

Tuesday, 17 November 2020

(10.00 am)

**SIR BRIAN LANGSTAFF:** Good morning, Dr Al-Ismael. Can you see me?

**THE WITNESS:** Good morning to you, sir, yes, I can see you.

**SIR BRIAN LANGSTAFF:** Let me start by saying a few words before I am going to ask you to take the affirmation. It would have been far better, as I think everyone who is watching, and you yourself may well agree, if you had been able to come in person. Plainly you can't because of the Covid restrictions which we have. But it has had this effect, that there are very few people in the hearing room. And I'll describe that to you in a moment or two, just as I will describe to those who are watching remotely who might have wanted to be here to see you in person, what the position is so they can visualise it and they know where you are.

You are, I think, in a hotel, and there is a member of the Inquiry staff -- and nobody else -- in close proximity but not so close that it's dangerous. They are keeping proper social distance. Is that right?

**THE WITNESS:** That's correct.

**SIR BRIAN LANGSTAFF:** So in this hearing room you can't

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been my wish that they could have attended in person had they wanted to. This is, however -- it is important, as I said again at the start of the Inquiry, not just to put people first but also to be as fast, as reasonable thoroughness permitted, in coming to a conclusion, because people have waited too long to know what an inquiry like this would have to say.

That's why we are continuing our work during the pandemic and that's why I'm giving you a description, so that they understand what's happening here, you understand what's happening here, we have to be here because this is our place of work, and that's where we start today and where we will go on throughout the week.

**THE WITNESS:** Thank you for explaining that. Thanks very much for explaining that. And I would have wished to have been there but, as you already explained, there are circumstances which are beyond our control.

**SIR BRIAN LANGSTAFF:** I'm going to ask Mary to administer the oath to you. I understand you want to affirm so, Mary, would you, please.

**DR SAAD AL-ISMAIL, affirmed**

**Questioned by MS RICHARDS**

**MS RICHARDS:** Good morning Dr Al-Ismael. Can you see and

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see, but you will in a moment, counsel to the Inquiry, Ms Richards, who will be asking you the questions. Behind and beside her there are two members of the Inquiry legal team, again at safe distance. We have three members of the Inquiry staff watching and a technician. And we have Mary, who will give you -- who will ask you to swear the oath.

The reason I'm mentioning this is because you need to know who you are talking to immediately, but you're not just talking to us. This is a public inquiry, and I said right at the start of the Inquiry that we would be putting people at its heart. And for that reason you might normally have been expected to sit at the desks in the Inquiry room in the centre of the room talking directly to a number of people in front of you. They are not there in person but they are there virtually because a lot of them will be watching. It will be about somewhere between 150/200 people, thereabouts, who will watch during the day, and there may be more who will pick up what you have to say remotely. So you are talking to a lot of people even though there are very few people here.

I want you to understand that and I want those people who are listening to understand too who is here, what your position is and that it would have

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hear me?

**A.** I can see and hear you. Good morning to you.

**Q.** I'm going to start by asking you to give us an overview of your career. You took up your post as a consultant haematologist with West Glamorgan Health Authority in June of 1982?

**A.** That's correct.

**Q.** Where had you worked prior to Swansea?

**A.** Okay. So I qualified in Baghdad, Iraq, in 1970.

I did one year of what we call internship, where you would rotate between different specialities, and the idea really is to give the junior doctor the opportunity to have a taste of what medicine, obs and gynae, surgery -- and I also chose paediatric as a fourth three-month rotation. Then I chose to go into medicine. General medicine, that is. I did nearly four years of general medicine and then I came, toward the end of the fifth year, to the UK to do some postgraduate qualification, that's the membership of the Royal College of Physicians, and have a taste of what -- the UK system. So I took a few locums and had a taste of what general medicine and I also did a locum in paediatrics.

And then I passed my membership, the Royal College of Physicians, both Ireland and the UK, and

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1 then I decided to go into haematology. And the reason  
2 for that is partly because I've already tasted  
3 haematology when I was working in the teaching  
4 hospital in Baghdad and I liked what I saw there. So  
5 I applied for a haematology job which came up in  
6 Cardiff, as a Senior House Officer in haematology. So  
7 I took that job, and I think it was 1 June 1976. That  
8 job was actually entirely based on what used to be  
9 called ward A7. That is the haematology ward.

10 So my tasks were really to work with the  
11 registrar and the senior registrar to look after the  
12 in-patients. And the vast majority of them were  
13 patients with haematological malignancies, but we  
14 would see the occasional patient with bleeding  
15 disorder. At that time I was taught how to prepare  
16 and administer cryoprecipitate. Also we used to take  
17 blood samples from the patient.

18 I finished that one year, and then Professor  
19 Allan Jacob and Dr Jack Whittaker -- or  
20 Professor Allan Jacob, who was the, if you like, head  
21 of the department, asked me if I could stay for  
22 another year, and they found me what's called at the  
23 time a leukaemia fellow -- they had some money from  
24 the MRC -- and I worked as a leukaemia fellow for one  
25 year.

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1 Cardiff and -- as what to give. But when Dr Khurshid  
2 came to Swansea, he was persuaded by Professor Bloom  
3 to take more active role, and I think the rest of it  
4 follows from there.

5 But perhaps I'll stop here until you want me to  
6 continue on the same theme.

7 **MS RICHARDS:** I'll ask you a little more about that in a  
8 moment, but just sticking with your own training, in  
9 those years in where you were working in Cardiff,  
10 prior to taking up the post in Swansea in 1982, to  
11 what extent did your work involve the care and  
12 treatment of those with bleeding disorders in Cardiff?

13 **A.** Okay. So, as I said, in the first year the only  
14 encounter would be for the in-patients who would come  
15 under Professor Bloom, would need to be treated for  
16 haemophilia and other bleeding conditions. But when  
17 I became a registrar, it was as a registrar then you  
18 rotate between different specialties of the  
19 haematology. Until that time, my work was mostly to  
20 do with haematological malignancies, but when you  
21 became registrar then you would do three months of  
22 coagulation and haemophilia and then three months of  
23 day unit, three months of laboratory, and so on and so  
24 forth.

25 So when I did my three months with

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1 After that they've asked me to apply for the --  
2 they had a vacancy of a registrar in haematology, so  
3 I applied for that and I got it, and then there was  
4 a vacancy which came up after -- I think 18 months  
5 after that, as a senior registrar, and Professor Allan  
6 Jacob persuaded me not to leave, and stay and finish  
7 my training in haematology and apply for the  
8 membership of the Royal College of Physicians, whereby  
9 you'd be accredited as a fully trained haematologist.

10 So I did that. And I think just before I sat  
11 my exam in 1980 I was appointed as a lecturer in  
12 haematology, and I sat my exam in 1980.

13 Then I was in two minds whether to go for an  
14 academic degree, an MD or PhD, and then the  
15 opportunity came in and I -- I don't know how I was  
16 persuaded but I was persuaded to go to Swansea to  
17 apply for a consultant haematologist. And I joined my  
18 colleague then, Dr Khurshid, Mohamed Khurshid, who was  
19 appointed in 1975.

20 As I said in my statement, prior to that  
21 Swansea did not have a haematologist as we know it.  
22 All the haematology work was supervised by  
23 pathologists, whether from the general pathology or  
24 from the histopathology, and patients with bleeding  
25 disorders were very much under the direction of

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1 Professor Bloom, both as registrar and senior  
2 registrar, my task would be to actually go and see all  
3 the in-patients with haemophilia and allied disorders,  
4 go down -- what I used to do, if I was not on call  
5 I would go and ask the registrar on call whether he  
6 had any admission during the night, and if so I'll go  
7 and see the patients and then go and brief  
8 Professor Bloom. And Professor Bloom always would  
9 then come and see them and, you know, sort of give me  
10 the instruction to -- what to do in terms of  
11 management plan and whatever.

12 But he -- even though the number of patients  
13 were, you know, in single figures really, never more  
14 than four or five at any one time, and sometimes none,  
15 he used to spend quite a good time, actually, to go  
16 around and speak to them. His habit was to see the  
17 patient -- you know, examine them, and then usually  
18 sit by their bedside and talk to them.

19 Then I would go down to the laboratory after  
20 I've done my task in terms of preparing whatever  
21 needed to be prepared, and then start to learn about  
22 the laboratory side of coagulation. I was introduced  
23 to the different laboratory tests. And once I've, you  
24 know, sort of been shown how to do them, then I was  
25 given, you know, stuff as a tool, a rack and whatever,

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1 and I was given, you know, sort of different reagents  
2 and asked to do the tests.

3 So that's how you become to know what these  
4 tests mean and how to interpret them. I would be  
5 called by the haemophilia nurse to see a patient who  
6 is attending as a day case. And initially I used to  
7 go to Professor Bloom almost with every single case,  
8 ask him what are the plans. He was a superb mentor,  
9 really, because he would explain and -- he would  
10 explain how to examine a joint in a haemophiliac and  
11 explain the principle of management. So he used to  
12 spend quite a lot of time teaching the junior staff  
13 how to deal with haemophilia.

14 You know, when you are on call you may be  
15 called during the night to administer, because the  
16 on-call in Cardiff was also responsible to administer  
17 the coagulation factor concentrate or the  
18 cryoprecipitate and there were many nights where  
19 I would be called to administer.

20 I remember one particular night -- the reason  
21 why I remember it is because it was quite late in the  
22 morning about three or four o'clock when I was called  
23 to come and see a patient who -- and the management  
24 plan was to give cryoprecipitate -- I don't remember  
25 the detail of the patient. But I remember the day

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1 Dr Khurshid left in 1985 you became the director of  
2 the haemophilia services.

3 A. Yes, that is not something you apply for. It's  
4 something which you take on because I was left, if you  
5 like, single-handed for about two or three months  
6 until Dr Beddall came. When I started in 1982,  
7 Dr Khurshid was a director. In fact, I could not  
8 remember so much of that so I had to give him a call  
9 when the Infected Blood Inquiry asked me under rule 9  
10 to give the history. So I've asked him what was the  
11 history and he told me that when he first started,  
12 Professor Bloom -- he then was Dr Bloom, and persuaded  
13 him that he need his assistance to provide a better  
14 care for the haemophiliac living in the vicinity, even  
15 though he told him that he will be guiding him all the  
16 way in terms of things beyond what Dr Khurshid was  
17 familiar with.

18 He initially told him, look, we will make you  
19 a subcentre but, in fact, there wasn't anything like  
20 called subcentre, but that's what Dr Khurshid told me  
21 that's how Arthur persuaded him to actually take it  
22 on. But then Swansea was given the full title of  
23 haemophilia centre and I think the number 151.

24 So when I took over in 1982, prior -- 1985,  
25 sorry. Prior to taking over, Dr Khurshid would

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1 because I was flagged down by a police car and when  
2 I asked them why they flagged me down in my little  
3 Datsun they said, "You were driving too slow". So  
4 I learned that probably when you drive at night in  
5 Cardiff you have to go a bit faster.

6 But anyway so I remember that. The one thing  
7 I remember about preparing the concentrate, the  
8 cryoprecipitate, is that this is the one thing which  
9 probably will take the longest time for a registrar to  
10 do because I timed it at one time and it took me about  
11 just under two hours from the time I reached the  
12 hospital to thaw the cryoprecipitate, draw it up, and  
13 record the units which have drawn up in the patient  
14 notes.

15 Professor Bloom was very -- he was gentle but  
16 he was very strict in making sure that whatever we do  
17 in terms of units and batches and whatever has to be  
18 recorded in the patient notes. So you cannot leave it  
19 until the next day. But the cryoprecipitate used to  
20 take the longest time to prepare and give to the  
21 patient.

22 Q. I'll come back and ask you about Cardiff's policies,  
23 Professor Bloom's policies and Swansea's in a few  
24 minutes. Just picking up on your career you worked  
25 with Dr Khurshid at Swansea 1982 to 1985 and then when

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1 receive any communication from UKHCDO and he would --  
2 after we finished ward rounds, whatever -- he would  
3 say, "Saad, look, we've received such and such  
4 communication and whatever", he would show me what he  
5 received. So, if you like, we tried to brief each  
6 other. So I would have briefed him about any leukemic  
7 or any patient with a haematologic malignancy.  
8 Similarly, he would brief me about any haemophiliacs  
9 and that was essential because you could be called at  
10 any time. I mean, the way it worked before I reached  
11 there, Dr Khurshid was literally on-call every day.

12 So when I got there -- so we agreed to share the  
13 on-call and so you could be called at any time about  
14 a patient. So you really have to be very familiar  
15 with the patients in terms of there would be a known  
16 management plan of what the patient should have.

17 Prior to coming to Swansea, I think we were  
18 taught by Arthur that for children we try to give NHS  
19 concentrate because it was felt that they may be --  
20 you know, sort of home-made concentrate, they are  
21 safer. To be honest, I did not question that until  
22 many years later. I thought must be something known  
23 about the imported concentrate. But, anyway, so we  
24 were told that children, try to give them NHS  
25 concentrate. If they need concentrate, that is

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1 a severe haemophiliac, try to use cryoprecipitate.  
 2 When DDAVP became available initially we didn't take  
 3 DDAVP very quickly, I think, in the 80s. We started  
 4 DDAVP in Swansea, I can't remember exactly when.  
 5 **Q.** I'll come on to the returns and we can see that.  
 6 **A.** Yes.  
 7 **Q.** You remained director until September 2015 when  
 8 Dr Percy joined and then you took over the role of  
 9 director, again I think, at the end of 2016 when  
 10 Dr Percy moved to a different job and then you retired  
 11 from the NHS as a consultant and as director of the  
 12 Swansea service in February 2018.  
 13 **A.** Quite, that's true.  
 14 **Q.** Your statement says that the treatment of patients  
 15 with bleeding disorders was only one part of your  
 16 overall work. Your main specialism during your career  
 17 was blood malignancies, haemato-oncology?  
 18 **A.** That's true.  
 19 **Q.** Very roughly, if we're thinking about the 1980s, what  
 20 kind of proportion of your time was spent dealing with  
 21 patients with bleeding disorder as opposed to patients  
 22 with haematological cancers or general haematology?  
 23 **A.** I think I put in my statement 5 per cent but that is  
 24 probably quite an optimistic estimate actually. Would  
 25 it be helpful if I give you when I first started, very

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1 Dr Khurshid. The other person would go to the other  
 2 hospital, so I would go there and see the patient with  
 3 leukaemia. The one thing about acute leukaemia in  
 4 children they would have treatment every week for most  
 5 of the time, so you would need to be there. You need  
 6 to be there to administer the treatment because at  
 7 that time we didn't have any junior staff, it was just  
 8 the two consultants. We didn't have any specialist  
 9 nurses but there was a consultant paediatrician,  
 10 Ryan Griffiths, in Neath who was very keen that we  
 11 help him manage the patients with acute leukaemia. So  
 12 we used to use what used to be called the MRC trials  
 13 so we go on the same schedule.  
 14 Then, once I would finish that, then I would go  
 15 and look at whatever blood films left over from the  
 16 clinic on Monday in Neath before going to Singleton to  
 17 do a very large clinic, which was a Tuesday  
 18 out-patient clinic.  
 19 On Wednesday, I would start in Singleton, see  
 20 the in-patients, and then see the blood films of the  
 21 clinic the day before and then travel to Morriston to  
 22 see the in-patients in Morriston. We used to do the  
 23 ward round in Morriston on Wednesday afternoon both  
 24 myself and Dr Khurshid.  
 25 On Thursday, it would be the morning in new

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1 briefly, my weekly schedule?  
 2 **Q.** Yes.  
 3 **A.** Then you could probably be -- you know, sort of have  
 4 a clearer picture. So on Monday I would go to Neath  
 5 General Hospital for the haematology out-patient  
 6 clinic and we used to do that together with both  
 7 myself and Dr Khurshid. We continued to do that  
 8 until -- I'll come back to it later on -- when  
 9 I thought we need to divide the work more when  
 10 Dr Khurshid left. So I'll do a haematology  
 11 out-patient clinic on Monday in Neath and then I would  
 12 go and see with Dr Khurshid the in-patient in Neath  
 13 because, unfortunately, initially we admitted patients  
 14 with whatever haematologic condition in any of the  
 15 three sites and then I would jump in the car and then  
 16 go to Morriston. In Morriston, I would go and see the  
 17 patient who may have been admitted over the weekend,  
 18 see the in-patients, look at the blood films and  
 19 whatever.  
 20 Then on Tuesday we will start again in Neath  
 21 because until the reorganisation of the cancer  
 22 services we also were dealing with haematological  
 23 malignancies in children. So we would go to Neath to  
 24 do the leukaemia and we used to divide that. So one  
 25 week would be myself, the other week would be

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1 out-patient clinic in Singleton and then in the  
 2 afternoon it would be Morriston, and on Friday is the  
 3 out-patient clinic in Morriston, and in the afternoon  
 4 it's seeing blood films and whatever, seeing all the  
 5 refills.  
 6 The one thing which probably would horrify any  
 7 haematologist now is that the out-patient clinic we  
 8 also used to give all the day case chemotherapy, do  
 9 all the blood letting, what we call venesection for  
 10 patient who need it. So the out-patient clinic would  
 11 double as a day unit because we didn't have any day  
 12 unit.  
 13 I've looked at the figures and I estimated that  
 14 in one year I would have seen anything between 3,500  
 15 to 4,000 episodes. Now, I thought if I see two  
 16 patients with haemophilia, which was very, very  
 17 unlikely, a week then I would see about 100 patients  
 18 a year. As I said, the estimate of 5 per cent was  
 19 maybe an optimistic estimate.  
 20 So the haemophilia work was not really a big  
 21 part of my duties. The unfortunate thing when I first  
 22 started is that the only place to give treatment to  
 23 haemophiliac would be either as an in-patient or, if  
 24 we needed to give the patient as a day case, the  
 25 patient has to come to the adult ward -- the adult

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cases or the paediatric ward and then we go and prescribe the treatment.

In the paediatric side, the paediatric team would agree to do it. In the adult side, it depends. If there's no junior staff, then we would have to put the Venflon in and give the treatment.

That continued really until after Dr Khurshid left and it was clear that we could not continue when Dr Beddall came in. We sat and had, you know, a long chat and we agreed that we divide the work a bit more and then I spoke to Professor Bloom and he said, "Saad, you really need to get a haemophilia nurse". Then it took me two years and we got the haemophilia nurse in 1987 and that is when things start to change.

So this is a very long answer to your question but really, just to put it in some sort of perspective, as when I first started as a haematologist in Swansea what were my duties.

**Q.** Your statement has told us that most of the haemophilia care that was provided was at Morriston?

**A.** That's true.

**Q.** As you describe, patients were treated on the ward because there weren't any designated rooms or facilities for the care of patients with bleeding disorders?

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**A.** Absolutely. Actually, you know, sort of -- they are, in a way, the forgotten, you know, sort of people really, because they were instrumental in keeping record of treatment, making orders for the treatment, and there was -- one particular one of them who actually got interested in coagulation and he developed the different assays. So we really had very much the similar type of assays, laboratory assays, as Cardiff would have had, simply because of the interest of this one particular person.

And then he did his PhD in coagulation, with the help of Professor Bloom. And so when the haemophilia services moved, if you like, to be delivered mostly in Singleton, we thought it will be unwise to remove the expertise and the knowledge from Morriston, whereby all the assays had been done. And Morriston was instrumental because it was the largest hospital. It was the hospital with the largest casualty department. It was the hospital where the cardiac services was started. So you do need a 24-hour coagulation lab, if you like, to be able to cope with all the demands that these services would impose on coagulation and, you know, sort of blood testing and whatever.

So we kept the specialised coagulation test in

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**A.** That's true.

**Q.** As I understand it, there were not dedicated bleeding disorder out-patient clinics in the 1980s?

**A.** No.

**Q.** They were general haematology clinics?

**A.** Absolutely. They really -- a patient would be seen in a general haematology clinic and, even though the haemophiliac would take a longer time than an average patient, because most of the average patients is either repeat prescription or just telling them what their blood look like, but for the haemophiliac you really have to ask about whether they had any bleeds since the last time you saw them, and whatever else, really. But they were seen in the general haematology out-patient clinic. We did not start to see patients in a dedicated haemophilia clinic until 1991, when we managed to get the current accommodation for the haemophilia centre.

**Q.** Your statement describes that the main coagulation laboratory was at the Morriston and you talked about the role of the medical laboratory scientific officers, MLSOs, at Morriston Hospital.

**A.** Yes.

**Q.** They kept a record of products used per patient; is that correct?

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Morriston. And to this date it is still there.

**Q.** It was in 1991/1992 that designated space for a haemophilia clinic was finally made available at the Singleton Hospital, and that's the point at which you started having dedicated monthly haemophilia out-patient clinics?

**A.** That's true. And probably prior to that there was another milestone, and that was 1987, because in 1987 I managed to get the -- a haemophilia nurse, a dedicated haemophilia nurse.

So the haemophilia nurse, when she joined in 1987, I don't think she really had an office, but she was instrumental in actually shaping the way we looked after the haemophiliacs. So when she first joined in, she contacted every -- she started with the severe haemophiliac. She contacted every one of them, told them that she's there, and asked them to come and meet her. And I think they used to meet either in the laboratory or one of the -- I think Dr Khurshid's room when he's not there. I can't remember the details. But she actually started to see a change in terms of the approach of the way we manage haemophiliacs. And she took over from the -- what used to be called the medical laboratory scientific officer, and then changed to the biomedical scientist after that, that

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1 role.  
2 And I'm still to this date so grateful to the  
3 MLSOs at the time. But then she took the -- from them  
4 the, you know, keeping count of the concentrate we  
5 used and preparing the returns to the UKHCDO.  
6 **Q.** You've told us in your statement that when you arrived  
7 in Swansea across these three hospitals in 1982,  
8 a home treatment programme was already established?  
9 **A.** That's true.  
10 **Q.** Did that include adults and children?  
11 **A.** Yes.  
12 **Q.** In terms of patients with haemophilia A, was home  
13 treatment only made available for patients who had  
14 severe haemophilia A?  
15 **A.** Yes, the home treatment is only for severe  
16 haemophilia.  
17 **Q.** We'll see -- sorry, carry on.  
18 **A.** But we will come to that, and I'm sure -- there was  
19 one exception to that, and that is von Willebrand's  
20 disease, and we'll come to that in a minute I'm sure.  
21 So the home treatment was for the severe  
22 haemophilia. And you could see from the returns, the  
23 way the returns are made, really, to say how much  
24 Factor VIII you use for in-patients and for home  
25 treatment and how much cryoprecipitate you use for

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1 treatment either the same year or the year after.  
2 Professor Bloom was -- and his, you know, successors  
3 as well -- actually kept us informed of any new  
4 development and any practice. And because we  
5 shared -- well, our patients were all, if you like,  
6 those who need to be seen regularly, were seen by  
7 Cardiff. So they would have visited Cardiff, they  
8 would have seen the haemophilia nurse there.  
9 Our haemophilia nurse would have -- when we  
10 first appointed the haemophilia nurse, she had to go  
11 and spend some time in Cardiff to learn from the  
12 haemophilia nurse there, you know, what are the roles  
13 and responsibilities. A job description is one thing  
14 but to see it in real life is different.  
15 So they kept in touch with each other and the  
16 haemophilia nurse would also attend the  
17 haemophilia nurses, you know, sort of meetings and  
18 whatever. So when Cardiff started, I would suspect  
19 that we started very shortly after.  
20 **Q.** We're going to look at the annual returns for 1980  
21 through to 1985, doctor.  
22 Could we have WITN3761008, please.  
23 If we could go to the second page, please. If  
24 we could zoom in on that top part. Thank you.  
25 So we can see here, doctor, these are the

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1 in-patient in home treatment and whatever, both in  
2 haemophilia and von Willebrand disease. But the home  
3 treatment was dedicated for the severe haemophilia.  
4 The reason for that really is very simple: to  
5 be able to deliver home treatment, whether for an  
6 adult or whether for a child, usually a parent or  
7 guardian until the child learnt to inject themselves,  
8 you really need to have regular, if you like,  
9 administration, otherwise you will lose the skill. So  
10 home treatment is not suitable for mild haemophiliac.  
11 And even the moderate haemophiliac, who would only  
12 need occasional treatment, it's not suitable. It's  
13 only for the severe haemophiliac.  
14 **Q.** But you also had a home treatment programme  
15 established with patients with von Willebrand's  
16 disease, as you mentioned?  
17 **A.** That's true, yes.  
18 **Q.** We'll look at the returns in a moment in relation to  
19 that. Treatment was not, as I understand your  
20 statement, on a prophylactic basis until possibly  
21 the 1990s?  
22 **A.** Yes. I tried really to figure out exactly when, but  
23 I think if you do have a statement from Cardiff which  
24 will tell you when they started prophylactic  
25 treatment, we would have started prophylactic

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1 annual returns for 1980. The centre is, in fact,  
2 identified as Morriston Hospital. And you've  
3 correctly identified the centre number as 151.  
4 Director, Dr Khurshid.  
5 We can get a sense of the number of patients  
6 treated. So, haemophilia A patients treated during  
7 the year, 19; von Willebrand's patients treated during  
8 the year, 4. And this obviously is prior to your  
9 arrival but when you are working in Cardiff.  
10 Then we can see the figures there.  
11 Cryoprecipitate used in hospital, to a fairly  
12 substantial amount, 130,970 units. Not -- sorry?  
13 **A.** Can I stop you there?  
14 **Q.** Yes.  
15 **A.** So these are assumed units. So the 130,970, if you  
16 divide that by a denominator of 70, because that was  
17 the assumption made, that each unit have got 70 --  
18 each pack of cryoprecipitate would have 70 units of  
19 Factor VIII. Now, let's not go there because, you  
20 know, sort of we had quite an interesting discussion  
21 about this when I first arrived, but that was the  
22 assumption. So the 130,970, if you divide it by 70,  
23 it would be I think 1,000 --  
24 **SIR BRIAN LANGSTAFF:** 1724, roughly.  
25 **A.** Yes. So I think that's an important issue because if

24

1 we had used 130,000, I don't think BPL could have made  
2 any NHS concentrate. The similar thing when you would  
3 come to -- so that was used for the haemophilia A  
4 patients. And similarly when you come to the  
5 von Willebrand disease. I'm sorry to stop you there.

6 Q. That's quite all right.

7 A. I wanted to clarify that.

8 Q. So that's the usage of cryoprecipitate. We can see  
9 none used for home treatment for haemophilia A  
10 patients. And then we can see the figures for  
11 NHS Factor VIII: 8,167 in hospital, 46,629 for home  
12 treatment. And then we can see Armour Factor VIII,  
13 not used in the hospital at all, but 150,978 units for  
14 home treatment.

15 So the bulk of the home treatment in 1980 for  
16 haemophilia A patients was with Armour Factor VIII  
17 concentrate.

18 A. That's correct.

19 Q. And in terms of hospital treatment, the bulk of the  
20 treatment was with cryoprecipitate and some  
21 NHS Factor VIII treatment?

22 A. Yes, that's true.

23 Q. Then, as you've already observed, doctor,  
24 von Willebrand's disease patients were treated with  
25 cryoprecipitate at home and in hospital, and we can

25

1 forth.

2 I've asked, you know, sort of -- because in  
3 von Willebrand disease, some of them -- well,  
4 afterwards, we used to treat them with concentrate,  
5 which caught a lot of von Willebrand factor, but  
6 unfortunately at that time the concentrate did not  
7 have substantial amount of factor.

8 Dr Khurshid explained to me that they have  
9 tried everything. Even though she was given mainly  
10 cryoprecipitate to be given at home, sometimes they  
11 had to supplement it with Factor VIII concentrate.

12 As I said, I met her when I first came to  
13 Swansea and she was 16. And she was the most pleasant  
14 patient you could have; even with all her predicaments  
15 she used to bring a smile whenever she used to visit  
16 the lab to collect her whatever. She was very  
17 popular. And she used to tell me that her life goes  
18 around cryoprecipitate, and I asked her what did she  
19 mean, and she said, "Look, I really can't leave home  
20 because of worry about a bleed. I have to give  
21 myself" -- and I looked at some of her returns  
22 for 1987, and actually she was having cryoprecipitate  
23 almost every day.

24 The reason I'm mentioning all this because, you  
25 know, unfortunately her life was cut short because of

27

1 see the figures there: 77,000-odd in hospital and  
2 70,000, in the way in which you have explained, those  
3 were worked out for home treatment.

4 A. Can I clarify one point here?

5 Q. Yes.

6 A. That the cryoprecipitate for home treatment is for the  
7 one patient. And let me explain a bit more.

8 We had very pleasant patient. I met her when  
9 she was 16, when I came to Swansea. And she had what  
10 we now call type 3 von Willebrand's disease. Now that  
11 is, if you like, a rare type of von Willebrand  
12 disease, inherited as a recessive character. And so  
13 she did not make any von Willebrand factor,  
14 von Willebrand antigen.

15 And consequently she would not have circulating  
16 any amount of Factor VIII. Because you need the  
17 von Willebrand antigen factor to carry the Factor VIII  
18 to maintain its half-life. So this is a patient who  
19 really had the most horrendous, you know, sort of  
20 experience in terms of bleeding because unfortunately  
21 she experienced both the symptoms of severe  
22 von Willebrand's disease as well as the symptoms of  
23 severe haemophilia. So she would have bleeding in the  
24 joints, bleeding in muscles but also nose bleeds,  
25 horrendous menstrual blood loss, and so on and so

26

1 a bleed. And that was, if you would like to say, such  
2 a simple bleed. She was in the city centre, she said  
3 that her legs gave way under her and she fell and she  
4 bled. By the time she got the cryoprecipitate, she  
5 had what we call a compartment syndrome. She had  
6 severe necrosis of the muscles. She was in renal  
7 failure when she was admitted to Morriston Hospital.  
8 I was there and consulted with the renal physician.  
9 I phoned Professor Bloom at the time and said that we  
10 have a serious issue here. So he asked me to keep him  
11 informed. To cut a long story short, the surgeon, the  
12 vascular surgeon and the surgeon came to see her, and  
13 they said, look, she's going to lose that leg unless  
14 we operate.

15 I really could not give that authority so I had  
16 a long chat with her and her family and she decided to  
17 go for surgery.

18 Q. If we turn on to the returns for the following year,  
19 doctor, 1981 -- it's page 6, please, of the same set  
20 of documents -- again, we can get a sense of the  
21 number of patients treated during the year,  
22 Dr Al-Ismael: 17 haemophilia A, six von Willebrand's.  
23 We can see, again, the figures for cryoprecipitate:  
24 219,240 hospital, none used for home treatment for  
25 haemophilia A patients. And then we can see NHS

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1 factor concentrates being used for both hospital and  
2 home, 34,200 and 27,720. But the predominant  
3 treatment again for home treatment is the Armour  
4 Factor VIII, 100,534 units there, and some used in  
5 hospital.

6 A. Yes.

7 Q. If we read across to the von Willebrand's. Again, we  
8 can see the figures there. The total used for home  
9 treatment is given as 110,600. Is that also for one  
10 patient, the same one patient?

11 A. The only person who had home treatment with the  
12 cryoprecipitate was that particular patient. And  
13 I asked the question: how did you manage to do that?  
14 And I think they managed to get her a deep freeze.  
15 I'm not sure whether the deep freeze was with  
16 a monitor and whatever. So she had a deep freeze at  
17 home and she used to give herself the cryoprecipitate.  
18 But as I said, her life revolved around  
19 cryoprecipitate.

20 Q. Then if we go to the 1982 returns, so this is the year  
21 you joined part way through the year.

22 It's page 13 of the document, please, Soumik.

23 We can see here the figures. And it would  
24 appear that the amount of cryoprecipitate used in  
25 hospital for haemophilia A patients substantially

29

1 FEIBA, 38,500. That would have been for a patient  
2 with an inhibitor?  
3 A. Absolutely. We had a child with inhibitor, and in  
4 fact most of the time he was treated with Factor VIII  
5 because you could swarm the inhibitor with  
6 Factor VIII. He was a normal child and, you know,  
7 sort of he wanted to play rugby, even though he was  
8 advised not to do that, and he had some severe bleeds.  
9 And I can't you exactly what was -- the FEIBA is, but  
10 knowing the particular patient, I wouldn't be  
11 surprised if it was not for severe bleed which they  
12 couldn't control with the Factor VIII. But I can't  
13 remember the full details.

14 Q. Do you know why, in 1982, and we see the pattern  
15 repeated later, cryoprecipitate was being used very  
16 little in hospital for haemophilia A patients as  
17 opposed to the previous years where it was still being  
18 used to a reasonably substantial extent?

19 A. No. I suppose it all depends on the patients. I'm  
20 speculating here. It all depends on the patient who  
21 needed it. Because we had a large family, a very --  
22 quite an extended family with mild haemophiliacs. And  
23 even though they were mild haemophiliac, some of them  
24 actually develop inhibitor. And I suspect that -- but  
25 they were not high responder inhibitors, so you could

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1 decreased this year, in 1982, and the treatment  
2 predominantly used in hospital was NHS factor  
3 concentrates and Armour Factor VIII. Does that accord  
4 with your recollection?

5 A. Well, to be honest with you, my recollection of  
6 whatever 38 years ago is not -- so the figures are as  
7 what you would see it there.

8 We had quite a number of patients with  
9 von Willebrand's disease. None of them of the severe  
10 type. I would tell you that, even for the  
11 in-patients, I wouldn't be surprised that so much of  
12 that was used by this one particular patient but I'm  
13 sure the other also would have had some of it.

14 That year we had quite a good supply of the  
15 NHS. Just to say here, I mean, the motto was that get  
16 as much NHS as you could put your hand on. So the NHS  
17 supply was very much not in our hands. So if we were  
18 told that we've got having more NHS supply, that was  
19 very welcomed. But there were, you know, some fallow  
20 years where we had very -- we had much less than this.  
21 But, yes, these are the figures. And I think there  
22 must have been one patient who had some  
23 Cutter Factor VIII concentrate because the amount is  
24 only small.

25 Q. We can see under "Other Materials", references to

30

1 actually swarm the inhibitor with -- sometimes even  
2 with the cryoprecipitate. But like I said, without  
3 having the notes in front of me, I cannot give you  
4 exactly the reasons. But one possibility is that the  
5 milder patient had required more of the treatment,  
6 whether they were the milder patient with an inhibitor  
7 or not.

8 We had many more milder patients with  
9 haemophilia than severe patients. We only had a few  
10 severe patients.

11 Q. We can see that the treatment most given to patients  
12 with haemophilia A there is the Armour Factor VIII.

13 A. Yes.

14 Q. If we then come on to 1983.

15 Soumik, it's page 18, please.

16 We can see here, again, we get a sense of the  
17 number of patients treated. So 15 haemophilia A  
18 patients, two von Willebrand's patients. Again,  
19 a very small amount of cryoprecipitate used in  
20 hospital. But in this particular year there is more  
21 NHS concentrate used, so --

22 A. Yes, we had a good year.

23 Q. -- 209,995 for home treatment, 68,000-odd in hospital,  
24 and a smaller amount of Armour Factor VIII together  
25 with a small amount of the Alpha Profileate.

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- 1 A. Yes.
- 2 Q. Would that change reflect simply what was available in
- 3 terms of supplies or would there have been some other
- 4 reason?
- 5 A. Yes. Yes, yes, that's really -- so that year we had
- 6 307,179 NHS and only 45,304 commercial. Yeah, I think
- 7 that all depends of what we could get our hand on.
- 8 And unfortunately I cannot tell you why should there
- 9 be such huge fluctuation from one year to another.
- 10 There was one letter which I remember which came from
- 11 Tony Napier, but I can't remember the year, when he
- 12 told us that because we used -- and when I said he
- 13 told us -- not just in Swansea, he told us in Swansea
- 14 and Cardiff -- that because we've used so much
- 15 cryoprecipitate that our supply of the NHS concentrate
- 16 was still reduced accordingly.
- 17 But even though we were using quite a lot of
- 18 cryoprecipitate there in the home treatment, we had
- 19 a fantastic year with NHS supply.
- 20 Q. Dr Napier was the director of the Regional Transfusion
- 21 Centre in Cardiff?
- 22 A. Yes. So he was -- I mean, that was one of the
- 23 advantages of actually working in South Wales, because
- 24 Tony Napier was actually a senior registrar when I was
- 25 an SHO in Cardiff and so, you know, having a personal

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- 1 treatment, this is the one patient and also you could
- 2 see that she also had some NHS Factor VIII
- 3 concentrate.
- 4 Q. We can see in relation to the treatment of patients
- 5 with haemophilia A the primary treatment in that year
- 6 appears to have been NHS Factor VIII concentrates,
- 7 157,540 in hospital, 240,620 for home treatment, and
- 8 a smaller amount -- although still a reasonably
- 9 significant amount -- of Armour Factor VIII for both
- 10 hospital and home treatment?
- 11 A. Correct.
- 12 Q. So another year in which you had more supplies of NHS
- 13 concentrate than you had previously; is that a fair
- 14 inference?
- 15 A. Correct.
- 16 Q. Then finally, for present purposes, 1985 -- that's
- 17 page 28, please, Soumik -- and we can see here
- 18 11 patients with haemophilia A treated, I think for
- 19 the first year we see a carrier treated, and looks
- 20 like is that three patients with von Willebrand's at
- 21 the top of the page?
- 22 A. Yes, three patients.
- 23 Q. Then we can see for 1985 there is no cryoprecipitate
- 24 being used for the treatment of patients with
- 25 haemophilia A.

35

- 1 relationship -- and later he actually asked me if
- 2 I could be on the advisory panel for the Blood
- 3 Transfusion Service, and I think in the last year he
- 4 was there.
- 5 But it was useful because you could pick up the
- 6 phone and ask if you could have some more and you
- 7 would get a polite no, if he hasn't got them.
- 8 Q. Then if we go to 1984, this is the first return that
- 9 you complete --
- 10 A. No -- well --
- 11 Q. Page 23.
- 12 A. I have a correction here. 1984 it was still under
- 13 Dr Khurshid but because these forms are completed,
- 14 I think, in January of the next year, by then, then
- 15 Dr Khurshid, I think, either have left or about to
- 16 leave. So they put my name on it. So 1984 most of it
- 17 was Dr Khurshid was the director.
- 18 But that year I've asked if we could change to
- 19 packs rather than units. By the way, I think in 1983
- 20 your denominator for the cryoprecipitate became 80.
- 21 So if you want to know the number of packs in 1983 you
- 22 have to divide by 80, previously you have to divide by
- 23 70.
- 24 So this year we started using -- we started
- 25 recording the packs and, as you can see, the home

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- 1 A. Yes.
- 2 Q. NHS Factor VIII is now reduced back down again, 50,390
- 3 in hospital, 75,000 for home treatment, and the main
- 4 product, again, is Armour Factor VIII, 64,000-odd
- 5 hospital, 223,440 units for home treatment, and some
- 6 Cutters Factor VIII Koate. We'll come on to look at
- 7 the introduction of heat-treated products in a little
- 8 while, Dr Al-Ismael, but to what extent in 1985, as
- 9 far as you can recall, would the commercial
- 10 concentrates there being used have been heat-treated
- 11 concentrates?
- 12 A. Well, I think when the heat-treated became available,
- 13 we switched very quickly to heat treatment and I must
- 14 say that was very much with the direction of
- 15 Professor Bloom. So as soon as the heat treatment
- 16 became available, we switched to heat treatment. So
- 17 the thing is about Swansea, unlike Cardiff, because we
- 18 were a small centre we did not hold big stocks so, if
- 19 you like, our stock would be used within a month. So
- 20 when heat treatment became available, we immediately
- 21 switched to heat treatment and -- you know, I was
- 22 asked to say how did we do with the finance, and the
- 23 problem is that I can't remember any problem with the
- 24 finance. In fact, I can't remember signing any
- 25 invoice. I contacted the people who were, you know,

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1 in the blood bank and whatever and asked them if they  
 2 remember signing any invoice and we were not.  
 3 I don't know. I think it's probably because we  
 4 were a small centre, whether whatever allocation was  
 5 given to the West Glamorgan Health Authority was  
 6 accepted -- you know, whatever we ordered was  
 7 acceptable with that requirement. But, as soon as the  
 8 heat treatment became available, we introduced it.  
 9 **Q.** We can see towards the bottom of this return for the  
 10 first time an entry for DDAVP and tranexamic acid. Is  
 11 it fair to infer that this was the first year it was  
 12 used, because there's no earlier reference in the  
 13 returns?  
 14 **A.** You know, I honestly cannot -- I questioned that  
 15 myself, how come that's so late in the day that we  
 16 used DDAVP and tranexamic acid. It really all depends  
 17 as to the person who's preparing this was made aware  
 18 that DDAVP may be -- DDAVP was ordered, you see, to  
 19 pharmacy. It did not come through the blood bank and  
 20 so whether it was, and I suspect it is, that we did  
 21 not convey that to the person who was putting these  
 22 returns together, because I think we must have used  
 23 DDAVP before then, because we simply had quite a large  
 24 group of mild haemophiliacs.  
 25 But because this is the only thing could find

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1 of, he would always dismiss that and he said, "I look  
 2 after you more than I've looked after Cardiff".  
 3 So he is -- the quick answer to your question  
 4 is I don't know.  
 5 **Q.** NHS concentrates you also obtained, as I understand  
 6 your evidence, from the Regional Transfusion Centre?  
 7 **A.** Yes.  
 8 **Q.** You have told us effectively that -- is this right,  
 9 please correct me if it's wrong -- that you would have  
 10 wanted more and you took what you could get; is that  
 11 correct?  
 12 **A.** Absolutely right.  
 13 **Q.** Were representations made by you or by Professor Bloom  
 14 or Dr Khurshid or anyone else, to Dr Napier to try to  
 15 get more NHS concentrates?  
 16 **A.** Well, I must say here the flag bearer was  
 17 Professor Bloom because, really, he was very gentle  
 18 but he was always fighting the corner for us to get  
 19 more of the NHS concentrate. So I think if --  
 20 Tony Napier would tell us how much he gave us and how  
 21 much he gave Cardiff, and if I felt Cardiff had too  
 22 much more -- I know that they have much more patients  
 23 so I cannot argue with that, but I used to say to  
 24 Tony, you know, "Why don't we -- can't have more?"  
 25 But I'm sure if there were any noises made to

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1 on paper, then I cannot be certain about anything  
 2 else.  
 3 **Q.** In terms of the mechanics of obtaining the various  
 4 different products, you've told us just now DDAVP was  
 5 obtained through the pharmacy, cryoprecipitate was  
 6 that obtained directly from the Regional Transfusion  
 7 Centre in Cardiff?  
 8 **A.** Correct.  
 9 **Q.** Do you recall whether there were difficulties in  
 10 obtaining sufficient supplies or whether you usually  
 11 had sufficient supplies of cryoprecipitate?  
 12 **A.** That I cannot recall. If you ask me have we asked for  
 13 more and we were told we cannot have any more,  
 14 I cannot remember any whether we did or we did not.  
 15 Because I've got a feeling I could sense what your  
 16 next question is going to be, is why didn't you switch  
 17 more of your patients to cryoprecipitate and we could  
 18 discuss that if you do ask it.  
 19 But I can't remember. As I said, we had such  
 20 a superb relationship with the director of the Blood  
 21 Transfusion Service and he was such a courteous and --  
 22 you know, the old ways, if you like, stood for  
 23 Swansea, even though Cardiff was the main user.  
 24 So I always argued with him, you know,  
 25 jokingly, that you only look after Arthur and, sort

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1 higher authorities, it would have been Arthur.  
 2 **Q.** Now, in terms of obtaining commercial products, your  
 3 statement suggests that initially -- this is  
 4 paragraph 64 of your statement --  
 5 **A.** Okay.  
 6 **Q.** We'll just put it on screen, in fact. WITN3761005,  
 7 please, Soumik. Do you have some water available to  
 8 you there, doctor?  
 9 **A.** I've got it, don't worry. Thank you.  
 10 **Q.** So we can --  
 11 **A.** I'm looked after well here.  
 12 **Q.** If we can go to I think it's page 20 please,  
 13 paragraph 64. So paragraph 64, I just want to ask you  
 14 about the actual arrangements, the mechanics whereby  
 15 you obtained commercial products.  
 16 **A.** Yes.  
 17 **Q.** This suggests that the haemophilia centre in Swansea  
 18 received blood products acquired on its behalf by  
 19 Cardiff, initially, and then later on products were  
 20 acquired via the West Glamorgan Health Authority, then  
 21 latterly the Blood Transfusion Service.  
 22 Can you just explain a little more what you  
 23 recall about the processes for obtaining commercial  
 24 concentrates?  
 25 **A.** Well, I remember that, you know, Dr Khurshid told me

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1 that and the MLSOs told me that before Khurshid came  
2 in all the treatment was directed from Cardiff and  
3 I think Cardiff used to send the product to Swansea,  
4 and then when Dr Khurshid came in, he ordered the  
5 products. I can't -- I wouldn't know whether it's via  
6 Cardiff or directly but the person who was making the  
7 orders from the blood bank, he told me that he  
8 distinctly remembers putting orders via West Glamorgan  
9 Health Authority for concentrates.

10 Then there came a time that we all agreed that  
11 whatever we need could be ordered by the Blood  
12 Transfusion Service and then the Blood Transfusion  
13 Service would supply whatever Swansea needed and  
14 whatever Cardiff needed, and then charge us  
15 accordingly. We found that as the very useful way for  
16 two reasons. One is that we would not come to any  
17 product which would expire. I remember during my time  
18 that very often the UKHCDO would send us a note  
19 saying, "Such and such a centre have product which is  
20 about to expire, can you use it?" We never faced that  
21 and the reason we never faced it simply because there  
22 was stock of supply held on our behalf by the Blood  
23 Transfusion Service.

24 For a certain time that arrangement were  
25 devolved to West Glamorgan Health Authority but then

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1 did you have any direct dealings, as far as you can  
2 recall, with the commercial pharmaceutical companies  
3 to discuss products with them?

4 A. I think you reminded me about one of the reps, I think  
5 from Cutter, who came to see me -- I could not  
6 remember that -- and, of course, the rep from Armour.  
7 I did not have any contact with them prior to 1985  
8 because Dr Khurshid was responsible for that. But in  
9 1985 they clearly came to visit me. Whether that for  
10 me to put an order directly to them or via the Blood  
11 Transfusion Service, again, I cannot tell you.

12 As I said, I could not remember signing  
13 an invoice for Factor VIII. In latter years, when we  
14 had a recombinant, I signed all the invoices for the  
15 home treatment but not for the hospital treatment.  
16 But I could not remember signing the invoice. So,  
17 yes, I did see, but I think I only remembered when you  
18 reminded me in the letter.

19 Q. Just so that we see that, so there's no mystery about  
20 what we're referring to, we sent you some documents  
21 from Cutter, Dr Al-Ismael. BAYP0000007\_080.

22 We can see this is a letter from a Cutter rep  
23 dated August 1985. It refers to a meeting with you  
24 and discussing your possible requirements for Koate  
25 heat-treated Konyne heat-treated and Gamimune. Then

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1 was taken by the Blood Transfusion Service and was  
2 taken by the Blood Transfusion Service until, to this  
3 day, except for home treatment of recombinant, but we  
4 can talk about that later.

5 But if you ask me when every stage happened,  
6 I could not tell you and I tried to find out,  
7 unfortunately, all the records of the blood  
8 transfusions prior to 1984. We could not access them  
9 and we could talk about that maybe in additional  
10 questions you may have for me at the end. So I cannot  
11 tell you when the Blood Transfusion Service took the  
12 responsibility of stocking on behalf of Cardiff,  
13 Swansea, Newport and any other -- and Carmarthen in  
14 South Wales. We found that as the most useful  
15 arrangement, really, because we did not have to worry  
16 and if in the middle of the night you have a patient  
17 who requires a different concentrate and/or a patient  
18 who may be visiting Swansea for a holiday and you did  
19 not have any particular Factor IX or whatever, then  
20 you could pick up the phone and get in touch with the  
21 Blood Transfusion Service on call and get the  
22 concentrate. So that was most useful.

23 But I cannot dissect as when each stage  
24 happened.

25 Q. Between 1982 and 1985 when you took over as director,

42

1 if we just look down to the fourth paragraph:

2 "... should you wish us to reserve batches for  
3 you, we would be happy to do so. This policy is  
4 followed by eminent doctors such as Professor Bloom,  
5 the principle behind it is minimising patients'  
6 exposure to a large number of batches."

7 I'll come on to the general issue of reserving  
8 batches and reserving concentrates in a little while,  
9 doctor, but do you recall whether you did ask Cutter  
10 to reserve batches for you, or indeed Armour to  
11 reserve batches for you?

12 A. Well, I cannot recall but if Professor Bloom had asked  
13 for them I certainly would have done the same. If you  
14 ask me to recall, I cannot recall. I think what  
15 I recall after is that Arthur told me that he is  
16 falling out with Cutter because they could not reserve  
17 all what he wanted, but I think because we were  
18 a smaller centre he asked me whether we had a similar  
19 problem and I said no. So we must have reserved it  
20 but the mechanism of it I wouldn't be able to tell you  
21 now.

22 Q. Sir, I note the time and I am going to come on to ask  
23 the doctor in some detail about the treatment  
24 policies, so perhaps this is a good moment for  
25 a break?

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1 **SIR BRIAN LANGSTAFF:** Yes, it is. What we do, doctor, is  
2 we take about a half hour break, 20 minutes to  
3 half-an-hour in the morning. It's to allow you to  
4 have a break. You say you are being well looked after  
5 there but it gives people a chance to look after you  
6 again. You mustn't talk to anyone about the evidence  
7 you have given or may yet be asked to give you think.  
8 You can talk about anything else but not about your  
9 evidence. That applies to any break that there is.

10 **A.** Okay.

11 **SIR BRIAN LANGSTAFF:** It is also important not only that  
12 you have a break but that those in the hearing room  
13 do. And the third and largest group of people to whom  
14 this applies, those who are watching at home, would no  
15 doubt benefit by having the half hour as well. So we  
16 will take half-an-hour and come back at ten to 12.

17 **MS RICHARDS:** Thank you, sir.

18 **SIR BRIAN LANGSTAFF:** Ten to 12.  
19 (11.21 am)

(A short break)

21 (11.51 am)

22 **MS RICHARDS:** Dr Al-Ismail, you told us in your statement  
23 that your general policy was to adhere to one  
24 concentrate per patient unless directed by Cardiff or  
25 there were infected batches. What was the rationale

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1 the exposure to different batches and different  
2 products.  
3 **Q.** There's one document I'm going to ask you to look at,  
4 Dr Al-Ismail.  
5 Soumik, it's BYOP0000024\_214.  
6 This is an internal Cutter memorandum dated  
7 8 May 1985 between two Cutter employees. If we go to  
8 the second page, please, the second paragraph, so  
9 towards the top of the page, records this:  
10 "It must also be remembered that it is the  
11 policy of Professor Bloom to change suppliers once  
12 a year. This change was due last September and Cutter  
13 have held on very well to delay it until the end of  
14 March, 1985."

15 So this would suggest that Professor Bloom's  
16 policy was, as recorded there, changing suppliers on  
17 an annual basis. Do you recall that being his  
18 approach? Because it wouldn't be consistent with  
19 a policy of sticking to one concentrate per patient?

20 **A.** No, I don't know. I simply do not believe that  
21 whoever wrote that got it right. That was never, in  
22 my mind, the policy of Professor Bloom. I can't  
23 really comment as what was the reason behind the  
24 person writing that, but that is certainly not what he  
25 taught us and what he practised.

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1 for the one concentrate per patient policy?  
2 **A.** That was mainly to be able to identify if anything  
3 untoward happened to the patient. And to be truthful,  
4 the main thing which were on our mind before the HIV  
5 and, later, hepatitis C identified, was the  
6 development of antibody. Because development of  
7 antibody in a patient with severe haemophilia is  
8 a real problem and a real difficulty. So adhering to  
9 one batch would probably reduce the, if you like,  
10 number of antigens -- or that was the thought behind  
11 it -- a patient may be exposed to.

12 So that was perhaps the main reason until the  
13 advent of the retroviral infection, in which case we  
14 needed to know exactly what batch would probably have  
15 contributed to the infection.

16 **Q.** Was that the policy when you began in 1982 in Swansea?

17 **A.** True, yes.

18 **Q.** Was that your understanding of Professor Bloom's  
19 policy in Cardiff?

20 **A.** Yes. I think he very much taught us to try to adopt  
21 that policy. The difficulty for me is to be able to  
22 say exactly when I've learnt such and such a thing,  
23 but I remember when I was a trainee there are certain  
24 things he explained to us that we need to think about  
25 when treating haemophiliac. One of them was to reduce

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1 **Q.** You say in your statement, and this is  
2 paragraph 56(ii).

3 Soumik, it's WITN3761005, page 18, please.

4 At paragraph 56 you talk about certain general  
5 principles applied for selecting products. The first  
6 is all products were licensed products, and then  
7 secondly you say this:

8 "Safety and efficacy of a selected product for  
9 a patient would have to be a priority."

10 How was the safety of a product assessed from  
11 your perspective?

12 **A.** Well, maybe in retrospect it was probably a misplaced  
13 trust in the medicine licensing agency in the UK, in  
14 that we never used a product which is not licensed.  
15 We never used a product which has not proved to be  
16 efficacious. This is what the statement is based on,  
17 in that whatever we used were supposedly licensed, and  
18 to be licensed you had to have a safe and efficacious  
19 product. But, you know, that -- I mean, we could talk  
20 about that later on if you want, but that is our trust  
21 in the system in the UK, like you trust that system  
22 for any medicine you use.

23 **Q.** I'll come on at a later stage to talk about the risks  
24 of hepatitis with you, but paragraph 57 of your  
25 statement then suggests in the second sentence:

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1 "... having discussed the issues with  
2 colleagues at the time, it would appear that perhaps  
3 financial pressures may have played a part."

4 Could you identify for us the colleagues with  
5 whom you've discussed the issue and what the financial  
6 pressures are that may have played a part?

7 A. I did not discuss anything with the colleagues but, if  
8 you look at this statement, this is exactly the same  
9 wording that appeared in the Chief Executive statement  
10 in 1988 because I, you know, sort of helped in getting  
11 the information for the Chief Executive. The truth of  
12 the matter is that we went and asked whoever in  
13 finance and whoever was -- worked in West Glamorgan  
14 Health Authority whether they do remember if there  
15 were any financial pressure applied in terms of the  
16 haemophilia centres. They said they do not but they  
17 think they could have been because financial pressure  
18 were applied everywhere.

19 So I do not -- I haven't discussed with any  
20 particular person but when I've asked to -- because  
21 I've told them, look, I do not really know how we paid  
22 for this product, whether there were any questions  
23 mark raised by the finance director as worry -- nobody  
24 has at any time during my time in Swansea come to me  
25 and say, "You cannot order this", or "This is too

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1 example, is that when we went to Cutter and I passed  
2 by him and he said yes, they okay if you could get  
3 them to supply you on regular basis with the same  
4 products. When we wanted -- when I said, "Look, we  
5 really need to have a haemophilia nurse, would you  
6 help us", he was very helpful there. But we also --  
7 I used to go to the meetings in Cardiff whenever I can  
8 but, I would say, from day to day, week to week, it  
9 used to be telephone contact. I knew that he -- when  
10 Dr Khurshid was director he received communication  
11 from him in terms of what policies they want us to  
12 adopt. I can't remember, and I did say in my  
13 statement I cannot remember or cannot get hold of  
14 a written policy, but the fact that I could not get  
15 hold of written policy did not mean that we did not  
16 have a policy. We had a policy but I cannot show the  
17 Inquiry a written copy.

18 But how did we speak to him? We could speak to  
19 him at any time. He was very available to us. And if  
20 there were any issues -- and whatever we've used he  
21 would have known about, because when a patient --  
22 he -- you know, we used to make sure that he sees the  
23 severe patient at least once -- at least once a year.  
24 And if the patient has got any issues with joint and  
25 whatever, he could see them many more times. And if

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1 expensive for us."

2 As I said, that may be because the haemophilia  
3 centre in Swansea was a small centre. Talking to  
4 colleagues round the country, I think that was  
5 a hurdle -- everyday hurdle for them, really, to  
6 ensure that what they wanted they, you know, got for  
7 their patient.

8 So I haven't discussed with anyone in  
9 particular, but when I made the enquiries I said,  
10 "Look, I cannot remember, can you go and ask?" And  
11 I think contacts were made with whoever finance person  
12 they could get hold of who may remember the era, and  
13 they told them probably financial pressure were  
14 applied but no further details.

15 Q. You have said throughout your statement that you  
16 followed the advice of Professor Bloom in terms of the  
17 approach to treatment.

18 A. True.

19 Q. Had that been Dr Khurshid's approach as well?

20 A. Yes.

21 Q. How was the advice of Professor Bloom communicated to  
22 you? Were there regular meetings? Was it in writing?

23 A. Well, I think Professor Bloom really -- we were in  
24 regular contacts with him. You know, whenever we want  
25 to make any decision really. I'll give you an

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1 the patient needed any, you know, sort of input from  
2 their haemophilia nurse, before we had a haemophilia  
3 nurse we could see the patient. He would know what  
4 the patient would be receiving, he would know what the  
5 patient had been treated, how much the patient is  
6 likely to use.

7 So the channel of communications were many,  
8 including, you know, sort of written letters and  
9 whatever. And you would find some letters from me and  
10 from Dr Khurshid asking him to see a patient because  
11 we are concerned about a joint or whatever. So the  
12 routes of communication were many. He did not have  
13 any hesitation in picking the phone and phoning any of  
14 us if he thinks that there are certain issues he wants  
15 to direct us to.

16 We used to invite him every now and then -- and  
17 I must say, it was before I started, the Swansea  
18 haematology department used to have a monthly  
19 symposium where actually we used to invite all the  
20 biomedical -- the MLSOs at the time, all the junior  
21 staff, colleagues from other departments, and we would  
22 have, you know, sort of buffet dinner and we used to  
23 invite a speaker, and Arthur was, you know, sort of  
24 a regular speaker. Mind you, he wasn't just a regular  
25 speaker for us, he would -- you know, he was regular

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1 speaker in other hospitals, really to advise them  
2 about haemophilia and whatever.  
3 So many, many, you know, sort of forms of  
4 communication with him. But he was always available.  
5 **Q.** So is this correct, Dr Al-Ismael: the general policies  
6 followed at Swansea were the policies of  
7 Professor Bloom, in terms of, "This is the kind of  
8 treatment you should give to a patient with mild and  
9 moderate haemophilia", et cetera; is that correct?  
10 **A.** True. That's correct.  
11 **Q.** In terms of the decisions as to which pharmaceutical  
12 companies to purchase commercial concentrates from, to  
13 what extent was that determined by Professor Bloom or  
14 taken by you or Dr Khurshid autonomously?  
15 **A.** Well, that is the difficulty I had in actually pinning  
16 down exactly what happened. When you showed me the  
17 Cutter reps, so surely we must have ordered something  
18 from Cutter directly. But for most of the time the  
19 products we ordered were, you know, stocked in the  
20 Blood Transfusion Service and it would be a product  
21 that we used and Cardiff may have used. But, you  
22 know, if you ask me did he pick a phone and say,  
23 "Look, Saad, you really have to get in touch with this  
24 company and order", he never did. But, I mean,  
25 I cannot really be certain as, you know, sort of what

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1 **Q.** Was that predominantly patients with severe  
2 haemophilia A that he would become involved with or  
3 was it patients of any category?  
4 **A.** Well, patients of any category if they needed his  
5 input. I'll give you several examples. Before the  
6 advent of the HIV, if a patient with mild haemophilia  
7 in a sort of -- as I said, we had a group of mild  
8 haemophiliacs who unfortunately, even though they were  
9 mild, they would develop inhibitors. So we would  
10 have, you know, sort of shared that information with  
11 him, asked him for input. Patients who -- we didn't  
12 have any social worker dedicated to the haemophilia.  
13 The social worker who helped us, very kindly,  
14 was a social worker who was assigned to look after the  
15 haematology in-patients, and the vast majority of  
16 these were patients with haematological malignancies.  
17 But she did actually got herself involved when we've  
18 asked her to look after the social aspect of  
19 haemophiliac when they are admitted, and she continued  
20 to follow them up. But most of the social worker  
21 input was from Cardiff. So if there were any issues,  
22 then I would pick up the phone or write a letter to  
23 Professor Bloom and ask for help or ask -- for  
24 example, training the parents, very often we would ask  
25 for the help of Cardiff in training the parents or

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1 were -- apart from what -- the letters you've kindly  
2 shared with me, I could not be certain as Armour, you  
3 know, sort of clearly came and saw me at the time, but  
4 I cannot remember exactly. Profilate, we used some  
5 Profilate in 1987, if you look at the returns of 1987.  
6 And that was very much influenced by him, when he told  
7 me that Profilate, he felt, even though they were more  
8 expensive, they have got certain advantages. But  
9 then, you know, we found that after a while he stopped  
10 using Profilate because for one reason -- I think it  
11 was to do with the hepatitis C.  
12 But he never dictated to us that we can only  
13 use that product. You have to remember that he  
14 really -- he really led, in terms of directing us, by  
15 his knowledge, and we respected, you know, sort of his  
16 authority so much. And that's not just us, mind you.  
17 I mean, you go to any international or national  
18 meeting and you could see how much he was respected  
19 and, you know, sort of listened to in terms of the  
20 knowledge he had.  
21 **Q.** As well as following Cardiff's -- what you understood  
22 Professor Bloom's general treatment policies to be,  
23 you've referred to his role in relation to individual  
24 patients.  
25 **A.** Yes.

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1 training the child. There were certain children with  
2 needle phobia and they did have a programme -- which  
3 was improved later on, you know, sort of the role play  
4 or whatever they called it.  
5 So we did ask him for so many issues. But  
6 certainly in terms of any issues that we felt that we  
7 need his input and you would find letters from  
8 Dr Khurshid or myself asking him for an input in any  
9 particular patient. In other words, he was there.  
10 Whenever we needed any help, he was there.  
11 **Q.** Did you always follow his advice or were there  
12 occasions when you disagreed and took a different  
13 course?  
14 **A.** No, I think to have, if you like, ability to make your  
15 own decision, you really have to be very well  
16 informed. I think that is not just my motto, I think  
17 that's the motto of most of my colleagues. So I will  
18 be able to make a decision about a particular patient  
19 with haematological malignancy, who there are more  
20 than one option of treatment, if I felt that I really  
21 have all the information which I then could cascade to  
22 the patients and their carers and say, look, these are  
23 the options.  
24 In terms of haemophilia, I think I know I could  
25 make a decision as when to treat a patient, when to do

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the levels, when to look for inhibitors, when to have a second thought that this patient joint is going to be a problem, but I was not that informed as Professor Bloom or UKHCDO's working parties, so I would not think that it was right for me to take that decision. It really depends how confident you are with the information you possess, and it would be very wrong for me to say, look, I think I would take a different path from what Professor Bloom would advise.

**Q.** In terms of the actual treatment policies, your statement tells us that, and as we've seen from the returns Von Willebrand's patients were, generally at least, treated with cryoprecipitate and then, for haemophilia A, patients who were mild or moderate, your statement says that the policy would have been -- was to treat them with cryoprecipitate or DDAVP; is that correct?

**A.** That's true. Sorry, let me just explain a bit more. There are issues with DDAVP. DDAVP is effective in some patients and we actually did produce response for every single patient under our care but that only occurred not in the '80s but maybe in the '90s and 2000s.

DDAVP is effective in some of the mild patients

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intervention and in one patient which I included in my statement he was a mild haemophiliac, in 1980, I think, where he needed several teeth extraction under GA, and my colleague -- my ex-colleague Dr Khurshid -- gave him concentrate. In other words, when you felt that you really need to achieve a certain level and sustain that level for maybe a few days, the DDAVP would not be adequate.

With cryoprecipitate you could try but, if you have a patient undergoing surgery, you cannot really afford but to get them to about 100 per cent or what we call 100 units or whatever because of the fear of bleeding. So there were patients -- I remember one patient with mild haemophilia who insisted on having one of his -- I think the big toe was causing him so much problem he was seeing the orthopaedic surgeon and the orthopaedic surgeon said, "Look, we could correct that but it means an operation", and we chatted about the operation and I said, "In which case, we have to use concentrate, you have -- you know, it may expose you to other risk". At that time, to be honest, I was thinking more of Factor VIII inhibitor.

As it happened, he actually did develop Factor VIII inhibitor with the concentrate and I was so concerned about him at one time because he

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depending on their base level. It could increase it to maybe 20 or 30 units, enable you to maybe have a tooth extraction, but it would not be adequate if you are going to operate on a patient. The other problem with DDAVP is that, because of what we call tachyphylaxis, you lose the effect of DDAVP after a couple of days, and there are other issues about fluid retention and whatever.

So DDAVP is useful for the mild and probably less useful for the moderate but in some of them you do get a reasonable response, but only for a limited period of time.

**Q.** For patients who for whatever reason you didn't use DDAVP, either because, as the return suggested, it wasn't used until 1985 or for reasons that you've given that it was not appropriate in an individual case, would those patients then have been treated with cryoprecipitate as the first line of treatment?

**A.** Yes.

**Q.** Were there circumstances when you were at Swansea when mild or moderate patients were treated with concentrates?

**A.** Yes.

**Q.** In what kind of circumstances would that arise?

**A.** That would have been a surgical operation or surgical

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continued on bleeding and with the input of Cardiff we actually -- there was a programme which he used which you take the plasma of the patient and exchange it. We had what we call a self-separator in Swansea, and it was a horrendous time. I'm glad to say that he's still with us and we often joked about his other foot, which again had the same problem and he said he may be thinking of having that done and, as I said, we joked about it saying "Do you remember what happened then?"

So the short answer to your question, did we use some concentrate for some mild haemophiliac: yes, if we had to undertake surgery where we think the cryoprecipitate cannot be relied on for certain to achieve the desired level.

**Q.** What was the treatment policy in relation to children, your statement suggests you think it was NHS concentrates if possible?

**A.** Yes. So NHS concentrate -- we talk about the severe haemophiliacs here because children with mild haemophilia could manage them with cryoprecipitate or even DDAVP after the age of two or whatever. But for the severe haemophiliacs we -- as I said, it was ingrained in us that NHS probably safer than the commercial concentrate. It turned out later on that, in terms of what used to be called non-A, non-B

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1 hepatitis, there isn't really much difference at all  
 2 but, in terms of the HIV, there was a difference. But  
 3 that was all before the HIV and if you like the real  
 4 and serious thinking about hepatitis C, and I'm sure  
 5 you would ask me: what do you mean by "serious  
 6 thinking"?

7 Q. I'll come back to that Dr Al-Ismael. Just sticking  
 8 with the treatment policies, you said NHS concentrates  
 9 because it was believed to be safer or that was the  
 10 ingrained thinking. What was it at the time about NHS  
 11 concentrates that led you to understand them to be  
 12 safer?

13 A. You know, I mean -- to be truthful, I cannot remember  
 14 exactly. You know, something which you have come to  
 15 know but if you tell me which article or which  
 16 information -- whether, you know, sort of that is what  
 17 Professor Bloom have taught us when we were in  
 18 training, maybe. It may be because we came across  
 19 certain articles which I cannot remember now, could  
 20 be, but it was something in our mind that if you could  
 21 use NHS concentrate, use NHS concentrate. Mind you,  
 22 some of them are so difficult to dissolve but we still  
 23 preferred them to commercial.

24 Q. Your statement says you'd use the NHS concentrates for  
 25 children, I think, if possible. Does that mean that

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1 father, and whatever, would you advise any particular  
 2 concentrate, any particular product?" It depends as  
 3 what -- I think the patient I'm talking about was with  
 4 the advent of the -- I can't remember when we were in  
 5 the recombinant era or just before the recombinant,  
 6 but with the safer concentrate. So I would call the  
 7 family with the haemophilia nurse and whatever, and  
 8 you actually have to take it in stages.

9 First of all, the state of shock because that  
 10 family did not have anybody with haemophilia. They  
 11 didn't know what haemophilia means. So you explain  
 12 what haemophilia is, you explain it in simple terms,  
 13 and you -- you know, draw a chart or whatever. And  
 14 then you will talk about the need for treatment,  
 15 treatment would be needed at some stage. They will  
 16 ask you what to look for, "How do we know that our  
 17 child would have a bleed?" And you explain all that.

18 And even at that time, you -- at that time  
 19 where all the product were sort of HIV-clear, then  
 20 I would say, "Look, we have different products, and  
 21 I would be asking colleagues in Cardiff, which is the  
 22 comprehensive care centre, would advise you very much  
 23 to go and see them as well over there", and they  
 24 always usually take that offer and they would make an  
 25 appointment and see in Cardiff.

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1 if there were insufficient supplies of NHS  
 2 concentrates you would have to use commercial  
 3 concentrates to treat children?

4 A. That's true.

5 Q. Then, in relation to previously untreated or rarely  
 6 treated patients, your statement suggests that  
 7 patients falling within that category would be jointly  
 8 managed by Swansea and Cardiff and you'd consult  
 9 Cardiff?

10 A. Yes.

11 Q. Could you just elaborate upon that please?

12 A. Yes, by all means. Fortunately for me, I did not have  
 13 any new patient with severe haemophilia until the '90s  
 14 but I'll use, you know, that incident to tell you what  
 15 would happen. So this is a patient who was admitted  
 16 and I was called by the paediatrician because there  
 17 was an issue about whether it could be the patient was  
 18 abused or whatever. Cut a long story short the first  
 19 thing we do is coagulation profile and we find that he  
 20 has clearly abnormal coagulation profile, do  
 21 Factor VIII on the same day and Factor IX and his  
 22 Factor VIII was less than 1 per cent.

23 Immediately pick up the phone and speak to  
 24 colleagues in Cardiff to say, "Look, we've got a new  
 25 severe haemophiliac, I'm going to see mother and

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1 Cardiff was very good, really, in that they  
 2 would see them the next day if need be.

3 So it would be jointly to do that. When we --  
 4 when Professor Bloom was there, and I gave you the  
 5 example of the mild haemophiliac who developed  
 6 inhibitor, I would immediately be on the phone to him  
 7 and say, you know, sort of, "What would your advice  
 8 be?" But for any previously untreated patient,  
 9 I've -- it's not just me, myself and my colleagues  
 10 felt that it is essential to explain to the family the  
 11 availability of the comprehensive care centre.

12 Mind you, that's not just haemophilia. I'll  
 13 give you another example. We used to see many more  
 14 cases of leukaemia, and even though we are fully  
 15 accredited in terms of treating leukaemia with  
 16 intention to cure in adults, I still would say to the  
 17 family, "There is a larger centre down the road from  
 18 us and you are more than welcome to go and speak to  
 19 them and see them and, if you want, the treatment to  
 20 be there."

21 That was particularly true for the children,  
 22 because Cardiff had a superb childhood leukaemia  
 23 centre, and so many of them would have taken that on.  
 24 Some of them, when they knew that it meant a weekly  
 25 visit, felt that: look, we'll have the treatment here,

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1 but we want the help, the direction of Cardiff.  
 2 Sorry to enlarge on the leukaemia but it is,  
 3 you know, always essential to explain to the patient  
 4 and their family what is available in Swansea and  
 5 what's available in Cardiff.  
 6 Q. But as I understand your evidence, doctor, you  
 7 didn't -- in the period 1982 to, let's say, 1985/86,  
 8 when heat treated products were more widely available,  
 9 you didn't have any previously untreated patients  
 10 during that period?  
 11 A. No, I can't remember any patient. And I certainly did  
 12 not -- I can't remember, even of the mild  
 13 haemophiliacs, I didn't have any previously untreated  
 14 patients.  
 15 Q. I'm going to ask you to look at a document, doctor.  
 16 Soumik, it's CVHB0000002\_006.  
 17 You will see this is a document entitled  
 18 "Haemophilia Treatment Policy Guidelines - May 1983".  
 19 There's a date on the second page which is  
 20 18 May 1983.  
 21 This has been produced to the Inquiry by  
 22 Cardiff, so it would appear to be a written treatment  
 23 policy from 1983 governing Cardiff.  
 24 Do you recall whether you ever saw this at the  
 25 time?

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1 to be an in-patient treatment.  
 2 So if you have a small child whereby you could  
 3 give enough cryoprecipitate to deal with  
 4 haemarthrosis, or you think you could do it, then you  
 5 use it, you always do a post infusion Factor VIII.  
 6 But if that is not adequate, then you have to use  
 7 concentrate. And I'm sure that's what Cardiff would  
 8 have used anyway, even though it's a -- when I say  
 9 where feasible, that is exactly what it really means,  
 10 that it is not always feasible. So if you have a small  
 11 child whereby you could give enough cryoprecipitate to  
 12 deal with haemarthrosis, or you think you could do it,  
 13 then you use it, you always do a post infusion  
 14 Factor VIII. But if that is not adequate, then you  
 15 have to use concentrate. And I'm sure that's what  
 16 Cardiff would have used anyway, even though it's a --  
 17 when I say where feasible, that is exactly what it  
 18 really means, that it is not always feasible.  
 19 Q. We can see in (3), "Adults with severe haemophilia",  
 20 cryoprecipitate, again, is identified "where feasible"  
 21 as the treatment of choice for in-patient treatment,  
 22 but we've seen from the Swansea returns that the use  
 23 of cryoprecipitate declined in 1982 and 1983. Do you  
 24 think you were following the order set out here?  
 25 A. I think so. And, as I said, 1982/83 was, you know,

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1 A. No, I -- you kindly shared that with me and, no,  
 2 I can't recall seeing it. But this would probably  
 3 have -- if it was shared with Swansea, it would have  
 4 been sent to Dr Khurshid. And I'm sure if Dr Khurshid  
 5 had received it that he would have discussed it with  
 6 me, showed me, because, as I said, I may be called in  
 7 any time to treat a patient. So we were -- really  
 8 wanted to speak in unison, me and him, as to what to  
 9 do. But I cannot remember seeing that one. But if  
 10 you ask me any of this information is new to me, no.  
 11 Q. Can we just look at a couple of the paragraphs  
 12 a little more closely. In relation to mild  
 13 haemophiliacs, it says DDAVP or cryoprecipitate or  
 14 NHS Factor VIII concentrates. And you've already  
 15 explained your approach towards mild haemophiliacs.  
 16 Here, children with severe haemophilia,  
 17 cryoprecipitate is put as the first order of treatment  
 18 or NHS Factor VIII.  
 19 Your evidence to us has been that the treatment  
 20 process was NHS Factor VIII and not cryoprecipitate  
 21 for children with severe haemophilia.  
 22 A. No, I think if you look at the returns you'll find  
 23 that some of the cryoprecipitate was used for  
 24 in-patient. I really do not think that you can treat  
 25 a small child with cryoprecipitate at home, so it has

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1 sort of very much under the direction of my  
 2 colleagues, but I'm sure he was following what  
 3 Professor Bloom and the order in Cardiff was there  
 4 really.  
 5 Q. But in terms of this actual document, you've got no  
 6 particular recollection of seeing it at the time?  
 7 A. No, I don't. And I've seen the name on the document  
 8 and I tried to figure out who's that and I still  
 9 cannot.  
 10 Q. Again, I'm thinking about the period 1982 to 1985, in  
 11 particular. To what extent were patients offered  
 12 a choice about which treatments to receive?  
 13 A. In terms of cryoprecipitate or NHS or commercial?  
 14 Q. Certainly, by way of example, yes, to what extent  
 15 would they be offered a choice?  
 16 A. I honestly don't know. I say I don't know because, by  
 17 the time I joined, it was the same patient who was  
 18 treated before that we carried on with their  
 19 treatment. A choice is usually offered at the start  
 20 of a treatment, so if I put the example of previously  
 21 untreated patient, then I would explain to the patient  
 22 and the family what products we have and what the  
 23 advantages and disadvantages known to me at any one  
 24 time of each product, and very often patient and  
 25 family would say "What would you suggest, doctor?"

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And I think that is not just true of haemophilia, true of so many other conditions that, you know, sort of when a person is faced with a choice and they do not really know what would be the best choice for them.

As I said in my statement -- and I think that's because I was more trained in haematological malignancies, and in haematological malignancies you truly cannot take a decision for a patient, and the reason for that, even with the conditions that are curable, the treatment itself may shorten the life of the patient because of its complication. So in haematological malignancies, you cannot take a decision for the patient. You can inform the patient with all the information you have at the time and try to get the patient to make the choice for you. Sometimes the patient would insist that they cannot make the choice so you turn to their carer and whatever and ask them to help, and you ask them, look, don't make today you can come and make the choice tomorrow.

I think that attitude toward haematological malignancy influenced my practice not just in haematological malignancy but in non-malignant conditions in haematology, whether that is in general haematology, and we have certain conditions in general

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rather than with you?

A. Yes.

Q. I wanted to ask you about your knowledge of hepatitis.

A. Yes.

Q. First of all, what did you learn as part of your haematology training about the risks of transmission of hepatitis?

A. Well, from medical school, I think we knew about homologous CM jaundice, and then the Australia antigen and then hepatitis B and whatever, and we knew that blood could transmit viruses. We also knew, by the way, that blood could transmit malaria. That was the only thing which remained in my mind, until, I think, when I sat my MRCPATH in 1980, I had to master everything, if you like. So I came to know that some patients who were hepatitis B negative would also have altered liver function test, but there are different views as what's the cause of that, some people called it non-A, non-B hepatitis, some people thought it's nothing to do with an infective agent. Interestingly, at the time, I wondered if it is an infective agent why somebody does not take the plunge and say non-A, non-B viral hepatitis, but nobody did that. They said non-A, non-B hepatitis.

So I knew of that but whenever you come in

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haematology which are even more awful than haematological malignancies. So that influenced my approach: try to say to the patient, "Look, I'm here to help you to make a decision but I cannot take that decision for you".

That certainly was my practice when I started to deal with haemophilia. But you've asked a simple question: do you know whether these patients were given a choice? That choice is usually explained right at the beginning of offering a patient any treatment. You explain what the treatments available, and if the patient come to you and say, "Look, I've heard in the news that such and such a thing could give me a problem, can you change me", you certainly would sit down and try to explain to the patient "Yes, I will change you but you have to go through the following".

But throughout my career no patient came to me and say, "Look, I've heard in the news about this product will cause such a problem, can I change to something different?"

Q. So is this right: in the period '82 to '85/'86 because you were dealing with patients who were already on a course of treatment, any conversation about choices would have been with Dr Khurshid or Professor Bloom,

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a discussion or whatever you were told that, look, this is probably going to be a mild problem because it's not a big issue. I think I am right in saying that during the '80s, even though since the Inquiry came in and I've become more knowledgeable about publication before the '80s, you know, during the '80s most of us thought that non-A, non-B hepatitis is not going to be a big issue, is not going to be a big issue for the vast majority of patients. So this is -- you know, the initial knowledge I had about hepatitis was mainly hepatitis B but then this issue about patients with altered liver function tests.

Q. What, if anything, did Professor Bloom teach you or discuss with you about non-A, non-B hepatitis?

A. Well, yes, we did ask and he said he, I think -- he would have referred to all the publication which have happened and, I must say, you know, at that time I don't think any of them stuck in my mind for a long time until hepatitis C became known and whatever. But he would have told us about, you know, sort of what other -- you know, what the literature said and his opinion that, you know, sort of for the vast majority of patients non-A, non-B hepatitis is probably not going to be a big issue. But I don't think he was alone in that.

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1 I think -- I remember that we talked about the  
2 liver biopsy which happened in Sheffield and we also  
3 heard about a patient who died in the Royal Free  
4 because of a liver biopsy and we certainly, you know,  
5 sort of we felt that Professor Bloom was not a person  
6 who would be keen to do liver biopsy on a patient who  
7 had got this, what you call, non-A, non-B hepatitis.

8 But he would have -- I mean, as I said, he used  
9 to come and present -- in Cardiff we had always  
10 a Thursday lunchtime meeting. So people would munch  
11 their crisps while the presenter would present. You  
12 know, there used to be invitation for, you know,  
13 different speakers, even from abroad. Allan Jacobs  
14 was very well known in the haematology world, really,  
15 and so many of these talks would have been on  
16 haemophilia and allied disorders and, you know, sort  
17 of, so many of the presentation would have included  
18 some of the latest, you know, papers.

19 But if you ask me how much of that stuck in my  
20 mind later on, very little, I would think.

21 Q. So you have some recollection of the Sheffield biopsy  
22 work. We know that that was reported in The Lancet in  
23 1978. Would you have been reading The Lancet in 1978  
24 regularly or is that something you would have picked  
25 up from Professor Bloom?

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1 Inquiry sent you but you would not have seen this,  
2 I think, at the time. It's a letter, April 1979, and  
3 it's from Dr Kernoff at the Royal Free to Dr Colvin at  
4 The London Hospital.

5 If we could go to the second page, please,  
6 Soumik. And if we just go slightly a little further  
7 down the page, so we can see the whole of paragraph 2  
8 please. Thank you.

9 So there is a long paragraph there under "Types  
10 of therapeutic material available", and I'm going to  
11 direct your attention, doctor, to one sentence. It's  
12 about two thirds of the way down, and it says -- well,  
13 two sentences:

14 "The clinical reason [this is for preferring  
15 NHS material] is the growing awareness of the  
16 probability that commercial concentrates have a higher  
17 risk of transmitting non-A, non-B hepatitis than NHS  
18 material."

19 I'm not asking you to comment on that, doctor.  
20 But then it continues:

21 "This [so non-A, non-B hepatitis] is a serious  
22 disease with long-term consequences ..."

23 Now that's the view being expressed by  
24 Dr Kernoff, who had a particular interest in  
25 hepatitis, to Dr Colvin.

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1 A. Well, the journals which I used to get at home were  
2 the New England Journal of Medicine, the British  
3 Journal of Haematology, the BMJ, and later on the --  
4 Blood, the American Society of Hematology. The  
5 Lancet, if I need to read it, I would have to go to  
6 the library to read it. But, yes, I would have --  
7 I don't remember reading the article but I remember  
8 that Professor Bloom told us about the work in  
9 Sheffield.

10 Q. What did -- I can show you the article if you want to  
11 but as you may not have read it at the time it may not  
12 be particularly useful.

13 Do you recall what Professor Bloom told you  
14 about what the Sheffield work showed or what the  
15 significance or otherwise of it was?

16 A. Unfortunately, no, I can't really, you know, sort of  
17 with any clarity tell you. I mean, it is all,  
18 unfortunately, mushed in the brain, 40 years ago.

19 Q. I am going to show you two short documents. You would  
20 not have seen them at the time but they're two  
21 expressions of you about non-A, non-B hepatitis and  
22 its nature. And I want to show them to you and then  
23 ask you again about Professor Bloom's views.

24 The first, please, Soumik, is BART0002487.

25 Now, this is part of the general material the

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1 Do you recall Professor Bloom ever discussing  
2 non-A, non-B hepatitis in these kind of terms, as  
3 being a serious disease with long-term consequences?

4 A. Now if I say I don't remember, and I don't remember,  
5 that does not mean that he has not actually maybe  
6 discussed the full implication of non-A, non-B  
7 hepatitis with us.

8 But the simple answer is I don't remember. But  
9 as I said, that does not mean he did not discuss it.

10 Q. No, I understand that, doctor. But your impression --  
11 or your evidence suggests that Professor Bloom's view  
12 as communicated to you was that non-A, non-B hepatitis  
13 was a fairly mild condition, not something to be too  
14 concerned about.

15 A. Well, I think he -- you know, the way he said in the  
16 vast majority of patients he's seen it was a mild  
17 condition, but because we did not know what the cause  
18 of it and there was no particular treatment, he taught  
19 us what our role would be, is to monitor, advise  
20 against any, you know, advice about alcohol, advise  
21 against any drug which could worsen the liver function  
22 tests, and whatever. Well, I think he -- you know, the  
23 way he said in the vast majority of patients he's seen  
24 it was a mild condition, but because we did not know  
25 what the cause of it and there was no particular

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treatment, he taught us what our role would be, is to monitor, advise against any, you know, advice about alcohol, advise against any drug which could worsen the liver function tests, and whatever.

You know, there are certain things which sticks in your mind simply because you are involved with them and I was -- when I was an SHO and it was Saturday and it was not unusual, either Saturday or Christmas Day or whatever, it was, you know, not a normal working day, and I remember there was a patient with haemophilia who had deep jaundice and because I was the SHO I was looking after that patient as well and I remember Professor Bloom came on that day, particularly to see the patient because he was worried about the patient.

The thing about that patient when you look at the liver function test, you find that the jaundice was not really what we call a hepatocellular jaundice, it was what we call an obstructive jaundice. There is something blocking the drainage of the bile.

Now, I remember that case because when I looked at the medication I saw that the patient was on an anti-sickness, which is called Largactil and that is well known to cause obstructive jaundice and, like any of these things, when you have done something

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think you would ever have seen it at the time. It's September 1980. In the third paragraph, it says this:

"I must emphasise that 90 per cent of all post-transfusion (and blood-product infusion) hepatitis in the USA and elsewhere is caused by non-A, non-B hepatitis viruses which (unlike hepatitis B) cannot, at present, be detected by testing donor blood. This form of hepatitis can be rapidly fatal (particularly when acquired by patients with pre-existing liver disease) or can lead to progressive liver damage. It can also result in a chronic carrier state, thus increasing the 'pool' of these viruses in the community."

I just wanted to break that down and see to what extent you understood any of these matters in the early 1980s.

A. I did not -- sorry.

Q. I'll just do it bit by bit if that's all right. Were you aware in the early 1980s, so 1980 through to 1983/4, that 90 per cent of post-transfusion hepatitis, or the majority in any event, whatever the precise percentage, of post-transfusion hepatitis was caused by non-A, non-B hepatitis viruses?

A. I do not remember the non-A, non-B -- as I said, I was always intrigued why they call it non-A, non-B

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useful, you tend to stick into your mind. So I mentioned that to the registrar and he mentioned it to Professor Bloom, and I think he said to the effect that all that is -- "I'm glad that is the case because I haven't seen such a type of jaundice in a patient who is not hepatitis B".

You know, these are glimpses which I could recall but, as to the rest of it, I'm afraid I cannot recall everything as what he said, but he used to convey to us in, you know, sort of -- I mean, he's not a person who actually was opinionated, he was very willing to change his opinion depending on what he had learned and he would convey to as trainees as what was the understanding of the time and he would not be a person who would take one position and will continue with that even when the evidence shows to the contrary.

Q. There's just one further description of non-A, non-B hepatitis, contemporaneous description, I wanted to ask you about. Again you would not have seen this document at the time, doctor. Soumik, it's WITN0282008.

This is an internal Department of Health memo, doctor. Again, it's in the material that has been generally provided to you but there's no reason to

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hepatitis and not non-A, non-B viral hepatitis. So this is maybe one of the few times where the word "virus" is mentioned.

I knew that after hepatitis B was eliminated from the blood transfusion and concentrates, the vast majority of patients which showed the abnormal liver function test is what this called non-A, non-B hepatitis. But that is after the elimination of the hepatitis B, yes, so it will be in the 80s.

Q. Did you know, did you understand, that non-A, non-B hepatitis could be rapidly fatal?

A. No, I haven't -- I haven't seen that. I'm sure there would have been reports about it but I haven't seen that.

And just to reflect on the small practice we had in Swansea, I've seen only two cases with hepatitis C who actually developed liver cirrhosis and was -- probably participated in their death. One is a patient with hepatitis C and HIV. Unfortunately, he was severely disabled, even though he lived to his 50s. His mother found it very difficult to persuade him to have any of the treatment for either. He did have some treatment for HIV but he would not continue with that.

The other patient is what I referred to you in

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my statement who -- we knew that he had a concentrate, because of the teeth extraction, and then he wouldn't attend the haematology out-patient clinic, and the next thing I knew is that he was under my colleague, who is a hepatologist, with liver cirrhosis, and he died of liver cirrhosis.

So, you know, as far as my own experience, I haven't seen that, but -- because I haven't seen enough of them, but non-A, non-B hepatitis in the 80s were by the vast majority of the haematologist. And not just in the UK, worldwide. I mean, there were the publication which shows that if you do a liver biopsy and you could find chronic persistent hepatitis, chronic active hepatitis, cirrhosis, even in some of the children from Lilleyman, who was -- used to work in Cardiff.

But I think the vast majority of us thought that non-A, non-B hepatitis was not a big issue.

**Q.** But did you know as a matter of fact, were you aware that it could, as put here, lead to progressive liver damage?

**A.** Yes. I mean, we knew that it could lead to progressive liver damage, but if you ask me when did you actually become aware of that, that I cannot tell you. I cannot tell you as when -- I knew that even in

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So I think I, you know, sort of, was so fortunate really in that in Swansea, all the time I worked in Swansea, we had a good hepatologist who we would be able to refer patients to. And I must say, I mean, for any liver condition, I would have informed Arthur that such a patient would, you know, may be experiencing whatever, but I would have to referred to the hepatologist.

**Q.** Can you recall in what year was Dr Kingham appointed? Was that -- you said when you were appointed -- was that '82 or are you talking about '85?

**A.** I think he was appointed in '84, '83 or '84.

I can't -- I mean, he was appointed soon after me.

**Q.** Do you recall any discussions with him in the early or mid-80s about the nature of non-A, non-B hepatitis?

**A.** Now, interestingly, one thing which springs to my mind, we were in the coffee room and -- but don't ask me on the year because I won't be able to tell you -- and he said to me, "Saad, I've been to this international meeting, did you know that all your patients who had received concentrate had non-A, non-B hepatitis?" I said, "Yes, I knew about that. What we are going to do about them, Jerry?" And he said, "I don't know."

**Q.** What, if any, information did you personally provide

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the 80s we used to send those patients for ultrasounds and that is -- really was -- and we would examine every single patient clinically for any signs of cirrhosis, including spider naevi, including ascites, including whatever signs we knew of palmar erythema. But I really did not know that -- you know, sort of, there are quite a percentage of them who would develop progressive liver disease and could die of cirrhosis or hepatocellular carcinoma.

**Q.** You have explained that in terms of the general approach to the treatment of patients with bleeding disorders, you relied upon and you deferred to the advice of Professor Bloom for the reasons you have given, that you understood him to be more well informed than you were. Is the same true in relation to hepatitis, that you would have regarded Professor Bloom as more knowledgeable than yourself or was that not the case?

**A.** No, I think we were blessed in Swansea in that shortly after I was appointed, my colleague Jerry Kingham was appointed I think a year or two later, and he made it very clear he was interested in hepatology as well as gastroenterology. And later on, in 2006, we had a superb colleague as well appointed who was -- main interest in hepatology.

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to your patients in the early or mid-80s about the risks of hepatitis from treatment with blood products?

**A.** As I said before, the risk of treatment with hepatitis you would discuss with the patient when you offer the treatment. But I'll tell you what would happen in the out-patient clinic. When we started regular out-patient clinic and, for that matter, even before we start regular out-patient clinic, what happened in when haemophiliacs would come in, the usual thing is you listen to the patient, what are the issues and whatever, you examine their joint, and then you go through with them with the investigation.

So you start with the full blood count and you go through the liver function test and you say, oh, by the way your liver function test showed that your enzymes, liver enzymes, are raised. What does that mean, doctor? Well, it means that there is an inflammation in the liver, probably related to the treatment but we do not really know how that is going to change, whether it is ever going to change but we'll advise you, you know, to be careful with alcohol and, you know, sort of in terms of what medication you are on to see any of that.

That is the sort of conversation and so many of them would say: Is there any treatment for it? No,

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there isn't any treatment that we know of, simply because we do not know what is causing it.

That would be, if you like, the classical conversation with a haemophiliac and, for that matter, for any abnormality. So if the patient had anaemia you would talk about, look, you've got anaemia and the picture is of iron deficiency, probably because you have lost blood in the urine or whatever. These are the sort of information. So the patient would know what their result would have shown and we would have explained to them what we think of it, gave them the chance to ask any questions. Very often, when you say that "Would you like me to ask our liver specialist to have a look", so many of them would say, yes, please, others would say, well, if they haven't got anything to offer me I would rather leave that for the time being. So that sort of conversation.

- Q.** I understand what you say about conversations in relation to liver function abnormalities, but did you, in the early or mid-'80s, have conversations with your patients in which you would tell them that there was a risk of them developing non-A, non-B hepatitis or developing chronic liver disease, as a result of the blood products that they were receiving?
- A.** Well, by definition they would have had non-A, non-B

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**SIR BRIAN LANGSTAFF:** Well, it is. Just before we break for lunch, can I mention one thing. We have been exploring a little, for obvious reasons, what Professor Bloom, Dr Bloom as he was in the 1970s, may have thought of the risks of non-A, non-B hepatitis and you've addressed the general risks by reference to a couple of documents. But I do have a note, and I am addressing this really to you and for those who may be listening, because the doctor won't himself have come across this but I have a note of a letter which Dr Bloom wrote on 10 February 1975. That's a date which may -- and I shall have to place the significance of this in due course, no doubt with the assistance of any submissions -- that date is some three years after the test for hepatitis B was first introduced. It is about six months after Prince wrote in The Lancet identifying that more than 70 per cent of post-transfusion hepatitis was caused by something which wasn't hepatitis B, therefore virus or viruses non-A, non-B. What he said to a GP concerning a patient of his, whom I certainly shan't mention, the reference is witness W0047002, he said a small percentage of these freeze-dried preparations -- plainly he is talking about concentrate -- contain, unavoidably, the virus of serum hepatitis and

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hepatitis, because they had concentrates. If they have not had concentrate and if I am to embark on concentrate, I would have explained that, look, there is a risk that, even though we know that hepatitis B is not transmitted any more, that there is a risk of your liver showing an abnormality, we call it non-A, non-B hepatitis.

But if you ask me have you told them that, look, this could progress to cirrhosis or this could progress to cancer, no. If they had -- if you turn the question the other way around and if they say, "Could that mean that I could die of it", well, I don't know, you could if it progresses but because we are monitoring you we will be checking how you are progressing. Now, I'm saying that not as to remind me of a particular conversation but I'm saying that because that is the attitude I would have taken with a patient. I've always said to my patients, look, the one thing I do not do here is speculate. I'll tell you the facts as I know them, but don't you ask me to speculate because I will not be able to speculate unless I know, you know, sort of the high percentage of certain things happening.

**MS RICHARDS:** Sir, I note the time. Is that a convenient point for lunch?

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therefore potentially dangerous -- that's the word he uses, "dangerous" -- to the patient, his relatives, et cetera.

That's a note which I came across and it struck me for three reasons. First, that he is describing serum hepatitis which could be and may well be in context non-A, non-B, as well as hepatitis B. He described it as "potentially dangerous", and he is describing the possibility that it may infect others than patient, ie it is transmissible, potentially. Since we have been talking about that I thought it right to indicate what is at least part of the state of knowledge -- the state of information, I won't say knowledge -- which I have and I will have to place that in due course.

**MS RICHARDS:** Yes, which we looked at --

**A.** Can I make a comment on that?

**Q.** Yes, of course, doctor.

**A.** I think -- you know, sir, from what you have read to me now, I think when he says a small percentage would have serum hepatitis, I -- you correct me if you think I'm wrong -- I think he was referring to perhaps the concentrates which escaped the elimination of hepatitis B.

**SIR BRIAN LANGSTAFF:** You may well be right, but the

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1 problem is that he can't help us with what he meant.  
 2 It has to be interpreted in the light of the context,  
 3 and he uses the expression "serum hepatitis", which is  
 4 capable of covering, and almost certainly did, before  
 5 the identification of hepatitis B, cover both B and  
 6 any other virus which was causing hepatitis. So  
 7 I just raise it. I don't want to debate it here.  
 8 It's for other times -- thank you.

9 **A.** If you permit me, I just want to say one word, because  
 10 when he says a small percentage, he must have known  
 11 that, in fact, the vast majority of patients who  
 12 haven't got hepatitis B would have these  
 13 abnormalities. When he says a small percentage, in my  
 14 mind, and I think he -- even in the 80s we will say  
 15 "Look" -- to the patient -- "hepatitis B is very  
 16 unlikely, but there is a small risk that, you know,  
 17 some of these may actually -- these concentrates may  
 18 convey it."

19 The reason why I'm mentioning that I think he  
 20 is referring to hepatitis B, the words "small  
 21 percentage", because if he was referring to the  
 22 hepatitis as we know it now, non-A, non-B, it  
 23 certainly was not a small percentage.

24 **SIR BRIAN LANGSTAFF:** Thank you, doctor.  
 25 I will have to consider that in due course.

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1 sorry to have to ask you to go through that again.

2 **MS RICHARDS:** Yes.

3 What I'm trying to explore with you, doctor, is  
 4 the extent to which you advised patients of the risks  
 5 involved in the use of concentrates, specifically the  
 6 risk that concentrates might cause liver disease.

7 **A.** Okay. I'll start right from the beginning because I'm  
 8 not very sure whether you heard me, Ms Richards, or  
 9 not.

10 **SIR BRIAN LANGSTAFF:** Assume we didn't hear anything,  
 11 please, and start again.

12 **A.** As I said before, the risk of the treatment the  
 13 patient likely or could have would have been explained  
 14 with the first consultation, when the treatment was  
 15 explained. And I certainly did that when I had a new  
 16 patient, I certainly did that when a patient who had  
 17 not had treatment before needed to have concentrate.

18 But what I did is, as I explained before lunch,  
 19 when a patient would come to see me we would go  
 20 through -- after examining the patient, we would go  
 21 through the results of the patient. And if --  
 22 the result, I'll say that, "Your blood count is okay",  
 23 or, "By the way, we did a liver test, and that showed  
 24 an increased enzymes", and if they ask me, "What does  
 25 that mean?"

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1 But for the moment let us take a break for lunch. We  
 2 will be back, please, at 2.05. So 2.05.

3 Again, doctor, don't talk to anyone about your  
 4 evidence, but I hope you have a pleasant lunch where  
 5 you are and look forward to seeing you again at 2.05.

6 **A.** Thank you, sir. I hope you will have a pleasant  
 7 lunch. I am having a packed one. I do not know  
 8 whether you are having a packed one as well.

9 **(1.07 pm)**  
 10 **(Luncheon Adjournment)**  
 11 **(2.05 pm)**  
 12 *(Technical issues - no audio feed)*

13 **SIR BRIAN LANGSTAFF:** The reason for doing it is this,  
 14 that not only are your words being heard, and online,  
 15 if they can be heard, but they are also being  
 16 transcribed. I am being told there is no sound.

17 If that's right and people can't hear what you  
 18 have to say, and that's obviously the whole point of  
 19 this, and also it can't be transcribed. So for both  
 20 reasons we will just take a break and see what is  
 21 happening and see if -- ah, we've got it back.

22 **MS RICHARDS:** Yes, I understand the issue is now resolved.

23 **SIR BRIAN LANGSTAFF:** The position is resolved. Thank you  
 24 very much.  
 25 Do you want to ask that question again? I am

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1 "That is probably related to the treatment you  
 2 had."

3 "What does that mean, doctor?"

4 "I really do not know what is going to come out  
 5 of it, but if you like, I could send you to the liver  
 6 doctor."

7 "Would he have any treatment to offer me?"

8 "Not at the moment. We do not have any  
 9 treatment because we do not know the cause of it."

10 But I would not have held any information from  
 11 the patient. I have not had any patient who would  
 12 turn to me and say, "By the way, if you think that is  
 13 causing the disturbance in my liver test, I'd rather  
 14 stop it". I've never had that. And I have never had  
 15 a patient who would say, "Would there be a possibility  
 16 to switching to another treatment and seeing what  
 17 happens?" I've never had that.

18 **MS RICHARDS:** So is this right, doctor, that because in  
 19 the period in the early to mid-1980s you were not  
 20 seeing new patients, you were not seeing patients  
 21 being treated for the first time, your assumption is  
 22 that they would have -- any conversation about the  
 23 risks of treatment would have taken place beforehand,  
 24 whether with Dr Khurshid, Professor Bloom or someone  
 25 else.

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- 1 A. Yes, I think -- you know, sort of, when you see  
2 a patient for the first time, it is the usual practice  
3 to explain to the patient what you've got to offer to  
4 them. And it is usual to explain what is the known  
5 side effect of what you have offered to them. And you  
6 tried to explain that to the best you can.
- 7 Q. Did you ever, in the course of the 1980s, before the  
8 test for hepatitis C was available, diagnose non-A,  
9 non-B hepatitis in your patients?
- 10 A. Oh, yes. I mean, some of the patients who were  
11 referred from other centres were referred, and they  
12 already with the first consultation they said that we  
13 know we've got this condition called non-A, non-B  
14 hepatitis. The patients who I have and they have this  
15 disturbed liver function test has said, "What does  
16 that mean?"
- 17 "Well, we've got a name for it. They call it  
18 non-A, non-B hepatitis."
- 19 "But what does that mean, doctor?"
- 20 Well, to be honest with you, I don't know."
- 21 "Is it a virus, is it any --"
- 22 "I don't know. Until we know the answer to it,  
23 I don't know what the answer to that."
- 24 Q. Was it your practice to record discussions about risks  
25 or discussions about non-A, non-B hepatitis in the

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- 1 you started your post as a consultant haematologist in  
2 Swansea in 1982. And, indeed, we know that  
3 publication was July 1982. Does that -- sorry, carry  
4 on.
- 5 A. Sorry. Keep going.
- 6 Q. Does that mean that at some point soon after you  
7 started your post you became aware of the  
8 CDC announcement?
- 9 A. I wish I know when, because I honestly cannot tell you  
10 when I knew. But at some stage I knew about the CDC  
11 announcement, about their report, and I knew, for  
12 example, in -- I think it was in 1983 I've heard about  
13 the patient with AIDS in Cardiff. So I came to know  
14 about the CDC report at some stage. But with all  
15 honesty I cannot tell you exactly when, which year.
- 16 Q. You told us in your statement, and you said earlier  
17 today, that in terms of the publications you read,  
18 they included the New England Journal of Medicine.
- 19 A. Correct.
- 20 Q. I won't go to the detail of all the various articles  
21 but does it follow it's likely that you would have  
22 read, for example, the articles and communications in  
23 the January 1983 edition in which there were various  
24 reports and discussions about AIDS?
- 25 A. I probably would have. If you particularly show me

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- 1 patient's medical records?
- 2 A. If I am to see the patient for the first time  
3 I certainly do that. And I'm saying that because that  
4 is my practice with patients, whether they are  
5 haemophiliac -- as I said, the vast majority of my  
6 patients were patient with the blood cancers. And  
7 I would document, maybe in bullet points, what has  
8 been discussed with the patient. It is usual to --  
9 that is -- usually happens with the first consultation  
10 or when something new crop up. For example, if you  
11 want to offer a treatment and whatever, you would  
12 probably go back and talk about the reason why you are  
13 offering treatment and so on and so forth.
- 14 That usually would be either in the notes in  
15 the letter or both. That would be the usual thing.  
16 If you ask me have you done it with every single case,  
17 I wouldn't be able to answer yes or no unless I see  
18 the notes.
- 19 Q. Can I then move on to the question of AIDS.  
20 You have said in your statement that you are  
21 not sure exactly when you came to know about the  
22 association between blood and blood products and AIDS,  
23 but you have recorded in your statement that the  
24 Centers for Disease Control in Atlanta published its  
25 first report about AIDS in haemophiliacs soon after

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- 1 what you have in mind and I will be able to tell you  
2 whether that's something I know or it's something new  
3 to me.
- 4 Q. We'll look at just one. There are a number of  
5 examples but we'll just look at one.  
6 It's PRSE0002410, please.  
7 This is January 13, 1983, in the New England  
8 Journal of Medicine, "AIDS and preventative treatment  
9 in hemophilia".
- 10 A. This is Jane Desforges --
- 11 Q. That's right. Do you think you would have seen that  
12 at the time?
- 13 A. I've seen it but I tell you it did not impress me  
14 then. Now, looking at it retrospectively now, it was  
15 very, you know, far-thinking article, but it did not  
16 impress me at the time. And if you permit me I'll  
17 tell you why.
- 18 Q. Yes.
- 19 A. Because I think you probably know that -- the  
20 New England Journal of Medicine had a habit of -- the  
21 main editorial usually discusses or discussed the  
22 couple of publications which are important in that  
23 journal. Now, the two publications which came with  
24 this article, I think one is Liderman and one is  
25 McNorth or whatever, both publications what they talk

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1 about, they talk about a change in the lymphocyte  
2 subsets in patients with haemophilia who had  
3 concentrates. Okay? But if you look at what their  
4 results shows, in fact neither of group of patients  
5 had any evidence of AIDS, and even the T4 lymphocytes  
6 were not below normal but was lower than the patient  
7 who did not have the concentrates.

8 And if you go back to the last paragraph of  
9 this article, please.

10 Q. Second page, please, Soumik.

11 Zoom in on the left hand column, bottom of the  
12 page.

13 A. If you can enlarge the last paragraph, let's read this  
14 paragraph together:

15 "The fact that haemophiliacs are at risk for  
16 AIDS is becoming clear. If the use of cryoprecipitate  
17 will minimise this risk, the current home-infusion  
18 programme needs to be revised. The studies reported  
19 in this issue demonstrate in vitro abnormalities of  
20 immunoregulation, but the numbers are too small for  
21 [definite] comparison of the risks of different modes  
22 of treatment."

23 SIR BRIAN LANGSTAFF: "Definitive", I think.

24 A. "Definitive".

25 "Unfortunately, the data are consistent with

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1 The other thing is, of course, if, let's say,  
2 theoretically that we would do that, you know,  
3 changing to cryoprecipitate that means the BPL would  
4 have to stop providing us with NHS concentrate and the  
5 logistics of the process of changing to  
6 cryoprecipitate is immense. I already hinted to the  
7 difficulty of giving cryoprecipitate as home  
8 treatment, and I refer to the patient which described  
9 to me that cryoprecipitate dominated her life and, in  
10 fact, at the end of the day, cryoprecipitate  
11 unfortunately did not deliver the goods.

12 So that is the reason why, you know, sort of  
13 most of us were not impressed by the suggestions.  
14 40 years later, of course, her prediction and other  
15 people's prediction proved to be correct but, at the  
16 same time, the World Federation of Haemophilia, the  
17 Haemophilia Society, what is called the equivalent of  
18 The Haemophilia Society in the US, they all came to  
19 the same conclusion that you could not stop using  
20 concentrates.

21 Then you talk to people, you know, sort of in  
22 big treatment centres, Cardiff, Manchester,  
23 Royal Free, and you mention to them, you know, would  
24 we be going to back to cryoprecipitate? Oh, you must  
25 be joking, it's impossible.

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1 a greater potential ... [whatever]. Physicians  
2 involved in the care of haemophiliacs must now be alert  
3 to this risk. Preventing the complications of the  
4 present treatment may have to take precedence ..."

5 If you go to the paragraph before that, it  
6 is -- the one before it before the last paragraph.

7 SIR BRIAN LANGSTAFF: Top of the page, I think.

8 MS RICHARDS: That's the one.

9 SIR BRIAN LANGSTAFF: "This issue of the Journal  
10 contains", I think is what you are looking for?

11 A. No, "Ease in obtaining the commercially ..."

12 "It would be difficult to design  
13 a home-infusion programme with a cryoprecipitate  
14 therapy since the material must be stored in the  
15 frozen state. The present programme has been  
16 extremely successful and would be given up by  
17 physicians and patients only with great reluctance.  
18 Yet it is time to consider doing so, even though we  
19 may not have enough evidence to demand such a radical  
20 change."

21 So that was suggested with this wording when  
22 there was no credible alternative and the author  
23 clearly said, you know, sort of cryoprecipitate is  
24 going to be a difficult thing to do when there was no  
25 credible alternative to concentrate.

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1 So that is the reason why cryoprecipitate was  
2 not a credible alternative. If there was a credible  
3 alternative, I think many people would have thought  
4 again, you know, than continuing with the programme.  
5 But there was no credible alternative.

6 MS RICHARDS: Can we just look at this article again, the  
7 last paragraph. There are two parts to this  
8 paragraph. You've alighted upon the second part of  
9 it, which is the suggestion that there may need to be  
10 revisiting the current home infusion programme and the  
11 greater use of cryoprecipitate, but the first part of  
12 it is the statement that the fact that haemophiliacs  
13 are at risk for AIDS is becoming clear. Did you take  
14 issue in January 1983, or whenever you became aware of  
15 it in 1983, with that statement, and did you  
16 understand by early 1983 that there was reason to  
17 consider that the haemophiliacs were at risk of AIDS?

18 A. In the early 1983, and I think I've sent you so many  
19 references, and fortunately you have already had them  
20 because you send me back the reference numbers, you  
21 know, there were two arguments going on at the same  
22 time. One argument is saying: look, the issues of  
23 AIDS in haemophilia is not related to an infective  
24 agent, it's related to the exposure to the antigen  
25 that is the foreign protein which comes with the

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Factor VIII from another person; and there is a group which said, look, this is going to be very much like hepatitis B. You know, you really do not know -- you did not know then as what is credible.

By 1983/84, the argument that an infective agent is more likely became more and more acceptable until the agent was identified as the retrovirus HTLV-III, initially. So there were two arguments going on at the same time but I think I sense what you want to ask me. Did you share that with your patient, Saad Al-Ismaïl? Well, you may know that the haemophiliacs, unlike other groups of chronic illnesses, they were truly informed as to what is happening around them in the world and I have yet to have had a patient who would come to me and say, well, I've heard about this, I want to stop using anything which may, you know, sort of, give me an infection.

I would have happily discussed that with them and thought what are the alternatives, the alternative is cryoprecipitate, but for the patients who were receiving cryoprecipitate, most of them have to and did having it in hospital, and for those who have to have it at home it was a big issue, and I think one of the witnesses which you sent me the statement for said that he spent most of his life in hospital.

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a reference was made, for example, to the hepatitis, not to the AIDS. So I think, you know, sort of, a long answer to your question: did I take action on the first sentence? No, because there was a counter-argument and there was no credible preference. Did I discuss it with the patient? Well, none of the patients certainly raised the issue with me and if I am to raise the issue I should really have a clear view as which argument is going to be the more credible argument. I think the argument of an infective agent would have been acted on if there was a credible alternative to cryoprecipitate much earlier.

**Q.** As I understand the answer to the question that you correctly anticipated I was going to ask you, you didn't yourself tell patients in 1983/1984 of the risk of AIDS. As I understand your answer, that's for potentially two reasons: firstly, you're saying that in early 1983 at least, I think you're saying that there was a credible alternative explanation and, secondly, you're saying that you assumed that patients would have the information themselves.

Is that right?

**A.** The third one is that there wasn't a credible alternative, for treatment.

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I have not watched the programme World in Action but I saw it since, when you actually included it in one of your evidences, and I managed to listen to it on the YouTube, and I remember one thing which Professor Bloom said to me, which I didn't understand at the time. He said to me, you know, the haemophiliacs are aware that they are taking risks, and I thought he was referring to the hepatitis B and I did not understand what he meant really until I watched that programme and I got the references for the transcript, which you've kindly sent, which I've read after watching the programme, which were Mr Robinson, I think, said that we knew of the risk and Mrs Robinson said -- I'm not quoting her exactly -- but she said we did not take a chance or something with our children's lives, but we knew of the risk. I think the programme was about Hemofil and she said Hemofil was a calculated risk.

The reason why I went into such a long answer is to say that I really do believe that haemophiliacs knew the risk and my understanding that with every single concentrate there was, you know, sort of, the drug information leaflet.

I was assured -- I haven't seen one, but I was assured by Professor Bloom that in each one of them

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**Q.** What's the basis for your assumption that patients in 1983 and 1984 understood the risk of AIDS from the use of blood products?

**A.** Well, I didn't understand fully the risk of AIDS from use of blood and blood products, simply because there were too many arguments, one pointing in one direction and one pointing in the other, and you asked me whether I've read The Lancet and I said I've read The Lancet in the library. There were so many articles, leading articles, in The Lancet to say, look, this AIDS issue is -- this reduced immunity in the haemophiliac is very much related to the concentrate -- to the antigens in the concentrate. There were other arguments saying, look, the AIDS in the haemophiliac is going to be different from the AIDS in the homosexuals and the drug abusers because there are certain mitigating issues in that population using nitrates and whatever, and that in the haemophiliacs the processes may have altered that.

There were so many arguments going at the time that it was very difficult to give an informed opinion to any patient as what I knew as for a fact then. When the virus was diagnosed and we had a test, it was much easier then to talk about it but it was too late. In fact, it was too late by 1982/83 as we learned

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1 later. But it was -- really to discuss something with  
2 a patient you have to be informed. We may be able to  
3 talk about variant CJD later on but when I call  
4 a patient I give them the opportunity to sit down and  
5 talk about variant CJD, some of them said why did you  
6 tell us this if you do not know the answer to it?

7 I explained, look, one of the reasons why I'm telling  
8 you is because of the public health issues whatever.

9 The point is you really are only able to discuss with  
10 a patient an issue if you really have made a firm  
11 opinion as what you want to advise the patient.

12 **Q.** Dr Al-Ismail, if you didn't fully understand the risk  
13 of AIDS, what's the basis for your assumption that  
14 your patients were sufficiently well informed?

15 **A.** Well, the patients were informed because of the  
16 meeting of The Haemophilia Society. The fact that  
17 Professor Bloom called the patients even from Swansea  
18 and their relatives to go to a meeting in Cardiff,  
19 I think he probably had more than one meeting, the  
20 newsletters which The Haemophilia Society distributed,  
21 there were so many things distributed. I'm not saying  
22 that they were better informed than me. What I am  
23 saying, for me to actually preach to a patient  
24 something, I really need to understand fully what are  
25 the evidences for it. Is it truly an infective agent?

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1 it is -- you know, sort of -- when the antibody test  
2 came in, we did not know what that antibody test meant  
3 until we had a chance to actually look for the  
4 transcript of the virus. So that antibody was not  
5 a protective antibody.

6 There were so many issues that nobody knew, but  
7 you have asked me did I speak to Professor Bloom?  
8 I spoke to him about this many times, and his view is  
9 initially that we are not going to have -- we are not  
10 going to see the same problem as the -- in the  
11 homosexual population and the drug addict, we're going  
12 to see it in some of the patients, and he based his  
13 opinion on the survey that so many patients were  
14 treated, so many patients had HIV antibodies but so  
15 a few of them developed.

16 Then, unfortunately for all of us, when the  
17 disease started to progress, it was like a bushfire  
18 really. Everybody was so depressed when that  
19 happened.

20 **Q.** Can I ask you to look at --

21 **SIR BRIAN LANGSTAFF:** Just before we leave this, can  
22 I just ask you a couple of things that arise out of  
23 the questions you have been asked, doctor, if I may?

24 **A.** Please.

25 **SIR BRIAN LANGSTAFF:** As I understand it, your first

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1 If it is an infective agent, like so many people have  
2 said, is it going to be like the hepatitis B virus or  
3 is it going to be like the non-A, non-B hepatitis?

4 There were so many issues I did not know and  
5 that is not just me. I think the vast majority of  
6 people, unless they are strongly in one camp or  
7 another, have the same view. Some of the haemophiliac  
8 doctors their patients, look, it is definitely not  
9 an infective agent, the others told them it is. But  
10 I did not really know which argument was going to be  
11 the true argument or the true cause of AIDS.

12 **Q.** Did you ask Professor Bloom for his advice as to what  
13 patients should be told about the risk of AIDS?

14 **A.** I think we have talked about it. Professor Bloom had  
15 initially, prior to -- I think, the first death he  
16 had, if I remember right, was in August '83 prior to  
17 that he thought that the AIDS is not going to be a big  
18 issue in the haemophiliacs. Even in 1984, as you well  
19 know, when his survey of more than 100 haemophilia  
20 centres including UK and Europe he had 13,000  
21 haemophiliacs who were treated and that is 1984.  
22 Only 11 of them showed the Acquired Immune Deficiency.

23 Now we know things that we did not know then.  
24 Now we know the incubation period of Acquired Immune  
25 Deficiency, of HIV, is a long one. Now we know that

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1 reason for not telling patients about AIDS was there  
2 were two different arguments. There was  
3 a counter-argument to the argument that it was a virus  
4 contained in the factor concentrate; have I understood  
5 that correctly?

6 **A.** You understood that correctly. But if a patient had  
7 asked me what -- "I've heard about this, doctor, what  
8 do you think", I would have presented both argument to  
9 them.

10 **SIR BRIAN LANGSTAFF:** You were taken to the very first  
11 sentence in that last paragraph:

12 "The fact that haemophiliacs are at risk for  
13 AIDS is becoming clear."

14 That's linked to concentrates. There's nothing  
15 in that sentence that talks about a virus, is there?

16 **A.** No.

17 **SIR BRIAN LANGSTAFF:** If it wasn't a virus, it was the  
18 factor concentrate, was it, that was creating the lack  
19 of immune reaction or the antigenic reaction which  
20 gave rise to AIDS, was it?

21 **A.** That's true.

22 **SIR BRIAN LANGSTAFF:** So whether it was the argument or  
23 the counter-argument as to what was the cause, there  
24 was, on both accounts, a risk of catching AIDS from  
25 having concentrate. Quite how you got it was unsure

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1 but there was a risk.  
 2 A. Yes.  
 3 **SIR BRIAN LANGSTAFF:** So in the light of that, was it  
 4 really an argument to say that you shouldn't say  
 5 anything about the risks of using concentrate to your  
 6 patients when both the argument and the  
 7 counter-argument ended up at the same place, that it  
 8 was the concentrate that was likely could give rise to  
 9 AIDS?  
 10 A. With all respect, sir, I did not say that it's not  
 11 right for -- to mention anything. What I was asked:  
 12 would you have to explain the risk of AIDS to your  
 13 patients? If I knew exactly what the risk of AIDS in  
 14 a particular patient, I would have, but I did not know  
 15 what would be the risk of AIDS in a particular  
 16 patient --  
 17 **SIR BRIAN LANGSTAFF:** That was all that I was asking.  
 18 I just wanted to clarify that. Thank you very much.  
 19 A. Pleasure.  
 20 **MS RICHARDS:** Could we have PRSE0002647, please.  
 21 Doctor, these are the notes of a meeting at  
 22 which there was a discussion on AIDS chaired by  
 23 Professor Bloom. It's not a meeting you attended.  
 24 It's 24 January 1983 and it was a meeting between  
 25 a number of clinicians and representatives of immuno

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1 only one or two cases having been reported. Reference  
 2 to possible precautions. There's then a discussion  
 3 about articles in the New England Journal of Medicine  
 4 and a distinction between concentrates and  
 5 cryoprecipitate and then comments on the possible  
 6 nature of the transmissible agents, indicating that  
 7 there may not be just one agent but a mixture, ie  
 8 possibly a barrage of viruses.  
 9 Two questions for you, doctor, arising out of  
 10 this. We know from this, we in fact know from other  
 11 material as well, that Professor Bloom was aware of  
 12 the case of the San Francisco baby case, the child  
 13 transfused with platelets developing an AIDS state.  
 14 Do you recall any discussions between you and  
 15 Professor Bloom about that case and its significance?  
 16 A. No, but I recall what he has written in his report.  
 17 That's his litigation report. And I recall very  
 18 clearly that he said in his report -- I think he was  
 19 in a meeting with The Haemophilia Society in 1983,  
 20 only two months after his first patient died  
 21 with AIDS, and in that report he said -- what was his  
 22 wording? "I became more concerned about the  
 23 possibility of ..."  
 24 I've written it here somewhere. He said ... he  
 25 was more circumspect than previously -- that is in

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1 at a London airport hotel. If we could go to page 3  
 2 please, you'll see there's a heading, "Acquired  
 3 Immunodeficiency Syndrome" -- bottom half of the page  
 4 please, Soumik -- and there's a description given,  
 5 what's said to be a summary of the current position by  
 6 Dr Kraske.  
 7 Go down so we can see the bottom of the  
 8 paragraph in full, please. Thanks.  
 9 So we can see in the penultimate paragraph it  
 10 says:  
 11 "Some 800 people had been reported as suffering  
 12 from AIDS, and there was a 45 per cent mortality."  
 13 Then there's an update about the position in  
 14 relation to haemophiliacs and then a reference to  
 15 other cases involving blood and blood product  
 16 transmission, including platelets transfused in three  
 17 cases, and specific reference to the case of  
 18 a 20-month old child who had received several units  
 19 including platelets and had developed a possible AIDS  
 20 state. We refer to that elsewhere, doctor, as "the  
 21 San Francisco baby case".  
 22 Go over the page, please. Look at the top half  
 23 of the page. We can see there there's express  
 24 reference to the length of the incubation period, it  
 25 appears to be six months to two years. Reference to

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1 October 1983 -- than previously with regard to blood  
 2 products and AIDS. So really by then he clearly  
 3 started to believe in the -- more the theory that an  
 4 agent is probably responsible for the AIDS.  
 5 So I'm very aware of that report. But as  
 6 I said, until the virus was identified, many of us  
 7 really -- the argument shifted more and more toward an  
 8 infective agent but it was only when the virus  
 9 identified that it was convincing. And by the way,  
 10 even when the virus was identified, so many papers  
 11 appeared afterward saying that this is not the cause  
 12 of AIDS, this is an opportunistic infection in  
 13 patients who has got AIDS.  
 14 So you could see how the arguments we know sort  
 15 of moved over the years. But if you ask me -- what  
 16 was the date of this meeting?  
 17 Q. 24 January 1983.  
 18 A. Yes. So if you ask me has he shifted his opinion,  
 19 yes. Have he conveyed that to me? I don't know when,  
 20 but I certainly read it when he shared the report with  
 21 me.  
 22 Q. Did he -- I think the answer to this is "no", from  
 23 your earlier answer -- did he, whether following this  
 24 meeting or otherwise, discuss with you the  
 25 significance of the infection of the baby in

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1 California?

2 A. No, he did not.

3 Q. Would you agree -- and picking up on the chairs

4 question a few moments ago, looking at this

5 discussion, there are obviously matters which are not

6 yet known but there's no suggestion here that there's

7 anything other than concentrates and a transmissible

8 agent that are being put forward as the likely causal

9 connection?

10 A. Yes, but this is, as I said, one argument. There were

11 a plethora of publications talking about an

12 alternative arguments. And the difficulty for people

13 who really was -- I think even people in the

14 haemophilia world, the people in the Royal Free and

15 the like, initially they did not believe an infective

16 agent was responsible until later on.

17 So I don't think Professor Bloom was alone in

18 that thought really. I think -- so if you are talking

19 about people like him, he probably would have

20 intermingled with people in the USA, in Europe and

21 whatever, and he was on regular correspondences with

22 them.

23 He reminded me so many times that, "Look, in

24 Germany they use more American concentrate than we

25 use here but they haven't had a case of AIDS". So all

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1 alternative, in the severe haemophiliacs and for home

2 treatment.

3 So the short answer to your question, was there

4 any specific measures apart from, you know, sort of

5 monitoring the patients more carefully? No. Apart

6 from trying to answer any question which the patient,

7 their mother or their family have raised? No. But we

8 answered the questions according to what we have read

9 in the literature.

10 Q. Could we have, please, HCDO0000517\_001.

11 This is a letter dated 22 March 1983. It was

12 sent to centre directors from Dr Craske, Dr Rizza and

13 Professor Bloom. And you will see it asked for the

14 reporting of possible cases of AIDS, and various

15 papers are there referred to.

16 Do you know -- this would have been addressed

17 to Dr Khurshid, as centre director, rather than you.

18 Did you see this, as far as you can recall, at the

19 time or are you unable to say?

20 A. I say that Dr Khurshid always would have told me what

21 he received and what he's acted(?), and I think

22 I found later on that he had some forms and he

23 reported to the UKHCDO, Dr Craske or whatever,

24 whatever they have asked him to report.

25 So I'm sure that Dr Khurshid would have told me

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1 this these things were happening. And he was a person

2 who, as I said, was listening to all these views

3 and -- and I said before, he wasn't an opinionated

4 man, he was quite happy to shift his opinion when the

5 argument points him in one direction or another.

6 Q. What steps were taken at Swansea in response to the

7 possibility that concentrates might cause AIDS in

8 haemophiliacs?

9 A. Well, I don't know of any specific -- I mean, what

10 happened is that we would -- became more adamant that

11 mild haemophiliacs should not receive anything but

12 cryoprecipitate or DDAVP. We became more adamant

13 that, if it is all possible, children should be

14 treated with the cryoprecipitate. Fortunately for me,

15 as I said before, there were -- I did not have any new

16 patients until the advent of the safe products came

17 through.

18 So in terms of the current patients we had, the

19 only thing we could do is really monitor them and look

20 after them. But in terms of changing the practice of

21 treatment, there were no change of practice, simply --

22 and we used as much NHS concentrate -- I've already

23 said that before -- as we could get hold of. And when

24 the heat treated product became available, we used

25 that. But there was no other alternative, credible

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1 that he -- that "You've got another set of forms which

2 you have to fill", and about the patients. But,

3 again, I do apologise for taking, you know, so long

4 because I could not remember in full, but that, I'm

5 sure he would have discussed it, knowing what used to

6 happen. You know, whenever he received anything, he

7 always mentioned it to me.

8 Q. If we could have HCDO0000517\_002, please.

9 This is a report, Dr Al-Ismael, from Dr Craske

10 dated 1 March 1983. I'm not going to go through it in

11 great detail. The Inquiry has looked at it on

12 a number of occasions, or earlier versions of it.

13 If we just go very briefly to page 3 you will

14 see the bottom half of the page says "Aetiology", and

15 says several theories have been advanced --

16 A. Can I ask to "Aetiology":

17 "The effect of drugs such as amyl nitrate taken

18 by homosexuals ... This is not a factor as the disease

19 has been described in patients who do not use the

20 drug."

21 Okay. So there are so many things which were

22 going round the immunosuppressive cytomegalovirus.

23 Sorry, carry on.

24 Q. We can see that -- my main question about this

25 document, Dr Al-Ismael, is, do you think you would

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1 have seen this at the time? Is this one of the  
 2 category of documents Dr Khurshid would have shared  
 3 with you?  
 4 **A.** I can't remember seeing the document, but I think,  
 5 knowing how we worked together, is that he would have  
 6 talked to me about it or mentioned it to me. But  
 7 I cannot remember seeing the document myself.  
 8 **Q.** Did you yourself report any suspected AIDS cases to  
 9 Dr Khurshid or Professor Bloom in the course of 1983  
 10 or 1984?  
 11 **A.** No.  
 12 **Q.** You have --  
 13 **A.** I didn't see it.  
 14 **Q.** You have referred to "the Cardiff patient". What, if  
 15 anything, can you recall Professor Bloom telling you,  
 16 not about the individual patient or who they were, but  
 17 about the fact that he had a patient under his care  
 18 who had AIDS, a haemophiliac patient?  
 19 **A.** I don't know where I've heard it, but most probably  
 20 because, you know, doctors in Cardiff and Swansea  
 21 talked on a regular basis. I don't know whether he  
 22 told us or somebody else told us. I don't know. But  
 23 I do remember that, you know, sort of, if you like,  
 24 the first hint that it is happening at our doorstep  
 25 happened in 1983, but we didn't really know what --

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1 Armour and then we added Cutter later on.  
 2 **Q.** What steps were taken to ask patients who were on home  
 3 treatment, and who had supplies of unheated  
 4 concentrates in their home, to bring those back in.  
 5 Were any such steps taken?  
 6 **A.** Yeah, I've asked that question to the MLSO, the  
 7 biomedical scientist who was -- and I asked him what  
 8 did we do, and he said, "I'm certain that we asked  
 9 patients to bring what they've got and we exchanged it  
 10 with each input."  
 11 **Q.** Do you recall any difficulties in obtaining sufficient  
 12 supplies of heat-treated products?  
 13 **A.** No.  
 14 **Q.** Do you recall whether any of your patients were  
 15 infected with HIV through the use of heat-treated  
 16 products?  
 17 **A.** Yes.  
 18 **Q.** What can you tell us about that? Again, without  
 19 identifying any patients.  
 20 **A.** Well, it was a patient who was on Armour product. And  
 21 to be honest, we would probably not have known about  
 22 the cause until, I think, the Armour product was  
 23 identified, because that batch, one of the donors was  
 24 an HIV -- later developed HIV and AIDS, and he had  
 25 donated. Then we had -- we had to follow all the

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1 what's going to happen after. Is it going to be the  
 2 odd case for whatever reason? We didn't know. We  
 3 really didn't know.  
 4 But I've heard about it, whether it was from  
 5 Professor Bloom or talking to colleagues in Cardiff.  
 6 We very often talked to each other for different  
 7 reasons, and whether they have told me, I don't know,  
 8 but I've heard about it, yes.  
 9 **Q.** Did Professor Bloom ever suggest to you that the cause  
 10 of his patient's AIDS was something other than the  
 11 treatment he had received with factor concentrates?  
 12 **A.** No, he didn't discuss that. He didn't discuss that  
 13 with me. But if you ask me whether he would have --  
 14 he could have -- even if he discussed it, could have  
 15 said that with me, I don't think he would. I think he  
 16 would have said it's the concentrate.  
 17 **Q.** We know in December 1984 UKHCDO recommended a move to  
 18 heat-treated product. Do you recall any discussions,  
 19 whether with Dr Khurshid or Professor Bloom, about the  
 20 move to heat-treated products?  
 21 **A.** I think as soon as the UKHCDO suggested that we move  
 22 to heat-treated products, I think Arthur was, you  
 23 know, sort of instrumental in making sure that all of  
 24 us would have gone to heat-treated product as soon as  
 25 they became available. And I think we started with

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1 patients who received that products, and sure enough  
 2 one of them converted on that product.  
 3 **MS RICHARDS:** Could we have on screen HCDO0000132\_039,  
 4 please.  
 5 Sir, I understand there's a problem with the  
 6 external broadcast and so I'm being asked by RTS if we  
 7 can have a break so they can resolve that problem.  
 8 **SIR BRIAN LANGSTAFF:** Yes. I just had that message  
 9 myself.  
 10 So I'm sorry to stop you in mid-flow,  
 11 Professor, it has happened twice this afternoon, but I  
 12 hope we will have better luck a bit later on. We will  
 13 take a break now. We normally have a break in the  
 14 afternoon. We will have a break for about  
 15 half-an-hour. So we will do that now and come back at  
 16 3.30. It gives us all a chance to have a cup of tea  
 17 and for our broadcaster to resolve what the problems  
 18 are.  
 19 **A.** Thank you.  
 20 (3.00 pm)  
 21 (A short break)  
 22 (3.45 pm)  
 23 **SIR BRIAN LANGSTAFF:** Right.  
 24 **MS RICHARDS:** Could we have the document that we were  
 25 going to go to before we broke, HCDO0000132\_039.

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1 We can see that this is a letter from you,  
2 dated 18 December 1986. I'm not going to ask you  
3 about the specific patient, doctor. But it refers to  
4 a patient having been exposed to an Elstree Batch,  
5 HL3186, in September 1984, and then you say this:

6 "Three of our haemophiliacs who were recipients  
7 of that batch seroconverted to HIV Antibody  
8 positive ..."

9 Then you refer to the seroconversion in one of  
10 them occurring between June 1985 and March 1986 and  
11 then you wonder if the particular patient about whom  
12 you are writing represents a another delayed  
13 seroconversion after exposure to that particular batch  
14 or possibly some other treatment he had.

15 Doctor, the first question is this: do we  
16 correctly understand from this letter that three,  
17 possibly four, of your patients seroconverted to HIV  
18 following receipt of this particular infected batch,  
19 HL3186?

20 We can't hear you, doctor. Hold on a second.  
21 We can see that you are speaking, but we can't hear  
22 you.

23 A. Can you hear me now?

24 Q. We can. Did you hear my question?

25 A. Yes, I heard your question very well. Do you want me

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1 A. So that is the letter from Dr Rizza to me saying we  
2 need to know how come that this patient was not  
3 reported before all of a sudden appeared as being  
4 reported to us. Can I give you -- about the same  
5 patient you have sent me two other documents and I've  
6 tied them together. Can I give you these, please?

7 So the first one is a letter from Dr Khurshid  
8 to Professor Bloom, the number, I'll spell it  
9 phonetically, Charlie Victor Hotel Bravo 0000003\_65.

10 Q. It will be \_065, I think. Could you just repeat that  
11 number please?

12 A. Charlie Victor Hotel Bravo 0000003\_065.

13 So the only difference is that, I think the  
14 secretary there on our part got the year of birth  
15 wrong, '75. It should be '76, but you could check the  
16 particular of the patient, and I've checked it through  
17 another document on the same. So that is the document  
18 which Dr Khurshid sent to Professor Bloom saying,  
19 would it be possible to see this patient who received  
20 HL3186, and Dr Khurshid had a meeting with the parents  
21 but he thought that Professor Bloom would need to have  
22 a meeting with them. This is an example of how we  
23 collaborated with Cardiff.

24 The other number is Professor Bloom's response,  
25 which is Charlie Victor Hotel Bravo, again,

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1 to tell you a bit about this batch?

2 Q. About the batch, yes, not the specific patients, but  
3 the batch, please.

4 A. So this is a batch which actually was prepared in  
5 Wessex region, 7,000 donations and we were alerted to  
6 it by the head of Blood Transfusion Service there and  
7 that, in one of the patients who donated then  
8 developed AIDS. Now, unfortunately -- well, the batch  
9 was distributed in different places but seven of the  
10 haemophiliac in Wales got infected with this  
11 particular batch, and you'd find that in the report of  
12 Professor Bloom actually.

13 So that is the Elstree Batch HL3186, and you've  
14 kindly sent me a couple of other Elstree documents,  
15 I think, last week and you see they carry different  
16 numbers. So would it be in order for me to actually  
17 tell you that all these documents refer to the same  
18 patient? I'll give you the number of the documents.

19 So the first one is HCDO0000348\_005. You find  
20 that is the letter from Dr Rizza to me, dated  
21 11 December, asking me the question is: how come that  
22 we're having report of seroconversion in 1986 when we  
23 did not see that. Do you want me to repeat that  
24 number?

25 Q. I think we have it.

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1 0000003\_064. That is Professor Bloom's response to  
2 Dr Khurshid. So that is the same patient which  
3 Dr Rizza has written to me, asking: how come that  
4 we're having this report here, we thought that you're  
5 using heat treatment?

6 There is an issue with the frequency of testing  
7 in this patient, in that the patient was -- even  
8 though we saw the patient, you know, sort of, maybe  
9 once a year or twice a year in Cardiff, the patient's  
10 residence was [redacted] so ...

11 Q. Forgive me --

12 SIR BRIAN LANGSTAFF: Just stop there. Dr Al-Ismael, I'm  
13 keen not to get into a discussion of the particular  
14 circumstances of particular patients.

15 SIR BRIAN LANGSTAFF: Can we just remove that from the  
16 record please.

17 A. I apologise.

18 SIR BRIAN LANGSTAFF: We will make sure you don't say  
19 anything untoward.

20 A. That patient was not living in our area so we would  
21 not test him as frequently as we would test our  
22 patients. So that is the reason for the delay,  
23 I don't know when he converted, but according to us  
24 the tests we did in 1976 show that he converted. So  
25 that was the recipient of that particular Elstree

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1 Batch. So all these documents tie together.  
 2 **MS RICHARDS:** Could we just go back to HCDO0000132\_039,  
 3 please, Soumik. The point I just wanted to clarify  
 4 with you, Dr Al-Ismael, is this: the batch in  
 5 question, HL3106, which seems from this letter to have  
 6 resulted in three or possibly four of your patients,  
 7 or of the local patients, seroconverting to HIV, this  
 8 is a batch that was, as I understand it, supplied in  
 9 August or September 1984 for use by the hospitals.  
 10 **A.** Yes.  
 11 **Q.** I think you made a point earlier in your evidence,  
 12 doctor, you suggested that many seroconversions would  
 13 have taken place in the early part of the 1980s, but  
 14 a number of your patients were infected at  
 15 a relatively late stage through the exposure to this  
 16 particular batch; is that right?  
 17 **A.** Yes.  
 18 **Q.** This is obviously a communication that you're having  
 19 with Dr Rizza, presumably in his capacity as  
 20 maintaining the records at the Oxford Haemophilia  
 21 Centre, nationally, of patients?  
 22 **A.** Yes.  
 23 **Q.** Did you tell your patients that you were providing  
 24 information on a named basis, so not an anonymised  
 25 basis, about their HIV status to Oxford?

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1 monitoring the issue on the UK basis.  
 2 That is what used to be happening in terms of  
 3 the HTLV-III. So I don't think I remember a situation  
 4 whereby we actually had to do it so regimentally as we  
 5 did it in HTLV-III, simply because there was no  
 6 treatment. We did not know what it meant in terms of  
 7 the outcome. Much more importantly, there was such  
 8 an awful social stigma about HTLV-III and the way it  
 9 could be transmitted.  
 10 So all these sensitive issues, really, we --  
 11 needed to be handled very carefully.  
 12 **Q.** Could we have a look next at ARMO0000574, please  
 13 Soumik. This is a letter that you wrote in  
 14 August 1986 to Dr Christie of Armour Pharmaceutical  
 15 Company and it's headed "Heat Treated Factorate Batch  
 16 Y69402":  
 17 "I am writing to update you on the HTLVIII  
 18 status on patients who had received the above batch of  
 19 Factorate."  
 20 You refer to an earlier letter, and then you  
 21 provide information about five patients. We're not  
 22 quite clear what the redacted passage bits are but it  
 23 doesn't look like you were providing names but you  
 24 were providing information about individual patients.  
 25 Is this the heat-treated batch from which one

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1 **A.** Yes. We told the patients when the tests became  
 2 positive that we would be sharing -- the HTLV test was  
 3 unlike any other test we did on haemophiliacs. There  
 4 was quite a stringent way of doing it, really, in that  
 5 we could not do it on the patient unless we had  
 6 actually counselled the patient and very often we  
 7 asked a patient if they want to bring anybody with  
 8 them before we do the test. Then we do the test and  
 9 when we convey the results, we also do it in  
 10 one-to-one basis, and we tell the patient that -- we  
 11 ask the patient that we need to inform their partner,  
 12 wife and whatever, if it is a child then we would tell  
 13 the guardian of the child, and our attitude then was  
 14 not to tell the child because of the stigma, and the  
 15 so many mishaps and stories you've heard about  
 16 children inadvertently telling their friends in school  
 17 and then being picked on, and some of the families  
 18 they had graffiti written on the doors and whatever.  
 19 We've heard the stories, didn't occur in our area.  
 20 So the point I was making is that the testing  
 21 telling the patient and asking the patient if they  
 22 don't mind it's important to share the information  
 23 with their GP, I didn't have any patient who refused  
 24 that and also telling them that we would be sharing  
 25 the information with the UKHCDO because they will be

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1 of your patients was infected?  
 2 **A.** Yes.  
 3 **Q.** Although this information doesn't appear to contain  
 4 names, did you tell your patients that you were  
 5 providing any information about them to Armour?  
 6 **A.** As far as I remember, whenever we see a patient or  
 7 guardians we will discuss saying that, you know, we  
 8 received this information about an Armour product,  
 9 where one of the donors, I believe, actually developed  
 10 AIDS and whatever, and we will be -- we have been  
 11 asked to provide information to -- now that is how  
 12 I remember it. Whether we documented it or not,  
 13 I don't know, but most probably we did. But that is  
 14 as far as I can tell you.  
 15 **Q.** Then there's a follow-up letter, ARMO0000573, please,  
 16 Soumik. We can see it's from Armour to you, dated  
 17 22 August 1986. It refers to there having been  
 18 a visit and then it says that:  
 19 "... we have been asked [that's 'we', Armour]  
 20 by the DHSS to follow up the progress and history of  
 21 all other patients who were sero-negative at the time  
 22 this batch was administered to them."  
 23 Then it is said that a particular interest is  
 24 one of your patients, and continues:  
 25 "It would be most valuable to check with you,

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1 in strict confidence, the pattern of previous  
2 treatment with heat-treated and non-heat-treated  
3 Factor VIII concentrates. Perhaps this would be best  
4 achieved during a visit, if you feel able to disclose  
5 this information to me."

6 There's some later reference to a visit being  
7 arranged. Can you recall whether you provided further  
8 information along these lines to Armour?

9 **A.** Well, I wouldn't -- I mean, as I said in my statement,  
10 I'm not -- that's not just in haemophilia. You get  
11 visited by different representatives and some of them  
12 will try to find out what I felt about their other  
13 product, or anything.

14 I was very careful and I made it very clear to  
15 a representative that I will be discussing their  
16 particular product. But in this situation there was,  
17 I believe, an issue in the sense that, in one of the  
18 meetings which I wasn't party of, it was said that  
19 haemophiliacs in Swansea converted on a heat-treated  
20 product. In fact, what they were referring to was the  
21 patient we were discussing a minute ago, the patient  
22 with the Elstree Batch.

23 I was a bit annoyed, and I shared that with  
24 Arthur at the time, saying if the UKHCDO was to get  
25 their fact right, then they really have to not listen

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1 were invited to attend the hospital, were they, to  
2 give a sample for testing?

3 **A.** No, they were invited to come and talk about the  
4 testing before they gave a sample and I think you may  
5 find, because I blanked the names and did not keep  
6 the -- you will find in that copy of the letter, which  
7 is -- I think is the same document, which is the  
8 returns one, in one of the pages you'd find the  
9 testing on the patients in 1976, maybe.

10 **Q.** 1986.

11 **A.** Yes. You would find that some of them did not attend  
12 the appointment. So they were given appointments and  
13 the appointment was really to discuss the tests and  
14 the significance of the test and the importance of  
15 having the test. None of the patients refused the  
16 test, but we explained that, depending on the result,  
17 we have another meeting and, as soon as the results  
18 came back, that meeting was arranged and, I think  
19 I probably would be right in saying, most of the  
20 patients when they got the phone call to come to the  
21 meeting, they sensed what to expect, particularly when  
22 they were asked if they could bring their partner with  
23 them, if they liked. Some of them did, some of them  
24 didn't but it was so important that, you know, sort of  
25 to explain to them the mode of transmission. If you

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1 to second-hand information, either they write to you  
2 or they write to me. But the answer to your question,  
3 would I have discussed with Dr Christie and --

4 I apologise for him if he is to listen to this,  
5 because in my statement I referred to him as "she",  
6 because I couldn't remember who was Dr Christie --

7 I would have, told Dr Christie whether in a -- that  
8 patient had received this product but I would not have  
9 said, you know, sort of -- I may have said look if  
10 that patient reported in the UKHCDO did not receive  
11 your product but may have received other product,  
12 I may have said that but I would not have given full  
13 details.

14 **Q.** Can I then move on to the arrangements that were made  
15 for testing patients for HTLV-III. You have  
16 touched --

17 **SIR BRIAN LANGSTAFF:** Can I just be clear: the Elstree  
18 Batch given the date that it was administered in  
19 September 1984 was almost certainly not heat-treated;  
20 am I right?

21 **A.** Oh, yes, it wasn't heat-treated.

22 **SIR BRIAN LANGSTAFF:** Thank you.

23 **MS RICHARDS:** Moving to the arrangements that were made  
24 for the testing of patients for HTLV-III, as  
25 I understand your answers a few moments ago, patients

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1 want to ask me about that later on.

2 But, again, I do apologise for the long answer  
3 but the point is the appointment is not just for the  
4 test, the appointment is for a meeting and the test.

5 **Q.** Is this correct, the patients provided a sample, it  
6 was sent off for testing and then when the result came  
7 back and you notified patients that the result had  
8 come back, was news of the positive result told to  
9 them by you or by a nurse or by someone else?

10 **A.** No, definitely by the consultant, either me or my  
11 colleague Dr Beddall, all that information, because  
12 there were so many questions that were asked and had  
13 to be discussed. The hepatitis C was different that  
14 the results were conveyed by the nurse to the patient,  
15 but the HIV was definitely by the consultant.

16 **Q.** Your statement tells us that six adults with severe  
17 haemophilia A were HIV positive and two children with  
18 severe haemophilia A were HIV positive.

19 **A.** Yes.

20 **Q.** No patient who had mild or moderate haemophilia  
21 seroconverted to HIV and no patient with  
22 von Willebrand's seroconverted to HIV; is that  
23 correct?

24 **A.** True. Even the patient who had used all these units  
25 of cryoprecipitate, she was having regular testing and

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1 even the year she unfortunately died after the  
 2 accident, she was seronegative for HIV.  
 3 **Q.** Do you recall over what time period roughly this  
 4 process of speaking to patients, testing them and  
 5 notifying them of their results took place?  
 6 **A.** Well, given the -- I mean, if you just give me  
 7 a second, please, because I want to give you more  
 8 details because I summarised them. *(Pause)*  
 9 Okay, so of the patients who were tested in  
 10 Swansea, the first test started in December '84. All  
 11 the patients except the ones which were not living in  
 12 our area they were all positive in '84 or '85. The  
 13 only patient who we tested in '86, as I said we talked  
 14 about that patient previously.  
 15 Now, three of these patients were actually very  
 16 much -- even though they were living in our area, they  
 17 were attending Cardiff. They were tested in our area  
 18 but they were seen more in Cardiff. So all of the  
 19 patients, as far as I remember, once the results were  
 20 there, the patients were informed within the week. So  
 21 the patient would be called back in as soon as the  
 22 result is.  
 23 As I said, that was not difficult, given the  
 24 small number of patients we had to deal with, and  
 25 there were two of us.

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1 what she said, look, if you want to see Dr Al-Ismail  
 2 or Dr Beddall, you just let me know. I think I've  
 3 only seen one or two after she gave them the result on  
 4 their request. Most of them were seen on the ordinary  
 5 out-patient clinic.  
 6 **Q.** Did you receive the results of the tests yourself and  
 7 see them before they were communicated to the patient  
 8 or was it something that was left to the nurse?  
 9 **A.** No, the result of the test would have come to the  
 10 secretary and the secretary would have passed it to  
 11 the nurse but I've seen, at least in one of the tests,  
 12 the result actually was put on my desk, and I've  
 13 written "to [her name]", to be given the form, so she  
 14 could communicate the result to the patients.  
 15 The number was, you know, in their 30s or 40s.  
 16 So the number was much larger than the HIV and I think  
 17 most of the ones who came positive had a notion that  
 18 they probably would become positive, because they were  
 19 told that they've got abnormal liver function tests.  
 20 **Q.** If we just look at your witness statement,  
 21 paragraph 130, doctor, it's WITN3761005 and it's  
 22 page 41, please. WITN3761005. I think I might have  
 23 given you an extra zero there.  
 24 My screen's not working. Is your screen  
 25 working, sir?

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1 **Q.** Then the process for testing for hepatitis C, I think  
 2 your statement tells us this began in 1990, can you  
 3 recall over what period that process took place and  
 4 whether it involved more than one type of test?  
 5 **A.** Well, unfortunately, I can't give you the details  
 6 because we started in 1990 because I found the  
 7 earliest positive result in 1990. Unfortunately, the  
 8 virologist who was doing all these tests has since  
 9 passed away. So there was first generation, second  
 10 generation, and God knows how many generation of  
 11 tests, but I remember that as soon as the test became  
 12 available, the haemophilia nurse contacted -- I think  
 13 she started with the severe haemophiliacs and said,  
 14 look, you know that you've got this what we call  
 15 non-A, non-B; yes. We've got a test for it, and she  
 16 actually arranged the test. She would give the  
 17 patient the form for the test and I think I've sent  
 18 you one request form which you could see her  
 19 handwriting. That's not my handwriting.  
 20 The result would come to her and I've seen some  
 21 of the results where they came -- I've written her  
 22 name -- to [her name], and she would see the patient.  
 23 Unfortunately, at that time, as I said, we did not  
 24 have a proper haemophilia centre. So she would call  
 25 the patient in and tell them the results and I think

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1 **SIR BRIAN LANGSTAFF:** The last thing I've got is:  
 2 "My screen's not working. Is your screen  
 3 working, sir?"  
 4 So I think it is.  
 5 **MS RICHARDS:** In terms of the actual ability to see the  
 6 documents.  
 7 **SIR BRIAN LANGSTAFF:** Yes, I've got the document, page 41.  
 8 **A.** Do you want me to tell you the references I've got --  
 9 **MS RICHARDS:** Don't worry. I think everyone except me has  
 10 probably got it.  
 11 **A.** Okay, sorry.  
 12 **Q.** It's paragraph 130 of your statement, in any event,  
 13 doctor, if you have that?  
 14 **A.** Yes.  
 15 **Q.** This is as at 2006, you say 22 had blood borne virus  
 16 infections which was made up of four patients  
 17 co-infected with HIV and HCV and 18 that had HCV only?  
 18 **A.** Yes.  
 19 **Q.** So that's 22 patients with hepatitis C, of whom four  
 20 were co-infected. That's by 2006, I think the number  
 21 you gave us a moment ago was you thought the magnitude  
 22 of the patients infected was in the 30s or 40s. Are  
 23 you able to be more specific?  
 24 **A.** Yes, that may be in 2006, but then if you look at the  
 25 number of patients in 2019, there were 25. So, yes,

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1 I apologise.

2 **Q.** That's all right.

3 **A.** May be a bit of an exaggeration.

4 **Q.** Did you have any system in place or take any steps to

5 check whether patients were being informed of their

6 diagnosis promptly by the nurse?

7 **A.** Because the nurse really was concentrating on the one

8 issue at a time, I believe that she informed them

9 promptly, knowing our patients they were in a, sort

10 of -- really quite well informed and had good

11 relationship with the -- in terms of the Morriston

12 Hospital. I would be very surprised if they did not

13 know the result within a week or two, very, very

14 surprised.

15 **Q.** Would you expect --

16 **SIR BRIAN LANGSTAFF:** Just a moment. The question

17 actually was whether you have put any system in place

18 or whether you checked to see that had happened?

19 I understand that you are saying you assumed it had.

20 **A.** Yes, I assumed, yes.

21 **MS RICHARDS:** Sorry --

22 **A.** I was thinking of a proper system in place to say,

23 look, you had the -- I told the nurse what needs to be

24 done, and the issues need to be discussed and if the

25 patient was to be seen by a consultant, to be seen,

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1 So whether the nurse did manage that, I'll be

2 very pleasantly surprised if she did.

3 **Q.** What arrangements were made at the centre for the

4 counselling of patients, first of all, who were

5 infected with HIV after the test result? Was there

6 any ongoing psychological or equivalent support

7 available for them?

8 **A.** No, we did not have any but, I tell you what, we

9 offered every single patient to go and see

10 Professor Bloom at his department in Cardiff because

11 they really had more facilities, and we had one

12 psychiatrist who actually was helping us with the

13 patients with haematological malignancy and we -- if

14 there was any issue with any other patient to be

15 counselled, we would have referred to him. But

16 I can't remember any particular patient who had maybe

17 requested they need that.

18 So the quick answer to your question:

19 unfortunately, we did not have anything until 2004 in

20 terms of a proper psychological counselling attached

21 to the haemophilia centre. Prior to that it would be

22 Cardiff or whatever help we could muster in Swansea.

23 **Q.** You said in a moment ago "2004", do you mean 2014

24 which is what your statement suggests?

25 **A.** 2014, I beg your pardon. You are absolutely right.

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1 but apart from that I did not check on the, if you

2 like, the execution of that request.

3 **Q.** Your statement suggests that the nurse might have

4 informed some patients by telephone?

5 **A.** Yes.

6 **Q.** Do you know that to be the case, that some patients

7 were told by telephone?

8 **A.** I don't know but I wouldn't be surprised because, as

9 I said, patients would probably, if they don't come to

10 the centre. I could see it from the correspondence

11 that she had difficulty in getting the patient to come

12 and see her on a regular basis. So if the patient had

13 called, saying what my results was, I wouldn't be

14 surprised that she told them the result and gave them

15 the offer to be seen by the consultant, if they want.

16 **Q.** Would you expect the nurse's communication of that

17 diagnosis whether by phone or in person to be recorded

18 in the notes?

19 **A.** That I do not know, and knowing the situation of the

20 notes and their availability when we did not have

21 a proper haemophilia centre, the notes would have been

22 in the general records. It would not be in the

23 haematology department. It's only when we moved to

24 Singleton that we kept the haemophiliac notes in the

25 Haematology Department.

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1 **Q.** In terms of HIV care, to what extent was HIV care

2 something that you undertook or did you make

3 arrangements for referrals for specialist assistance?

4 **A.** Okay. When the HIV start to -- patients come through,

5 first of all it started with the homosexual and drug

6 addicts and my colleague, who -- the late great

7 Cobbold was -- came to see me and said, look, some of

8 these patients will need to be admitted, because they

9 are immunocompromised it would be best if we could

10 have a look at them together.

11 Then there was a new consultant respiratory

12 position appointed and we actually recruited him into

13 this group of clinicians to discuss any patient. So

14 that started with the patient with acquired immune

15 deficiency outside haemophilia. When the haemophilia

16 patient started to occur, then that arrangement

17 continued until the need or the availability of

18 treatment for the patient and the appointment of

19 a specialist, a genito-urinary physician, who took

20 specialisation in HIV. I think he was appointed in

21 1995 or 6 -- I can't remember.

22 But he was appointed to look after the

23 non-haemophiliac HIV population. When he settled down

24 and I've asked him whether you would consider seeing

25 the haemophiliacs, he said the only place you could

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1 see them is in the genito-urinary clinic and he would  
2 not have -- you know, we did not have the ability to  
3 come and do a joint clinic with us.

4 So I put it to the patients. Some of the  
5 patients agreed to it, some of the patients actually  
6 reminded me saying, look, do you mind if we go to the  
7 genito-urinary physician, and -- but some of the  
8 patients refused point blank to go to the  
9 genito-urinary physician department. I remember one  
10 particular patient, fortunately that was the only  
11 patient who did not require any treatment for HIV, but  
12 he said he would not go to the genito-urinary  
13 department to be seen, and I suspect if he would need  
14 to have anything done he would have to be seen with  
15 the genitourinary physician in my department.

16 The good thing we had is that we were able to  
17 monitor CD4:CD8, long before the HIV came in. We had  
18 a floor cytometer and we were using that for  
19 haematological malignancies. So when the HIV hit us,  
20 both in terms of the homosexuals, the drug addicts, as  
21 well as the haemophiliacs, we were, if you like, the  
22 centre who would do the testing for these patients,  
23 both for us and for the West Wales, whatever, if  
24 anybody who wants to have a test on their patients.

25 For our patients, we kept the records in the

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1 some of them were very well informed professionals,  
2 and I said, look, treatment is now available would you  
3 like me to refer you to him, and they said, look, we  
4 read about the treatment and, because we feel okay, we  
5 don't want to be referred.

6 But when the, you know, the proper treatment  
7 came through later on, they all accepted referral.  
8 But before referral was made to the hepatologist, each  
9 patient was asked whether they accept the referral and  
10 they said, yes, they were referred.

11 Q. If we have up on screen, please -- and I'm now looking  
12 at arrangements for specialist liver care in more  
13 recent years. You've told us in your statement that  
14 after 2006 patients could be referred to a consultant  
15 physician with a special interest in liver disease.

16 Then could we have ABMU0000021, please.

17 You will see this refers to an issue about --  
18 this is from 2011 -- about access to a fibroscan, and  
19 the hope being expressed by the specialist physician  
20 to you is that they were hoping to have one soon.

21 Can you recall how long it took before  
22 fibroscan provision was available for patients in your  
23 area?

24 A. Well, I know we've got it after the Royal Gwent but  
25 I can't tell you the exact year. But we certainly --

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1 notes, as well as giving it to the genito-urinary  
2 physician. For the patients who is entirely under the  
3 GU physician we sent the results to them. So we know  
4 what is happening to our patients, even when they were  
5 referred to the genito-urinary physician in terms of  
6 the CD4 count. Needless to say, we also saw them  
7 regularly in the out-patient clinic and asked them if  
8 they have any symptoms and whatever, and offered them  
9 the prophylactic treatment and whatever.

10 Q. In terms of the patients who were diagnosed with  
11 hepatitis C in the 1990s, were they all referred to,  
12 I think, your colleague, Dr Kingham, for assessment  
13 and management or did that vary depending upon the  
14 particular circumstances of the patient?

15 A. Did I hear you right, you said hepatitis B?

16 Q. Hepatitis C. So after they were diagnosed with  
17 hepatitis C in the 1990s, did you refer all the  
18 patients who were hepatitis C positive to Dr Kingham?

19 A. Yes. Before we referred, we told the patient would he  
20 like to be referred to the liver specialist. Some of  
21 the patients said, do they have any treatment for me,  
22 and we'll say, well, as far as we know we don't have  
23 any treatment, but they could monitor you. Some of  
24 them accepted, some of them refused, and even when the  
25 treatment became available and I remember, you know,

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1 I think, as I said, we were lucky in Swansea in terms  
2 of hepatologist service. We had two clinicians, one  
3 was Dr Kingham and then the other was Dr Chinlye. Dr  
4 Chinlye actually was -- his particular interest, and  
5 was very active, in looking after these patients. But  
6 I can't tell you exactly -- you may find the answer in  
7 the original statement in 2018, because he gave me  
8 a briefing about liver services when I asked him to  
9 give me a briefing about liver services to present to  
10 the Chief Executive to include it in her response to  
11 the Inquiry. I can't tell you exactly but I know it  
12 was not long after Royal Gwent that we got ours.

13 Q. Do you recall from your own knowledge whether there  
14 was any difficulty in obtaining funding for treatments  
15 for your patients for either HIV or hepatitis C?

16 A. No.

17 Q. So you didn't experience difficulties in obtaining  
18 funding?

19 A. No, I didn't -- I mean, I -- actually, if you go back  
20 to the top of this letter, if you go back, and you  
21 could see that the -- I sent the letter to Dr Chinlye,  
22 copied it to the radiology, copied it to the finance  
23 department, copied it to the manager Swansea locality,  
24 to tell you that we really needed to have as much  
25 pressure as possible to say that, look, we really

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1 need, desperately need a sort of a proper monitoring  
2 of these patients.

3 So I suspect, you know, sort of this may have  
4 been -- this letter was prompted by the Task and  
5 Finish Group to look at the haemophilia services and  
6 whatever -- and what things we provide to them. But  
7 I do not remember either the GU physician or the  
8 hepatologist saying to me they are experiencing  
9 difficulty in getting proper funding for drugs.

10 I know that Dr Chin Lye actually got the  
11 protease inhibitors initially for some of our patients  
12 because he recruited them into national and  
13 internationally, and that's how he got the protease  
14 inhibitors. But as soon as the protease inhibitors  
15 became available, I know that it was made available to  
16 all the patients. And I'll tell you that I know that  
17 because I was chairing the medicine group, which is  
18 part of the WSMG, that is to monitor the entry of  
19 drugs in Wales, and Wales was one of the first who  
20 actually allowed all the protease inhibitors to be  
21 available to hepatitis C.

22 **Q.** Dr Al-Ismaïl, I'm not going to ask you about the  
23 detail of the vCJD notification process because we  
24 have quite a lot of documentation about that, but can  
25 you recall whether and if so to what extent patients'

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1 risk factor, but some of them may have been given an  
2 appointment but that appointment had to be altered  
3 simply because it came to the attention of the  
4 treating surgeon or physician that special  
5 arrangements need to be made.

6 **Q.** Dr Al-Ismaïl, I have a handful of questions suggested  
7 by others that I want to ask you about next, so we may  
8 dot round from topic to topic now.

9 Could we have, please, the doctor's witness  
10 statement back on screen. WITN3761005. And could we  
11 go to page 20, please.

12 If we look at the bottom of the page,  
13 paragraph 66, you have referred there to  
14 cryoprecipitate being used for patients with  
15 hypofibrinogenaemia, and you explain that's a rare  
16 bleeding disorder. How much cryoprecipitate did  
17 patient with that condition tend to require?

18 **A.** They usually require about ten packs. And it is  
19 something which is -- people still were using even  
20 just before I retired. Simply because fibrinogen was  
21 not licensed. I know that some of my colleagues in  
22 Cardiff were using fibrinogen but we continued to use  
23 cryoprecipitate in patients who have  
24 hypofibrinogenaemia. We continued to use  
25 cryoprecipitate in patients who needed massive blood

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1 statuses of being at risk for public health purposes,  
2 did that cause difficulties for them in terms of  
3 accessing surgery and the like or cause deferments of  
4 surgical procedures?

5 **A.** Well, not in terms of accessing surgery, definitely  
6 none whatsoever, but in terms of deferring,  
7 unfortunately some of the patients forgot to tell the  
8 person they were referred to, and when they were  
9 referred without our knowledge, and by our knowledge,  
10 the haematology department knowledge, the -- whoever  
11 had accepted the referral on the surgical side or the  
12 endoscopy side would have written to me saying: what  
13 am I to do in terms of treatment of this patient?

14 We picked some of these patients through this  
15 way, saying: look, just hold on a sec, this is  
16 a patient who needs special arrangements for the  
17 endoscope because it has to be quarantined, or for the  
18 equipment, if they are not disposable, to have to be  
19 quarantined, did you know about that?

20 And, of course, you know, you tell the patient,  
21 the patient forgets, GP sometimes forgets, colleagues  
22 who have been circulated with a different notification  
23 forget. So -- but in terms of accessing surgery or  
24 accessing endoscopy or accessing any service, no  
25 patient was refused such intervention based on their

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1 transfusion. We had a cardiac centre and so there are  
2 patients who would have, you know, bypass surgery,  
3 patients who would have valve surgery, and they  
4 usually would require cryoprecipitate simply because  
5 they would have massive blood transfusion.

6 So the usual thing is to give 10 units of  
7 cryoprecipitate, check their fibrinogen level, make  
8 sure it is above 2 before you stop giving them  
9 cryoprecipitate.

10 **Q.** Were any such patients in that category infected with  
11 HIV or hepatitis C as a result of their treatment?

12 **A.** Not to my knowledge. Mind you, I think since the --  
13 you know, that all donors were checked for HIV and  
14 then, later, for HCV, then all the donations were  
15 fine. But you can look at cryoprecipitate, in that  
16 context, in a very similar way to looking at a unit of  
17 blood, because many patients were transfused with  
18 blood at times we did not know about hepatitis C, and  
19 testing for hepatitis C really was not done afterward.  
20 And one of the things which I personally believe, in  
21 that every patient who had a blood transfusion or  
22 blood product should have a test for hepatitis C.  
23 It's such a simple test and the treatment is so  
24 effective.

25 **Q.** You said during the course of your earlier answers

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1 this morning that when you were trying to find out  
2 what the various stages were for ordering products,  
3 you couldn't access all of the blood transfusion  
4 records before 1984, and you said that that was  
5 possibly something to come back to. Could you just  
6 expand upon that, please?

7 **A.** I think you have sent me a document last week, and  
8 that is why I thought you may be coming back to it.  
9 So let me tell you a bit more about this.

10 So prior to 19 -- up to 1980, all the blood  
11 transfusion documents, that is blood and blood  
12 products on part of haemophiliacs, were actually paper  
13 documents, and they were since, being many years, been  
14 lost.

15 Then between 1980 and 1984 we acquired the  
16 computer system called TelePath, and -- oh, maybe  
17 before that we acquired a computer system.

18 Anyway, so at 1985 that was changed. It may be  
19 changed to TelePath, and we were told that the  
20 previous computer system we -- would be microfiche  
21 and stored. And -- but that actually -- it was  
22 microfiche but it was unrecoverable, I was told by  
23 the head of blood transfusion, when the first request  
24 from the Infected Blood Inquiry came to the Chief  
25 Executive.

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1 You thought that an explanation for that might  
2 be that DDAVP was ordered by the pharmacy and that its  
3 use may not have been communicated to the person  
4 completing the returns. Who was it who completed the  
5 returns? Was it the centre director?

6 **A.** No, I wish. Well, the centre director, as I said to  
7 you, would not have the time to complete the returns.  
8 These returns have to be done on a daily/weekly basis.  
9 So it was the MLSOs -- and I'm ever so grateful to  
10 them because it's not really part of their job --  
11 until the haemophilia nurse was appointed, and then  
12 the haemophilia nurse was filling the returns. And  
13 we -- as the director, whether it's Dr Khurshid or  
14 myself, looked over the returns and made sure that  
15 there is no major inaccuracies.

16 But the DDAVP would be ordered on a drug chart,  
17 and it still is, which would go to the pharmacy and  
18 the pharmacy would issue the DDAVP. So unless we  
19 highlight that to the person who is doing the return,  
20 the person who is doing the return would not know  
21 about it.

22 When the haemophilia nurse came in, then she  
23 would know exactly what each haemophiliac patient  
24 would have received for any particular treatment. So  
25 any DDAVP would be entered in the patient notes and

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1 In 1985 to 1981 was TelePath, and this is the  
2 one which was microfiche. And then after 1991 until  
3 2003 we changed to another system, called ACT, and  
4 when that laboratory system moved to another system,  
5 called MasterLab, in 2003, all the documents were  
6 transferring to MasterLab.

7 So anything really which was in TelePath -- if  
8 you like, you would not be able to get any  
9 documentation after 1991 from our computer system,  
10 unfortunately.

11 **Q.** After 1991 or 1981?

12 **A.** 1991. So after 1991 -- before 1991 you could not  
13 retrieve anything.

14 **Q.** Are those records of blood transfusions?

15 **A.** Yes.

16 **Q.** They are not records relating to haemophilia patients  
17 or do they --

18 **A.** No, no, the haemophilia records were separate, really,  
19 because, you know, sort of all the time we gave a unit  
20 of cryoprecipitate or a unit of -- or a bottle of  
21 concentrate, that was documented in the patient notes  
22 and then transferred to UKHCDO. So that's different.

23 **Q.** Next question, doctor, you will recall this morning we  
24 talked about the annual returns and the fact that  
25 DDAVP doesn't feature on the returns until 1985.

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1 would be on the chart, so she would know about that.  
2 But the MLSOs, if we do not communicate that  
3 information to them, they do not see the patient notes  
4 on a regular basis or they don't even see the patient  
5 notes, so the onus really was on us to communicate  
6 that to them.

7 **Q.** We can see that the 1985 return does record DDAVP.  
8 Why, if it was being used earlier than that, was it  
9 not recorded on the 1982, '3, '4 runs checked by you  
10 and Dr Khurshid?

11 **A.** Well, I mean, you are asking me something which  
12 I can't give you the answer to. 1985, I took over  
13 checking the returns, and I'm sure -- you have to  
14 remember, when Dr Khurshid was working, and until  
15 I came to the scene, he was working single-handed. He  
16 was doing all the things that two haematologists did,  
17 then three haematologists did, then four, five, six --  
18 six haematologists did in recent years. So, you know,  
19 there is a limit to what a person could do.

20 But I agree if you want for the record, then  
21 you would need to record everything about the patient.  
22 The only tragic thing is that if we did not have the  
23 destruction of the notes of the haemophiliacs, this  
24 Inquiry would have been much better informed about  
25 exactly what happened.

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1 Q. Just picking up on that, doctor, what notes relating  
2 to haemophiliacs were, to your knowledge, destroyed  
3 within Swansea?

4 A. Well, Swansea, and if you look into the Chief  
5 Executive response, has a destruction policy for  
6 notes. And I don't think they differ in any other  
7 health board in relation to that.

8 The haemophilic notes, when we moved to  
9 Singleton, were kept in the haemophilia centre. But  
10 when a patient dies, very often the notes would be  
11 taken by the medical records to prepare the death  
12 certificates. And unless you insist on the patient --  
13 on the notes being returned because you wanted to  
14 complete one thing or another, then that would be put  
15 in with the other notes, and I think after eight years  
16 or whatever they would have been destroyed.

17 As I said, I think one of the good things that  
18 happened in Cardiff is that somehow they stopped the  
19 destruction of these notes by pleading with the  
20 managers and whatever. And I wish I, you know, sort  
21 of -- or Dr Khurshid or any one of us had done the  
22 same. And to be honest with you, until the Inquiry  
23 came into one of the patients who was a mild  
24 haemophilic and then -- I mentioned him earlier, and  
25 I've put him in my statement -- until that patient

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1 is surgery, it would have -- if it's surgery, that  
2 meant that you really need to achieve haemostasis with  
3 50 -- with levels between 50 and 100 per cent, if you  
4 like, in simple terms, all the time for ten days, then  
5 the only way probably would have been concentrates.

6 Q. I asked you questions about discussions that you had  
7 with Professor Bloom about the risks of AIDS. Did you  
8 ever ask Professor Bloom what advice he,  
9 Professor Bloom, was giving to his patients about the  
10 emerging picture on AIDS?

11 A. I think Professor Bloom has, as I said in the morning,  
12 had a few meetings, and we encouraged our  
13 haemophiliacs to go to the same meetings, really, and  
14 he called them all to -- I think he -- to a lecture  
15 theatre and, I think, explained, you know, the issues  
16 as he knew them at the time.

17 The patients who went from Swansea were, you  
18 know, sort of quite comfortable with the meeting.  
19 I did not have any negative things to say from any  
20 patient, you know, sort of reflecting back on the  
21 meeting to me. So that is what happened.

22 And as I said, The Haemophilia Society had  
23 regular meetings, The Haemophilia Society sent  
24 regular, you know, sort of leaflets to patients. We  
25 had a stand in the haemophilia centre in Singleton

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1 I was told that they could not find the notes of,  
2 I said, "Look, it's only a few years ago, two years  
3 ago that I got the notes, how come the notes are not  
4 there?"

5 "Oh, because they were destroyed."

6 I did not know about that policy about  
7 haemophiliacs until that time. But it is one of the  
8 things which, you know, sort of -- it would have  
9 helped immensely, either the Inquiry would have  
10 taken -- been conducted many years back or we did not  
11 have any destruction of the notes. Because then you  
12 would have the facts as -- not just trying to recall  
13 from one's memory 30 or 40 years ago.

14 Q. I asked you earlier about the treatment policy in  
15 relation to mild haemophiliacs and you discussed the  
16 possibility of treating a mild haemophilic with  
17 concentrate if surgery was required. Between 1980 and  
18 1985 or 1986, when heat-treated products became  
19 available, what would the treatment policy have been  
20 for a mild haemophilic who required surgery if there  
21 was no NHS concentrate available and so the choice was  
22 between cryoprecipitate or commercial concentrate?

23 A. Heat-treated or not heat-treated?

24 Q. Not heat-treated.

25 A. Cryoprecipitate would have been preferred. But if it

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1 Hospital whereby we kept these leaflets, including The  
2 Haemophilia Society leaflets, and I distinctly  
3 remember that every time the haemophiliacs would come,  
4 the nurse would say, "Look, have you got this leaflet,  
5 have you got that leaflet", and -- you know, so she  
6 usually prepare a pack for them and give them -- do  
7 that with, you know, whatever else she had in terms  
8 of, you know, sort of freebies and whatever to them  
9 and to the children. So that is the way it was  
10 communicated to the patients.

11 Needless to say, if patients either tested  
12 positive or before they test positive had requested  
13 any information, we would have sat and explained to  
14 them whatever we could. I said that, and I'm  
15 repeating myself again here, is that I kept saying to  
16 my patients that I cannot speculate but I'll tell them  
17 the fact as I know them.

18 Q. Just to go back to my question, doctor, did you ask  
19 Professor Bloom what advice he was giving to his  
20 patients about AIDS?

21 A. I did not.

22 Q. Do you accept that there maybe had been haemophiliacs  
23 or patients with bleeding disorders who were not  
24 members of The Haemophilia Society or not regular  
25 attenders at a haemophilia centre or regularly engaged

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1 with The Haemophilia Society, particularly if they  
 2 were infrequent bleeders and had mild or moderate  
 3 haemophilia?  
 4 **A.** Would you like to repeat the question again, please?  
 5 **Q.** Of course. The question, Dr Al-Ismael, arises out of  
 6 your evidence that you thought patients were very well  
 7 informed and they had access to information from The  
 8 Haemophilia Society or from the nurse at the centre,  
 9 and so on. Do you accept that there may have been  
 10 patients particularly those with mild or moderate  
 11 bleeding disorders, who may not have engaged with The  
 12 Haemophilia Society or the centre on a regular basis  
 13 and may not have had access to information?  
 14 **A.** I suppose there's always that possibility and they  
 15 haven't read the newspapers and they haven't seen TV,  
 16 there's always a possibility.  
 17 **Q.** In relation to the authorisation of purchases for  
 18 commercial products, you said earlier you didn't sign  
 19 invoices or the equivalent. Do you know who did, not  
 20 necessarily by name, but in terms of the role or job  
 21 description of those who signed the invoices or  
 22 authorised the actual purchases?  
 23 **A.** It would have been a finance director of -- it would  
 24 have gone to the finance director's office and, you  
 25 know, whatever arrangement they had there.

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1 **A.** Yes, I do. If we go to -- do you have the returns of  
 2 1985?  
 3 **Q.** Yes, we do. It's WITN3761008. If you go to page 28,  
 4 please, Soumik. So that's haemophilia A. If you go  
 5 on two pages, it should be the return for 1985 for  
 6 haemophilia B.  
 7 **A.** As you rightly said, up to 1984, we didn't have  
 8 a single patient with haemophilia B. In 1985 one  
 9 patient, a 39-year old came in, he actually moved from  
 10 London to us. He was in St Thomas' and I had  
 11 a letter -- the reason why I recall that so vividly is  
 12 because I only looked at it last week.  
 13 I had a letter from St Thomas' to say that  
 14 so-and-so is a patient with severe haemophilia B and  
 15 he's moving to your area. They did not tell me what  
 16 the patient was on, so the first question -- he was  
 17 actually seen by my colleague Dr Beddall on  
 18 2 August 1985, and Dr Beddall recorded that the  
 19 patient is on heat treatment product and that is --  
 20 I could figure out from the notes. So that is why he  
 21 went on heat-treated product.  
 22 I can't -- you know, could not find out whether  
 23 he was started on Alpha and then Cutter or vice versa,  
 24 or whether we started on the same one as he was in  
 25 St Thomas' because St Thomas' letter did not tell us

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1 **Q.** To your knowledge in the 1980s, did the Welsh Chief  
 2 Medical Officer play any part in arrangements for the  
 3 supply of blood and blood products in Wales or in  
 4 providing information to consultants, such as  
 5 yourself?  
 6 **A.** I don't know anything about that, really. I don't  
 7 know whether they had anything. I know that they were  
 8 never named in any litigation but I don't know whether  
 9 they were engaged in any way, in relation to blood or  
 10 blood products.  
 11 **Q.** Then your returns for 1985 and 1986 show that, in  
 12 relation to patients with haemophilia B -- and I think  
 13 the returns prior to that show no patients with  
 14 haemophilia B -- you were using predominantly or  
 15 exclusively commercial Factor IX concentrates. If we  
 16 could have up on screen please, Soumik  
 17 BAYP0000008\_084.  
 18 Go to the last page of this, please. This is  
 19 another internal Cutter document, doctor. We can see  
 20 at the bottom paragraph -- sorry, the last paragraph,  
 21 please -- it says:  
 22 "Most English centres are receiving NHS  
 23 Factor IX. Swansea is an exception."  
 24 Can you recall why you were using predominantly  
 25 commercial Factor IX products in 1985 and 1986?

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1 exactly what products he was on, and my colleague has  
 2 written to Dr Savidge at the time saying can you  
 3 please give me full details of what the patient was  
 4 on, and I could not find a reply in the notes.  
 5 So the reason why we've used the commercial one  
 6 is because the patient was already on heat-treated and  
 7 he was, again, a well-informed patient and he asked  
 8 for heat-treated. At that time we did not have  
 9 heat-treated Factor IX.  
 10 **Q.** You didn't have heat-treated NHS Factor IX?  
 11 **A.** Yes. If you go to the year after, that is 1986.  
 12 **Q.** That should be if you go to page 35, possibly, Soumik.  
 13 Yes.  
 14 **A.** This time there's another patient. This was a 19-year  
 15 old who joined the Swansea University, and he was  
 16 a severe haemophiliac and he was already on NHS  
 17 Factor IX, so he continued on NHS Factor IX and the  
 18 patient on the heat treatment product was continued on  
 19 the Cutter product. So that is why, I suppose when  
 20 you have one patient in 1985, you'd be the odd-one-out  
 21 that is why Swansea was the odd one out.  
 22 **SIR BRIAN LANGSTAFF:** Just pause for a moment. At this  
 23 time, 1986, there would have been heated Factor IX,  
 24 would there not, from the NHS?  
 25 **A.** Yes, I think so.

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1 **SIR BRIAN LANGSTAFF:** Thank you.

2 **MS RICHARDS:** You referred a few moments ago to a meeting

3 or meetings which you understood Professor Bloom to

4 have arranged in a lecture theatre, or equivalent, in

5 Cardiff. Do you know approximately when that took

6 place?

7 **A.** No, unfortunately, I can't tell you, but it was soon

8 after the -- I think -- I don't know whether it was

9 before his patient developed acquired immune

10 deficiency or -- I can't tell you.

11 **MS RICHARDS:** Sir, those are my questions for

12 Dr Al-Ismail. Do you have any questions for him?

13 **SIR BRIAN LANGSTAFF:** Yes, I do just a few, if I may,

14 doctor. Can we go back to your witness statement at

15 page 18. You were asked about this this morning.

16 **A.** Yes.

17 **MS RICHARDS:** WITN7631005, page 18.

18 **SIR BRIAN LANGSTAFF:** Thank you. you were asked about

19 paragraph 56. Now, so far as choosing or selecting

20 a particular product was concerned, you didn't have to

21 ask anyone's permission to select which product to

22 use, did you?

23 **A.** Well, I would ask have asked Professor Bloom and

24 Dr Khurshid would have asked Professor Bloom.

25 **SIR BRIAN LANGSTAFF:** For permission?

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1 Does that answer your question?

2 **SIR BRIAN LANGSTAFF:** Well, it does. You've said, which

3 is consistent with the evidence you gave about when

4 you went with Cutter, you said you'd asked

5 Professor Bloom for his opinion and he'd given you it.

6 But it's in relation to 56(ii). You didn't know the

7 mechanism for purchase. When selecting a product,

8 I understand that you relied heavily upon what

9 Professor Bloom was telling you, but in your answers

10 you gave a further reason, I think, which was that the

11 product had been licensed and you took it on trust, as

12 I understand.

13 **A.** Yes.

14 **SIR BRIAN LANGSTAFF:** So when the -- this paragraph

15 begins:

16 "... the basis of decisions made about the

17 selection of a particular product or particular

18 concentrate for an individual patient."

19 Safety and efficacy came into that. Did it

20 come into that and, if so, how, if what you were doing

21 was placing your trust in the advice of

22 Professor Bloom and the decisions of the regulator to

23 allow product to be sold in the UK?

24 **A.** Would you suggest any other way of putting my

25 decision, because the -- since the Thalidomide

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1 **A.** Sorry?

2 **SIR BRIAN LANGSTAFF:** For permission to buy the product or

3 just for advice as to which to buy?

4 **A.** For advice as to which to buy. The problem I had

5 actually in figuring out how did we buy these

6 products, did we buy them directly, did we -- because

7 there was a paper by Rizza et al that talked about --

8 I think it's one of the documents which you've sent

9 me -- talked about the management of haemophilia in

10 the UK between 1980 or 1991, or whatever. I've got

11 the reference to it if you want and in one paragraph

12 of that paper, it said the commercial product were

13 supplied free to the haemophilia centres in England

14 and Wales until 1992.

15 If you ask me what did that occur or did not

16 that -- and I actually put it in my statement, I said

17 I believe that the commercial product were supplied

18 free based on that paper. The bottom line is I did

19 not know what were the mechanisms of purchasing

20 a product, whether in a, sort of, my health authority

21 was solely responsible for it, or was there a central

22 funding which the health authority had, but in terms

23 of which product to select, Professor Bloom would have

24 been asked what his opinion and we would usually

25 follow it.

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1 disaster happened, no product should have been

2 authorised for human consumption in the UK unless that

3 product has been passed by the -- what is the

4 equivalent of the MHRA previously, that the product

5 should have shown safety and efficacy. In other

6 words, we did not use any product which is not

7 licensed.

8 Professor Bloom's advice would have been on the

9 basis that he would have an experience in what product

10 would probably be more -- be better than others in

11 whatever measures he used. So the safety and efficacy

12 of a selected product, I personally would not have any

13 other way of assessing that.

14 **SIR BRIAN LANGSTAFF:** I see. So this was really relying

15 upon the regulator doing its job properly and, for

16 that matter, those who had more experience, perhaps,

17 in treating those with haemophilia giving you their

18 best advice?

19 **A.** Absolutely.

20 **SIR BRIAN LANGSTAFF:** Thank you. Do you have anything

21 generally to say about what experience has shown you,

22 from your experience, about the nature of the quality

23 of the product that the regulator permitted to be used

24 in the UK?

25 **A.** Well, do I need to say much except that, you know, if

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1 the regulator had known or had any information about  
2 the source of donation which had been used for any  
3 product, these products should not -- in my opinion,  
4 should not have been allowed to be marketed in the UK.

5 Unfortunately, and I say that with, you know,  
6 heavy heart, really, that even in the UK, you know,  
7 the Blood Transfusion Service relied on sourcing blood  
8 from prisoners at some time I was told. I can't tell  
9 you the figure but I'm sure you would have access to  
10 that information.

11 I think if the regulator had any information  
12 about the skid row type of donations that were used to  
13 prepare the product -- foolishly, probably they  
14 thought hepatitis B, once it's excluded everything is  
15 fine. And that is clearly not a way forward for  
16 anybody who would think at any time, even now, that we  
17 know everything about what blood and blood product  
18 could transmit.

19 So, yeah, I think the regulators at the time  
20 has really failed in making sure that whatever is  
21 marketed in terms of blood and blood product, whether  
22 that is from abroad or from the UK for that matter,  
23 should really have had probably proved more safety  
24 than, you know, sort of just to be taken that  
25 hepatitis B was excluded.

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1 think -- in medicine, you are always seeing your  
2 seniors and making decision and convincing the  
3 patient. In haematological malignancy, it did not  
4 work like that because, as I said, even though you may  
5 have a good treatment and even though that treatment  
6 may actually be curative, you may lose the patient  
7 just through the side effect of the treatment. So you  
8 explain to the patient what are the risks and possible  
9 benefits and then you put it to the patient and ask  
10 them for a decision.

11 Very often and most of the time the patients  
12 will take the decision that they would go for  
13 a particular treatment. But I had a number of  
14 occasions when I was a consultant and I sat with  
15 a patient and explained the diagnosis and the  
16 treatment, and the fact that once I start the  
17 treatment they have to spend about a month in hospital  
18 before the second course of treatment, and then they  
19 ask me what are the chances of them recovering  
20 completely and I explained the percentage, they turned  
21 to me and said, "No, thank you very much. I'd rather  
22 go home and come back to you and have a blood  
23 transfusion whenever I need it, and how long am  
24 I likely to live?" And I would say, well, you know  
25 about half of the patients will die within three to

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1 **SIR BRIAN LANGSTAFF:** Can I turn to something else.

2 You said, in one sentence which caught my ear  
3 in particular, in haematological malignancy you truly  
4 can't take a decision for a patient. That was my note  
5 of what you said. What struck me about that was the  
6 word "truly"; you truly can't take a decision for  
7 a patient.

8 Does that reflect your general understanding  
9 that other clinicians in the country sometimes did  
10 take decisions for patients? There were certain  
11 circumstances in which you in particular found you  
12 simply couldn't?

13 **A.** I can't speak in general like this but I know that --

14 **SIR BRIAN LANGSTAFF:** Well, I'm asking you about what you  
15 said, you see, and the word "truly" did strike me.

16 **A.** I was trained in, in terms of haematological  
17 malignancies, in Cardiff, and that was most of the  
18 training. I remember what my consultant,  
19 Mr Jack Whittaker, used to do with leukaemia, and  
20 I sat with him and -- when he discussed a new  
21 diagnosis with a patient and their family, and I was  
22 taken back for the first time I noticed that  
23 a consultant cannot really tell the patient what to  
24 do. I did not -- you know, it's not something which  
25 you experience before when you become a junior. You

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1 six months. And he said, "I'll take that". I had  
2 that occasion.

3 And so -- and I think that in a way is the  
4 current thinking, not just in cancers and haematology  
5 and whatever, in modern medicine is that you really  
6 explain -- you try to empower the patient, to give  
7 them as much knowledge as you can convey to them in  
8 as simplified way as possible without going into  
9 details of path of physiology and whatever, and try to  
10 get the patient to make the decision for you.

11 **SIR BRIAN LANGSTAFF:** So the way you see it, is it, is  
12 that treatment is something that is done for a patient  
13 rather than done to them?

14 **A.** Yes. My role is to explain to the patient to the best  
15 way I can as what are the conditions they have, what  
16 is the ailment, what can we offer them, what does that  
17 mean in terms of their quality of life, what does that  
18 mean in likely change to their longevity and their  
19 survival, and may even when they ask for a graph, show  
20 them the graphs, and then ask them what they want to  
21 do. And try to encourage them not to make an  
22 instantaneous decision, try to encourage them to go  
23 away, read about that. I always told patients when  
24 the internet became available: please do go on the  
25 internet if you wish to go on the internet, read as

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1 much as you like, come and talk to me because I would  
2 only tell you what I know as facts.

3 I found that really so easy with the patients,  
4 because I don't really need to write in full details  
5 every single word I've told the patients. I would  
6 almost certainly know what I have told patient A and  
7 patient B, because it will be exactly the same.

8 **SIR BRIAN LANGSTAFF:** The next question I'd like to ask  
9 you, again comes from something that you were  
10 describing, which is when you were talking to patients  
11 about HIV, and you said the conversation might go  
12 something like, and you described how the patient  
13 might say, "Well, will I die of it?" and you'd say,  
14 well, you don't know but you will be checking.

15 **A.** What I would have said -- I said some patients would  
16 die. How long -- whether you would be one of these --  
17 this is the very early days, when we did not know how  
18 long a patient is going to be. You see, if I could  
19 take you back a bit, when people started talking that  
20 this acquired immune deficiency is all related to  
21 antigenic stimulation. Now if that was true, that  
22 meant some patients may have this antigenic  
23 stimulation for years but they did not show any  
24 problem with HIV, while others are showing it now.  
25 Even when the virus was discovered and we found that

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1 the sense that if you did not err on the side of  
2 optimism, it would have been very difficult to  
3 continue with one's career really.

4 There isn't a treatment. There isn't anyone  
5 who will tell you in which path these patients are  
6 going to go. At least in haematological malignancy  
7 you have so many parameters that you could plot and  
8 you could say to the patient: this is the patient in  
9 the very high risk group, this is the patient in the  
10 lower risk group. You didn't have any of that. The  
11 only thing you had was to watch and wait. And until  
12 such a time as then the -- you start to learn what to  
13 try to avoid or protect the patient against in terms  
14 of infections, and you use that. But these were all,  
15 if you like, preventative of secondary infection. It  
16 was only when the real treatment came in that we could  
17 see the light at the end of the tunnel.

18 Prior to that it was terrible.

19 **SIR BRIAN LANGSTAFF:** Hepatitis C or non-A, non-B, I think  
20 you described a very similar conversation that you  
21 might have in respect of that, that you didn't know  
22 what the consequence of that infection would be, but  
23 we'll keep checking.

24 How would you have checked? How did you check?

25 **A.** Well, by, as I said patients, would have maybe once

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1 it is a virus which is causing it, the number of  
2 patients going down and unfortunately succumbing to  
3 the infection, initially, were very small, compared  
4 with the positivity in terms of antibody, and we  
5 thought, or we hoped, that it is going to be something  
6 which is not that disastrous.

7 Unfortunately, we all were proven wrong and  
8 I think that is, in a way ... yes, that was the  
9 tragedy, really.

10 **SIR BRIAN LANGSTAFF:** Do you want to say any more about  
11 that?

12 **A.** Well, not in the sense that, you know, sort of -- you  
13 know, the initial thinking that the HIV maybe is going  
14 to be different in the haemophilic -- on the other  
15 patients' group, because the haemophilic did not have  
16 any other what we thought contributing issues, all  
17 proved to be wrong.

18 **SIR BRIAN LANGSTAFF:** Do you think that you, collectively,  
19 erred on the side of optimism?

20 **A.** Yes, I think -- and I think the reason why we erred on  
21 the side of optimism is because, if you like, by the  
22 time we -- the test became available to us -- and as  
23 I said, all the patients with the first lot of testing  
24 proved to be positive, and we -- really, that was  
25 the -- if you like, the only thing you could do, in

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1 a year ultrasounds of the liver. Looking for the  
2 stigmata of liver disease, because when you start to  
3 develop cirrhosis there are certain things which you  
4 could see on the skin. You could see on the palm of  
5 the hand, you could see in the development of ascites  
6 you always relied on your hepatology colleague to have  
7 a look at your patients every now and then and tell  
8 you, well, nothing has changed really, the patient is  
9 told the same. The hepatologists are very familiar  
10 dealing with different liver disease the auto immune  
11 disease, the alcoholic liver disease, the different  
12 type of liver diseases. So they really have a better  
13 understanding of what to look for in a patient.

14 I remember, and I think the Inquiry have asked  
15 me about one particular patient I referred to  
16 Dr Kingham, and his registrar wrote to me back saying  
17 "We're going to adopt a policy of watch and wait",  
18 because they knew what they were doing. They were  
19 testing for the virus in the blood but they knew what  
20 are the issues to look for. Liver biopsy, certainly  
21 in, you know, in my practice or in Cardiff practice  
22 was not something to be undertaken lightly.

23 Later on when Dr Chinlye came to hepatology he  
24 actually could do liver biopsy through an endoscope,  
25 so if there would be any bleeding it will be much

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1 manageable, but he did not do it any of the  
 2 haemophiliacs. Then the issues, you know, about  
 3 FibroScan became available and, as I said, with the  
 4 hepatitis C, I think it is a sad story, but the happy  
 5 ending is that, for the vast majority of the patients,  
 6 the effective treatments came into effect, and  
 7 I think, or we're hoping that all these patients would  
 8 have a normal life expectancy.

9 **SIR BRIAN LANGSTAFF:** Thank you. The last thing which  
 10 I want to ask you about is in respect of the number of  
 11 patients of yours who converted to HIV seroconverted,  
 12 and I think you said there were eight.

13 **A.** Yes, six adults and two children, yes.

14 **SIR BRIAN LANGSTAFF:** Now, roughly what proportion of  
 15 those patients that were loosely under the care of the  
 16 Swansea centre, roughly what proportion was that?

17 **A.** What proportion of all the patients?

18 **SIR BRIAN LANGSTAFF:** Yes.

19 **A.** So it's eight out of -- I think at that time we  
 20 probably had 60 patients, so 8 out of 60 or  
 21 68 patients. So it's about -- you know, more than --  
 22 it's about 12 per cent.

23 **SIR BRIAN LANGSTAFF:** Yes. We get -- 8 out of 60 might be  
 24 15 per cent, perhaps, but it's something of that  
 25 order.

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1 into practice and the heat treatment came into  
 2 practice.

3 So the number of infusions they had, as I said,  
 4 would be very, very, very lucky severe haemophiliacs  
 5 to have escaped it. But fortunately, you know, some  
 6 of them did survive it, and we managed to get them the  
 7 treatment. And I hope -- well, there's -- even  
 8 though, you know, the treatment itself is not an easy  
 9 panacea, they did have so many side effects with  
 10 a different treatment, but at least in terms of life  
 11 expectancy then we would be able to say that hopefully  
 12 they would live an almost normal or normal life  
 13 expectancy.

14 But the unfortunate ones are the ones who  
 15 actually succumbed to the infection before  
 16 an effective treatment became available to us.

17 **SIR BRIAN LANGSTAFF:** Thank you very much. That's all  
 18 that I have to ask.

19 Ms Richards.

20 **MS RICHARDS:** Dr Al-Ismaïl, is there anything further that  
 21 you wanted to say?

22 **A.** If I may, I would like to make a brief comment really,  
 23 a brief statement. Would I be able to do that?

24 **MS RICHARDS:** Yes.

25 **SIR BRIAN LANGSTAFF:** Yes, indeed.

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1 The reason I ask -- oh, let me ask, how many  
 2 severe haemophiliacs were there in that 60 or so?  
 3 Roughly.

4 **A.** I think all the severe haemophiliacs became  
 5 HIV positive.

6 **SIR BRIAN LANGSTAFF:** Thank you.

7 Do you have a reason that you can tell us, from  
 8 your experience, why you think it was that all the  
 9 severe haemophiliacs should suffer from HIV infection  
 10 and largely the mild and moderate haemophiliacs did  
 11 not?

12 **A.** Well, it's all to do with their treatment. It's all  
 13 to do -- I think "should" is not the right word, with  
 14 all respect. They were unfortunate to suffer with  
 15 the HIV simply because the treatment they needed  
 16 conveyed that infection on them.

17 Now the mild who -- the occasional mild who may  
 18 have had a concentrate, you know, on the laws of  
 19 probability it's probably that concentrate did not  
 20 carry the virus, but for the severe haemophiliacs, the  
 21 number of infusions they would have, they would be  
 22 very lucky to escape the HIV virus, considering the  
 23 fact that, you know, sort of the issue probably  
 24 started in the late 70s and continued until 19 -- you  
 25 know sort of when the testing of donors for HIV came

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1 **A.** Well, I've written it down so I didn't want to miss  
 2 any important points.

3 What I'm saying is that I firmly believe that  
 4 the most devastating experience for a doctor is to  
 5 witness harm inflicted on his or her patient that  
 6 resulted from treatment the patient had received.  
 7 Now, this feeling of devastation is felt regardless  
 8 whether the harm occurred unintentionally and even if  
 9 the harm could not have been foreseen.

10 Now, I've seen that, particularly in the  
 11 haematological malignancies, as I said some of them  
 12 are curable, but the patients succumb because of the  
 13 infection which followed when the treatment -- you  
 14 know, as a result of treatment and their immune  
 15 suppression. So that had a devastating effect on the  
 16 whole department.

17 Now, I believe that feeling of devastation is  
 18 shared by many of my current and previous colleagues  
 19 that looked after the patient with haemophilia and  
 20 other inherited bleeding disorders. I would like to  
 21 mention specifically in that context, if I may, the  
 22 late Professor Bloom.

23 Now, Professor Arthur Bloom, as I said before,  
 24 was one of the most gentle, kind, compassionate and  
 25 caring doctors that I knew. He was also an excellent

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mentor. I think it is true to say that his main aim in his professional life was to improve the care and outcome for the patients with inherited bleeding disorder.

Arthur was a wise man, truly wise man and, hence, you find that his involvement in so many national and international advisory groups, really, in haemophilia and allied disorders. As I said before, he was never, never an opinionated man, always listened to the views of his patients and, as I said, he used to sit down on the side of the bed of the patient and give the patient as much time as the patient want, but he also listened to his colleagues.

Now, he taught us about the devastating effect of haemophilia on the life and well-being, not only of the patients but also their families as well. He really drilled that into us. Now, I remember this anecdote, there was a very pleasant young man in his late teens with severe haemophilia. He was from the Far East and was referred to Professor Bloom for advice and management in Cardiff. Now, that patient -- I think that was second or third year I was in Cardiff -- now, that patient had the most deformed joints I've ever, ever witnessed.

Now, I remember I told the other registrars who

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11 out of the 13,000-odd patients had AIDS, like it was, you know, as we knew then.

I think he thought that, unlike the transmission of AIDS -- and I'm talking 19 -- early 1983 -- that unlike the transmission of AIDS in the IV drug addicts and homosexuals, the causative agent maybe could have been attenuated or modified in the process of preparing the concentrate and that there were other mitigating factors in the non-haemophiliacs.

You know, he wasn't alone in these thoughts. If you look at the publication that came in the early 80s, as to the possible cause of AIDS, the publication -- the number of publications testified that the world leaders in haemophilia held similar views. Now he documented so many of that in the report he prepared in 1989 as part of the defence against the litigation raised at the time.

Now Swansea and its staff and the West Glamorgan Health Authority were never named or never had to answer any litigation in relation to the management of haemophilia or other inherited bleeding disorders. But Arthur sent me a copy of the report, and he did that because some of the patients who he looked after were shared with Swansea, and he said,

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were not doing haemophilia at the time that we had that and they would go and ask Professor Bloom whether they could go with him and see the patient because none of us have seen such terrible joints.

Now, Professor Bloom told us that such picture was not unusual, not uncommon in the UK, before the advent of concentrate. Now, I taught medical students, you know throughout my career but, you know, sort of from the 2000s onwards, or maybe before the 2000s, it's difficult when the session comes to talk about haemophilia and try to show them a young patient with haemophilia and at the age of 40 with a deformed joint, fortunately, you will not find one.

I do believe that Professor Bloom became aware, maybe in the early '80s that acquired immune deficiency could be transmitted by treatment for haemophiliacs. I believe that -- not just believe it, I think he may have mentioned it to me that he thought initially perhaps not going to be a big issue. His belief was perhaps based on the small number of the haemophiliacs that showed the clinical disease initially, but he also did the survey in 19 -- end of 1983/84. He published in 30 June, and that survey, as I said, included 13,147 patients, from 121 haemophiliac centres in the UK and Europe, and only

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"You know, I think you should read this". And to be honest, I read the report and I understood so many of the issues that must have made him say what he said at the time. Now I'm sure the Inquiry would give due consideration to his report, but I truly wish that his report would be made public, and the reason for that is so that patients and their families could read the facts as he saw them and he stated them in the report.

Now, I knew he was so concerned about the pain and suffering that haemophiliac could endure if the concentrate were abandoned, particularly when there was no credible alternatives. And I repeat I did not think that cryoprecipitate was a credible alternative. Again, that was not just his views but the vast majority of world leader in the care of haemophilia, as well as the doctor specialised in the haemophilia care in the UK, Europe and North America. I think he addressed The Haemophilia Society Council in October 1983 and he said that in his report -- he said that he became more circumspect than previously with regard to blood products and AIDS.

Now he suggested to the meeting at the time, that is in October 1983, two months after the death of his first patient, he asked if the role of concentrate could become -- he said until the role of concentrate

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became clearer it would be wise to revise the dosage and the treatment for haemophiliacs and ask if the haemophiliac could modify their lifestyle to reduce the need for these concentrates.

He reported in his report that he met with very poor reception by the audience, and I've read the same thing in -- when it was mentioned by the National Haemophilia Federation, which is similar to the Haemophilia Society in the US and the World Federation of Haemophilia.

Finally, I explained that the worst nightmare for a caring doctor is to witness the ill effect of the medication on their patients.

Now, I truly witnessed that on Arthur. The last time I saw him was -- was on 18 September 1992. I think it was a UKHCDO meeting. Now, I had not seen him before that meeting for quite a long time, actually, and I was taken aback. You know, whenever we used to meet, he was full of -- he had a big smile on his face and whatever, but he was looing -- he really looked terrible. He was so down and clearly was, you know, sort of -- something which is troubling him immensely. I said to him, "Arthur, what's the matter?" and he said "Oh, it's my gait, I'm having problem with my gait". Then when I pressed him

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**SIR BRIAN LANGSTAFF:** I am sorry too for those who have been listening remotely that they may have been on the screen for much longer than they too had anticipated, because they too are part and parcel of this hearing. But can I thank you in particular for giving us a view of what it was like to be in a much smaller centre, close to a centre of influence and knowledge, in Cardiff, and for giving us your views, from being the trainee doctor to taking up your role in 1984/85 in Swansea at the various places that you operated. The Inquiry is grateful to you for that and for your full answers in your statement. So thank you very much.

**A.** Of course.

**MS RICHARDS:** Sir, tomorrow we have Dr Mitchell at ten o'clock.

**SIR BRIAN LANGSTAFF:** Ten o'clock tomorrow. Dr Mitchell.

Thank you.

(5.45 pm)

(Adjourned until 10.00 am the following day)

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I really did not ... I thought: this can't be true.

I asked him about his family, could it be his wife, could it be his children, and he said no.

Then I really continued to press him because he really looked terrible, and then he looked at me and said -- I'm sorry. He said, "Saad, our patients have come to great harm". Now I firmly believe that the thought tormented him for the rest of his life.

Now that is regardless of the fact that he and my colleague, Dr Les Moffatt, had published a series in 1985 in The Lancet to say that he -- they did a look-back and they found that their HIV conversion started in 1980s. So he knew that he could not have changed much of what happened later on, but that made no difference to him. And I really feel that until he died that feeling of sadness stayed with him. It did not make a difference to his feelings of sadness for the haemophilia patients, what they had to go through and what they are currently going through as well.

Thank you.

**SIR BRIAN LANGSTAFF:** Well, thank you, Dr Al-Ismael. I'm sorry that we've kept you here for longer than you might have anticipated but you don't have to come back tomorrow.

**A.** Thank you.

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(56) genito-urinary... - heard

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[6]</b> 67/8 67/17 68/16 76/4 115/20 165/5 <b>I see [3]</b> 16/15 94/17 164/14 <b>I sense [1]</b> 101/9 <b>I sent [1]</b> 144/21 <b>I shall [1]</b> 87/12 <b>I shared [1]</b> 129/23 <b>I should [1]</b> 103/8 <b>I signed [1]</b> 43/14 <b>I simply [1]</b> 47/20 <b>I speak [1]</b> 107/7 <b>I spoke [2]</b> 17/11 107/8 <b>I start [1]</b> 167/16 <b>I started [3]</b> 11/6 52/17 70/6 <b>I still [2]</b> 64/16 68/8 <b>I summarised [1]</b> 133/8 <b>I suppose [3]</b> 31/19 157/14 160/19 <b>I suspect [4]</b> 31/24 37/20 141/13 145/3 <b>I taught [1]</b> 178/7 <b>I tell [2]</b> 96/13 139/8 <b>I then [1]</b> 56/21	<b>I think [140]</b> 1/9 1/19 6/4 6/10 7/3 11/23 12/17 13/3 13/9 20/18 20/19 22/23 24/23 24/25 29/14 30/21 33/6 34/3 34/14 34/15 34/19 35/18 36/12 37/3 37/22 39/19 40/12 41/3 43/4 43/17 44/14 44/17 46/20 50/4 50/11 50/23 54/10 56/14 56/16 56/16 56/24 57/8 59/3 59/15 61/25 63/3 69/1 69/5 69/21 71/8 71/13 72/3 72/15 73/1 75/2 76/15 76/22 78/3 81/17 82/19 83/1 88/19 88/20 88/22 89/14 89/19 95/12 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