Witness Name: Dr Pat Tomlinson
Statement No.: WITN5578001
Exhibits: None
Dated: 29th May 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PAT TOMLINSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 29 April 2021.

I, Dr Pat Tomlinson, will say as follows: -

Section 1: Introduction

1. My name is Patricia Tomlinson, of GRO-C. My date of birth is GRO-C 1934. My qualifications include MRCS, LRCP, MBBS from Guys Hospital 1957, DCH 1960.
2. July 55 - July 56 House officer in General Medicine and Surgery at Pembury Hospital, Kent.
   July 56 – Jan 59 Senior House Officer at Queen Elizabeth Hospital (QEH), London.
   Jan 59 – Nov 59 Locum GP Aylesbury
   Feb 60 – May 60 Paediatric intern at Vancouver General Hospital
   May 60 – Jan 61 Locum posts in General Practice and Paediatrics in Southend Hospital.
   Jan 61 – Jan 62 RMO at QEH
   Aug 62 – Oct 65 Paediatric clinical assistant at Wrexham Hospital (Part time)
   Nov 68 – Jul 69 Paediatric clinical assistant at Chester City Hospital and GP locum work
   1970 – 1976 Part time and locum GP and paediatric work in Alton and Basingstoke, Hampshire
   1976 - 1994 Part time partner of Tomlinson and Willis GP practice
   1978 – 1994 Medical Officer (MO) to Lord Mayor Treloar College
3. I was a member and on the executive committee of the Association for Spina Bifida and Hydrocephalus in the 1980s and 1990s. I cannot recall exact dates or membership of other medical associations.

4. I have not been involved with or given evidence to any other inquiries or investigations in relation to HIV, Hepatitis B and C, vCJD in blood products.
5. My only contact with the college prior to 1978 was in my role as a local GP.

Section 2: Decisions and actions and responsibilities of the College and the Haemophilia Centre

6. The Treloar Trust is a charitable trust established in 1908 for the Treloar Hospital and School for disabled children. The Treloar College is a residential boarding school for up to 280 children and young adults between the ages of 8 and 20. Of these students, during my time at the college, approximately 50 had Haemophilia. Other students had a number of other diagnoses, most commonly Spina Bifida, Cerebral Palsy and Duchenne's Muscular Dystrophy. The College had a small medical centre including a primary care ward with up to 10 beds for all the students at the college although the students who attended the medical centre were usually those without Haemophilia.

   The Treloar Haemophilia Centre was for the treatment of the boys with Haemophilia. The Haemophilia Centre was a separate unit on the college site for the treatment and care of boys with Haemophilia. It was managed by Dr A Aronstam, consultant haematologist, and Dr M Wassef, assistant to Dr Aronstam. Dr Wassef was on call for Haemophilia care every day and lived nearby. There was a day care ward in the Haemophilia Centre staffed by a ward sister.

   The Treloar Hospital is now used as a cottage hospital on a separate site run by local GPs and for the treatment of mostly elderly patients. Its management and funding is separate from the Treloar College.
7. The Treloar Trust was the charitable organisation which financially managed the College, the medical centre and the Haemophilia Centre. I am unsure where the funding came from but believe it was from a combination of charitable donations, NHS and local authority.
8. The Haemophilia Centre was managed by Dr A Aronstam, consultant haematologist, and Dr M Wassef, assistant to Dr Aronstam. Dr Wassef was on call for Haemophilia care every day and lived nearby.
9.
   a. I provided GP care for the students of the college when needed. I advised non-medical staff at the college about the students' needs and liaised with other health professionals such as physiotherapists. This role did not change with time.

b. The majority of my work at the college was providing primary care for students with Spina Bifida, Cerebral Palsy, Duchenne's Muscular Dystrophy and other life limiting conditions. I can recall seeing a number of boys in the college with what initially appeared to be Glandular Fever. I believe that subsequent blood tests showed that they might have contracted HIV but I did not request the tests and the boys were medically managed by the staff at the Haemophilia Centre. I cannot recall the date when this occurred.

c. The Haemophilia Centre treated the Haemophilia and associated medical problems. This included blood tests, Factor VIII treatment, joint treatments and, as far as I am aware, management of HIV and Hepatitis and related diagnoses. Non-haemophilia care that I provided included other diagnoses that would be commonly seen in a GP surgery.

10. Please see above in my response to Question 9.

11. Medical GP notes were kept in the College for every student. These were forwarded to the students' local GP when they left the College. Separate medical notes were kept by the Haemophilia Centre. I am unaware of the arrangements for storage of notes in the Haemophilia Centre.
12. As far as I am aware, only children enrolled at the College received treatment at the Haemophilia Centre.
13. Approximately 50 students at the college had Haemophila in most years that I worked there.
14. Prior to the school holidays, the medical staff at the Haemophilia Centre would write to the students' local GP and local haematologist requesting the Haemophilia care needed during the holidays. Other than being copied into correspondence from specialists, I had no part in this process. As far as I can recall, parents of students were kept informed of this process and of the medical condition of their children.
15. Medical staff at the Haemophilia Centre would communicate with me as needed. The Haemophilia Centre was generally a separate entity but occasionally a nurse from the College might be asked to work in the Haemophilia Centre. As far as I can recall, staff at the college might recommend a child to go to the Haemophilia Centre if they thought it was needed. However, children could go to the Haemophilia Centre directly without referral from an adult if needed. Staff at the college, outside the Haemophilia Centre, were not involved in decisions regarding their Haemophilia care.
16. I had no part in decisions, actions and policies formulated by the Haemophilia Centre regarding the use of blood products.

17. I had no part in decisions regarding particular treatments of pupils' bleeding disorders.
18. I had no part in decisions regarding the approach to prophylactic treatment of pupils with bleeding disorders.
19. Haemophilia was managed by medical staff in the Haemophilia Centre. I cannot recall the details of how Haemophilia was managed by the staff in the Haemophilia Centre. I cannot recall radioactive materials being used for children with Haemophilia and do not know if these treatments were successful.
20. I was not involved with the emergency treatment of children with bleeding disorders. The pupils would be sent to the Haemophilia Centre by College staff or attend themselves.
21. Children with bleeding disorders would be treated in the Haemophilia Centre. For more minor ailments that could be managed by a GP, they might have attended the College medical centre.
22. Blood products were only held in the Haemophilia Centre.
23. Generally, as far as I am aware, all haemophilia care was given at the Haemophilia Centre. I cannot recall pupils travelling to other centres for treatment but I was not directly involved.
24. I am not aware of any other infections transmitted to pupils at the college as a consequence of use of blood products.

Section 3: Knowledge of, and response to, risk

25. My understanding of the risks of infection from blood products came from my experience of working in hospitals prior to becoming a GP. GPs would not be expected to give blood products. This included my role at the Treloar College. My understanding developed over time with updates from medical journals and in the national media.
26. My understanding of the relative risks of different blood products was limited to that of most GPs at the time. I never prescribed blood products or made decisions regarding their use whilst working at Treloar College.
27. My understanding of the risks of hepatitis transmission from blood products came from updates from medical journals and in the national media.
28. I am not aware of any investigations or enquiries the Haemophilia Centre undertook in respect to the risk of transmission of Hepatitis.
29. I am not aware of any actions the Haemophilia Centre took to reduce the risk of Hepatitis infection.

30. My understanding of the nature and severity of different forms of blood borne viral hepatitis was limited to that of most GPs at the time.
31. My understanding of HIV and AIDS and the risks of transmission from blood products came from updates from medical journals and in the national media.
32. I became aware of the association between AIDS and the use of blood products after children at the college were diagnosed with HIV infection. I cannot recall the date, the patients involved or who told me.
33. I am not aware of any investigations or enquiries the Haemophilia Centre undertook in respect to the risk of transmission of HIV.
34. I am not aware of any actions the Haemophilia Centre took to reduce the risk of HIV infection.
35. As far as I can recall, the staff at the Haemophilia Centre tried to ensure that pupils and parents were informed and educated about the risks of hepatitis and HIV.
36. I had no part in decisions regarding heat treated blood products being used in the Haemophilia Centre and cannot remember hearing of their use.

Section 4: Treatment of patients at Treloar's and the College

37. I cannot recall any specific conversations with pupils or parents regarding HIV or AIDS.
38. Medical staff at the Haemophilia Centre managed blood tests, results and communication with families. This was not my role.
39. Communication with families and pupils with HIV was managed by staff at the Haemophilia Centre.
40. Information given to pupils about a positive diagnosis was managed by the staff at the Haemophilia Centre.
41. I cannot recall how many pupils were infected with HIV or what proportion had Haemophilia A, B or Von Willebrand's disease.
42. I am not aware whether the staff at the Haemophilia Centre investigated the time period to seroconversion.
43. I cannot recall whether any pupils were infected with Hepatitis B or if their parents were informed.
44. I don't know how many pupils were infected with Hepatitis B.
45. I cannot recall whether any pupils were infected with NANB/Hepatitis C or if their parents were informed.
46. I don't know if the Haemophilia Centre tested pupils for Hepatitis C.

47. I cannot recall whether any pupils were infected with Hepatitis C or if their parents were informed.
48. I don't know how many pupils at the College were infected with Hepatitis C.
49. Notification of results for HIV and Hepatitis to pupils and parents was managed by staff at the Haemophilia Centre. I cannot recall any parents or pupils saying or complaining of any delays. I was copied into letters from the medical team at the Haemophilia Centre to other specialists for information only as the pupil's GP. Notification of results was managed by the medical staff at the Haemophilia Centre.
50. Medical staff at the Haemophilia Centre would inform me and the headmaster if a child tested positive for HIV or Hepatitis. I cannot recall whether this was written, verbal or both.
51. Advice and information given was the same as public health messages being disseminated at the time.
52. Advice and information given was the same as public health messages being disseminated at the time.
53. I cannot recall the meeting that took place on the 21st October 1985 and cannot remember the actions and policies in place at the time.
54. I cannot recall the contents of the letter to parents. Dr Aronstam was the consultant haematologist and is likely to have advised me regarding the content of the joint letter.
55. I cannot recall what the College's policy on AIDS virus carriers was on 20th October 1986 or how it changed with time. I cannot recall what information was provided to parents of pupils who entered the College.
56. Consent to blood testing and treatment of pupils with bleeding disorders was managed by the medical staff at the Haemophilia Centre. I cannot recall being aware of those processes.
57. I cannot recall blood testing taking place without consent but was not involved with the process.
58. I cannot recall pupils being treated with blood products without their consent or consent of their parents but was not involved with this process.
59. Care of pupils with HIV/AIDs was managed by the Haemophilia Centre staff. I cannot recall whether the pupils were referred for specialist care. I cannot recall how they were treated by the staff at the Haemophilia Centre. I was not involved in discussions regarding treatments for HIV or AIDS.
60. I was not involved in ongoing monitoring of HIV infected patients. I believe this was done by the staff in the Haemophilia Centre.

61. Care of pupils with Hepatitis B was managed by the Haemophilia Centre staff. I cannot recall whether the pupils were referred for specialist care. I cannot recall how they were treated by the staff at the Haemophilia Centre. I was not involved in discussions regarding treatments for Hepatitis B.
62. I was not involved in ongoing monitoring of Hepatitis B infected patients. I believe this was done by the staff in the Haemophilia Centre.
63. Care of pupils with NANB Hepatitis/Hepatitis C was managed by the Haemophilia Centre staff. I cannot recall whether the pupils were referred for specialist care. I cannot recall how they were treated by the staff at the Haemophilia Centre. I was not involved in discussions regarding treatments for NANB Hepatitis/Hepatitis C.
64. I was not involved in ongoing monitoring of NANB Hepatitis/Hepatitis C infected patients. I believe this was done by the staff in the Haemophilia Centre.
65. I do not know whether the Haemophilia Centre offered any psychological support. In general, as with all the pupils with life limiting diagnoses, this was provided by the staff at the college including the headmaster, house masters, nursing staff and myself. I cannot recall any outside organisations providing psychological support.
66. I cannot recall any DHSS funding being provided to help with counselling of pupils infected with HIV.
67. I cannot recall any pupils who were engaged in medical research whilst I was working at the college.
68. I am not aware of any external organisations engaged in medical research involving any of the pupils at the college.
69. I was not involved in any research studies whilst working for the College relevant to the Inquiry.
70. I was not aware of any pupils involved in research studies.
71. I am not aware of pupils' data being used for the purpose of research.
72. I am not aware of pupils' data being shared with third parties without their express consent.
73. I have not written any articles or studies relevant to this inquiry.

Section 5: The financial support schemes

74. I have no memory of any of the Trusts or Funds mentioned.

Section 6: Other Issues

75. I am not aware of any complaints made about me to my employer, GMC, Health Service Ombudsman or any other body responsible for investigating complaints.

76. I am 87 years old and my memory of these events is poor. I have not kept any personal records of the events in question. To the best of my memory almost all the care that the Haemophilia pupils received was from the staff at the Haemophilia Centre and not in the College where I worked. The majority of my work was with the local GP surgery and with the pupils without bleeding disorders at the College. My memory of the non-medical, medical and nursing staff at the college including the Haemophilia Centre is that they were all extremely caring and treated the pupils as if they were part of their family.

Statement of Truth

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

Signed GRO-C

Dated 29th May 2021

Table of exhibits:

Date	Notes/ Description	Exhibit number