Witness Name: Dr Maurice Strevens
Statement No.: WITN3808006
Exhibits: None
Dated: 4th Aug 2022

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR MAURICE STREVENS**

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I provide this statement in response to the request under Rule 9 of the Inquiry Rules 2006 dated 01 February 2022.

I, Dr Maurice Strevens, will say as follows: -

**Section 1: Introduction**

1.1. My name is Maurice John Strevens. My address is GRO-C GRO-C Warks, GRO-C My date of birth is GRO-C 1945. My qualifications are MB BCh (Wales) FRCP FRCPath. My employment history is as follows.

1.2. Pre-registration Medical House Officer
Bridgend General Hospital
South Wales
August 1969 - January 1970

1.3. Pre-registration Surgical House Officer
Cardiff Royal Infirmary
South Wales
February 1970 - July 1970

1.4. In relation to the above roles. Pre-registration jobs are designed to give basic experience in general medicine and surgery and if completed successfully leads to entry on the GMC register.

1.5. Senior Medical HO
Sully Hospital
South Wales
August 1970 - July 1971

1.6. Senior Medical HO
Bridgend General Hospital
South Wales
August 1971 - July 1972

1.7. Registrar in General Medicine
Portsmouth Royal Infirmary
Hampshire
August 1972 – July 1974

1.8. The above posts gave experience in a range of medical disciplines and teaching towards gaining membership of the Royal College of Physicians. I achieved this while working in Portsmouth.

1.9. Specialist Registrar in Haematology
Aberdeen Royal Infirmary
Aberdeenshire
July 1974 - November 1975

1.10. The above was my first post in haematology. A lot of the time was spent in the haematology laboratory where I was introduced to microscopy of both blood films and bone marrows, the techniques of measurement in the general lab., techniques in coagulation and blood transfusion. The training was aimed at eventually passing the exams required to become a member of the Royal College of Pathologists.

1.11. Senior Registrar in Haematology
Sheffield Hospitals (Royal Infirmary, Hallamshire Hospital, Sheffield Children's Hospital) and The Sheffield Blood Transfusion Centre

November 1975 - November 1979

1.12. In relation to the above. I continued my training in both laboratory and clinical haematology. This included training and experience in the treatment of bleeding disorders. Sheffield was a Haemophilia centre for both adults and a separate unit for children at the Children's Hospital. I spent more time than was usual for senior registrars at the Children's Hospital because of personal interests. There was a lot of research taking place into bleeding disorders in Sheffield at that time. Professor Preston was particularly interested in liver disease associated with NonA NonB hepatitis in Haemophiliacs.

1.13. I spent 6 months in residence at the Sheffield transfusion centre. This gave me valuable insight into the workings of a regional transfusion centre. This included my attendance as a medical officer at large donation sessions. I learnt about the careful selection process of blood donors and the belief that blood from unpaid regular volunteers was inherently safer than the American system of paying blood donors. Although both the UK and the USA tested blood for known blood borne pathogens, in the United Kingdom there was concern about pathogens which at that time could not be defined.

1.14. In 1979 I took and passed the final exam and became a member of the Royal College of Pathologists.

1.15. Notes on Haematology Training:

1.15.1. In 1969 there was no clinical haematology service at Bridgend General Hospital. The haematology laboratory was led by a general pathologist who just happened to have an interest in clinical haematology. In spite of this I still found myself involved in the treatment of patients with leukaemia and lymphoma in a general medicine setting.

1.15.2. In the 1960s a group of senior haematologists from various backgrounds felt that haematology services in the UK should be provided by doctors rigorously trained in all aspects of both clinical and laboratory haematology. At the end of the training there was an exam leading to membership of the Royal College of Pathologists. One had to pass in all areas of haematology - membership of the college is an essential qualification for any consultant haematologist. At the time

the combination of both laboratory and clinical skill in one doctor was very different to the splitting of the two discipline which occurred in most other countries

1.16. Consultant Haematologist for the Coventry hospitals (Various hospitals around Coventry including the Coventry and Warwickshire hospital and the Walsgrave Hospital)
December 1979 - June 2005
For a more detailed history of my career, please refer to my witness statement WITN3808005.

**Section 2: Responses to criticism(s) by W2815**

2.1. *Section 2.4-2.8*

I started working as a consultant haematologist in Coventry from December 1979, so I was not involved with witness W2815's gall bladder operation. The doctor I replaced was Dr Paula Cotter (deceased) so the haematologist supervising her care would have been either Dr Cotter or Dr Keith Shinton (deceased).

I have no recollection of a consultation with witness W2815 in a haematology clinic in 1980. Dr Shinton ran a clinic specifically for patients with haemophilia, but it is possible that I saw witness W2815 in my general haematology clinic. The information that witness W2815 was given about non A non B (NANB) hepatitis would have been consistent with the generally held view at that time: that is that NANB hepatitis was, in general, a less severe form of viral hepatitis than Hepatitis B. With Hepatitis B, recovery was associated with the development of antibodies, which would both clear the infection and provided lasting immunity. Assumptions were made that NANB hepatitis would follow a similar course but these assumptions could not be confirmed as the virus (or viruses) had not been characterised at that time.

2.2. *Section 2.9 -2.12*

By 1998, the hepatitis C virus had been characterised and tests developed to identify viral antigen in the blood together with the antibodies it induced. My understanding is that the blood transfusion service had detected hepatitis C antibodies in witness W2815's blood

indicating previous infection (presumably as a result of her NANB hepatitis in 1979) but no antigen was detected, which is consistent with the antibody having eliminated the infection. By 1998, there was increasing concern in the haemophilia community because unlike hepatitis B, antibodies were often not produced to eradicate the virus and low-level infection was persisting in many patients leading to progressive liver damage over the course of many years. The good news for witness W2815 was that she had produced antibodies that had cleared the virus so there was no reason to believe that she was at risk of progressive liver disease. Although I have no recollection of the consultation, I hope that I tried to reassure her of this. There was no indication for further follow up at the hospital and I therefore do not understand why I would have suggested this.

2.3. *Section 2.23*

Background:

From the time of my appointment (1979) to Professor Shinton's retirement (1991) the regular haemophilia clinic was run by Dr/Professor Shinton. In his absence a registrar or senior registrar would have stood in for him. This covered the whole period of HIV testing and diagnosis and the early days of monitoring and treatment with antiretrovirals (Zidovudine) in the haemophilia clinic. All results of blood testing and monitoring would have gone back to Dr Shinton, via his secretary, before being filed in the patients notes. The clinic also involved the haemophilia sister who spent a lot of time supporting patients and their families in the community. A lot of the blood testing would have been carried out in a community setting (i.e.at the patients home). I do not know who reviewed those results.

When I saw haemophilia patients at the hospital it was for dealing with acute problems such as bleeding episodes with complications or inpatients with haemophilia. Occasionally, I saw patients in my clinic by special request, but I never saw patients, or their parents, in an outpatient setting for routine monitoring, or to discuss blood results relating to HIV, or Hepatitis until Dr Shinton retired from his Consultant post in 1991.

I have no memory of the incident referred to in para 23. As I was not dealing with issues relating to HIV I do not think that the discussion, which has been suggested by witness W2815 was with me. First, I do not believe that I would have arranged a meeting to talk to witness W2815 and her husband, about HIV in relation to their children, and, second then having arranged a meeting for this purpose, have not discussed this issue of HIV with them - this would make no sense. Mr Lavington was a laboratory chief technician in charge of the

coagulation section of the laboratory. One of his responsibilities was the routine distribution of clotting factor products to patients or parents, which were stored in the coagulation area. He would have met with parents for this purpose but he was not a clinician and should have had no clinical involvement with patients - and to ask them 'did you ask?' seems strange and would have been inappropriate.

2.4. *Section 2.31*

I have no memory of why witness W1390 was not told of his hepatitis C status until January 1996.

I presume the decision to check witness W1390's hepatitis status was around 1991/92 when I took over the haemophilia clinic after the retirement of Prof. Shinton. I have no memory of this.

Although, again, I have no memory of this, I can only assume that the positive hepatitis C result was filed in his notes and not actioned in error. My normal practice was to sign all results personally, before they were filed, to avoid situations like this occurring. It should not have happened and I apologised. My remark would not have been 'flippant' - it would have been based on a mistake, which is quite different. It appears that witness W2815 was not present at the consultation with the patient and so I am unsure how she can characterise my comment as flippant.

2.5. *Section 2.33*

A hospital clinic is not the best environment to advise families about the management of conditions such as Hepatitis C infection. The haemophilia sister in Coventry regularly visited families at home as well as schools attended by children with haemophilia. Haemophilia care and the management of infection risk was one of the important topics covered during these visits.

2.6. *Section 2.63*

Being able to self-administer clotting factor is a big step on the road to independence for patients with haemophilia and I would always take the opportunity to encourage children to make this progression. As well as boosting self-confidence, it also leads to earlier treatment of bleeding episodes, which leads to fewer bleeds and less long term joint damage.

Managing this transition process took place mostly in the community under the supervision of the haemophilia sister but I would always take the opportunity to encourage haemophilia patients to self-administer. Any comments that I made would not have been intended to be derogatory but as a means of encouragement.

**Section 3: Other Issues**

3.1. There are no other issues that I wish to raise at this time.

**Statement of Truth**

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

Signed GRO-C

Dated 4th Aug. 2022