest nor compassionate. I certainly would not have phrased my explanation in the tones suggested by Mr GRO-B family.

12. As I was keen to proceed with investigations for Mr GRO-B, I arranged for an urgent CT scan of Mr GRO-B lungs that was performed that very afternoon (6/1/20 at 15:38). I also gave Mr GRO-B a prescription for oral steroids and antibiotics to see if this would alleviate any of his symptoms.

13. The CT scan was reviewed in our lung cancer multi-disciplinary team meeting and clinic on 11/1/2010, 5 days later. Dr David Roberts, Consultant Radiologist, suggested some external pressure from the cancer on the right main bronchus, but this was of a minor degree and was felt that Mr GRO-B would not benefit from a further bronchoscopy or any treatment within the airway via a bronchoscopy. Therefore, although it was very upsetting for Mr GRO-B and his family that the bronchoscopy on 6/1/2010 could not be

carried out. this did not impact on his treatment for any effects of the cancer on his airway.

14. Mr GRO-B was seen by Dr Rowley, Consultant Oncologist, in the clinic on 11/1/2010 to explain the results of the CT scan and explained the possible role of chemotherapy. There is no mention in the letter of any concerns expressed by Mr GRO-B or his family regarding the cancelled bronchoscopy from 5 days earlier.

15. Of note, if at the time Mr GRO-B had required an urgent, life-saving intervention we would have proceeded with the bronchoscopy and not concerned ourselves with the costs and loss of equipment.

Section 3: Other Issues

16. Not applicable

Statement of Truth

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

Signed GRO-C

Dated 10.6.2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
7 June 2006 to 26 October 2010	Letters detailing Mr GRO-B appointments and treatment	WITN4467002
2008	Decontamination of Equipment for GI Endoscopy and vCJD Issues	WITN4467003
February 2008	BSG Guidelines for Decontamination of Equipment for Gastrointestinal Endoscopy	WITN4467004
October 2008	Example of CJD Surgical Incident Reporting Form	WITN4467005

11 January 2011	Endoscopy – Annex F	WITN4467006
February 2011	University Health Board Wales – CJD Policy	WITN4467007