Witness Name: DAWN SANDRA MOBEY
Statement No: WITN1402001
Exhibits: WITN1402002
Dated: JANUARY 2019

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF DAWN SANDRA MOBEY

I, DAWN SANDRA MOBEY, will say as follows:-

Section 1. Introduction

1. My name is Dawn Sandra Mobey. I was born on GRO-C 1970 and I live at GRO-C Wiltshire GRO-C

2. My husband, Christopher Brian Mobey (born on GRO-C 1963) was infected with the Hepatitis C Virus (HCV) from contaminated blood products. He died of liver failure on 24th August 2001, aged 38.

3. This witness statement has been prepared without the benefit of access to my my husband's medical records. If and in so far as I have been provided with limited records the relevant entries are set out in the medical chronology at the end of this statement.

Section 2. How Affected

4. Christopher had severe Haemophilia A, diagnosed at birth as his older brother also had haemophilia.

5. Christopher was under the care and supervision of Dr Matthews and then Dr Giangrande at the Oxford Haemophilia Centre, Churchill Hospital, Oxford. Christopher and I met in 1989 and we married in 1991. Christopher was treated with Factor VIII (FVIII). I would collect it for him from our local hospital, the Princess Margaret Hospital (PMH) in Swindon. The Haematologists at the PMH were Dr Green and Dr Gray. Christopher would administer the FVIII treatment himself at home on an ad hoc basis, as and when he had a bleed.

6. Christopher and I moved home with our two young children in 1997. Not long after we moved he started to feel unwell and lost weight. He would sporadically vomit or cough up blood. He had numerous endoscopies but the doctors could not get to the bottom of the cause.

7. On the date of 8th August 1999, Christopher and I realized that something was seriously wrong. It was the school summer holidays and Christopher had returned home from a day out in the sun with friends. He sat down and said 'I don't feel good'. He looked awful and he was hot and sweaty. He wanted the fan on and then he complained of feeling cold. He was having hot and cold sweats and he then began vomiting buckets of blood. I rushed him to PMH A&E. He vomited four pints of blood in the space of six hours. They could not find the source of the internal bleeding. He was sent to Oxford that same day. There they tried to do a TIPS insertion but it was unsuccessful. He was in a terrible state, suffering with his first bout of encephalopathy. Christopher was then blue lighted to the Queen Elizabeth Hospital (QEH), Birmingham. He had a successful TIPS insertion into his liver five days later on the 13th of August 1999.

8. It was at the QEH during Christopher's stay in hospital that August that we learned that Christopher had HCV and a problem with his liver. I do not believe that Christopher was aware that he had HCV beforehand. If he was told that he had hepatitis before, it was not explained properly to him. Neither

of us knew what it was and the information was not readily available to us in the form of Google and other search engines at our fingertips/on our phones.

9. Christopher was not provided with adequate information or advice to help him manage the HCV infection. No information was provided at all in relation to cross infection. We did not know what HCV was. We would not have had unprotected sex had we knew. I was in the early stages of pregnancy with our third child in August 1999.

10. Christopher was not warned of the associated risk before being given contaminated blood products. I was not aware of the risk. Moreover no-one told me and Christopher that he had contracted HCV from contaminated blood products. Christopher never knew that the source of the damage to his liver was through infected blood products. He died in ignorance that anyone was culpable for the damage to his health and his subsequent demise.

11. I have been unable to obtain Christopher's medical notes and records. I have a limited amount of notes and records from the Queen Elizabeth Hospital, Birmingham. The notes and records are incomplete and were not provided to me in chronological order. However, I refer to **Exhibit WITN1402002** being a letter dated stamped 25th May 2001 from QEH to the PMH stating that Christopher had contracted HCV via a transfusion 10 years ago, placing the date of infection at around 1991. When we were told that Christopher had HCV in 1999, we asked how he had got it and we were simply told that it was 'in the blood'.

Section 3. Other Infections

12. Christopher received a letter on 22nd January 2001 advising him that he is at risk of vCJD.

Section 4. Consent

13. I believe Christopher was tested for infection without his knowledge and consent and without being given adequate or full information.

Section 5. Impact of the Infection

14. The damage to Christopher's liver was so advanced (cirrhosis) that he needed a liver transplant. He was not aware that he had an issue with his liver prior to being hospitalised. Christopher had a liver transplant at the QEH under the care of Dr Mirza on 29th March 2000.

15. Our third child Kelly was born in GRO-C 2000. It was a difficult and stressful time for us but the transplant was thought to be successful. However, the medication/steroids Christopher was on after the transplant resulted in him developing diabetes and then his kidneys started to fail. He had to go on to dialysis treatment. He spent a long time in hospital that summer. He spent his 37th birthday there.

16. In or around the October of that year, Christopher's liver started to fail. Christopher had more internal bleeds. We were both very distressed.

17. Christopher had a second liver transplant in May 2001 but died in hospital on 24th August 2001. The children were just 8, 6 and GRO-C old when he died. Liver failure, gastritis haemorrhage, esophageal varices, Hepatitis C and Haemophilia were listed under cause of death on Christopher's Death Certificate.

18. Christopher suffered for years. He had been in and out of hospital all the time. At the end, Christopher knew that he was dying. I could do nothing to help him. It was horrendous.

19. I was devastated by Christopher's death. I became depressed and was prescribed anti-depressant medication. I had panic attacks and an overwhelming feeling of dread. I went back to my GP on multiple occasions asking to be tested for HCV because I was fearful that I had been infected. I was worried if I had HCV, I too would die and my children would be left with no-one.

20. The children had spent the entirety of the summer of their father's death at home to enable me to care for him. Whilst he was in hospital, they were passed from pillar to post to be cared for by family and friends. After Christopher died I could not bring myself to take them anywhere except school. I did not want for us to go out. It felt safer inside. I stopped driving for about a year because I was worried about having an accident. In my mind I relived my worst memories. I was referred to a specialist and diagnosed with Post Traumatic Stress Disorder.

21. Christopher's mother, father and brother were all devastated by Christopher's death. The children have missed out in losing their father. Kelly, being just GRO-C old, cannot remember anything about her father.

22. In terms of financial loss, I had to give up my job in a factory warehouse as soon as Christopher became ill. Christopher was a tailor by occupation in his former years but stayed at home and cared for the children as a house husband so that I could work. When Christopher became ill we were solely reliant, as a family, upon benefits.

Section 6. Treatment/care/support

23. No counselling or psychological support was offered to Christopher as a consequence of being infected with HCV.

24. In terms of care, I recall a distressing incident involving a nurse caring for Christopher at PMH before he died. Christopher could not eat and could

barely drink. He could only suck on ice to wet his lips. The nurse in question tipped Christopher's bag upside down looking for his 'whiskey' when he asked for crushed ice. She thought he wanted ice to accompany an alcoholic drink.

Section 7. Financial Assistance

25. Christopher did not claim anything from the Skipton Fund or from the Caxton Foundation. He was not aware of the Trusts.

26. I have not received anything as I believe that I missed the cut of deadline to be included in any claim.

Section 8. Other Issues

27. There are no other issues.

Anonymity, disclosure and redaction

28. I am not seeking anonymity. However I understand this statement will be published and disclosed as part of the Inquiry. I do not want to give oral evidence to the Inquiry.

Statement of Truth

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

Signed. GRO-C

Dated 10/2/19

MEDICAL SUMMARY

(This summary is not intended to be exhaustive but sets out key points in the records relevant to the Statement)

This witness statement has been prepared without the benefit of access to my husband's full medical records. I have a limited amount of notes and records from the Queen Elizabeth Hospital, Birmingham. The notes and records are incomplete and were not provided to me in chronological order.