Witness Name: Dora STUART
Statement No. WITN0086001
Exhibit Nos. WITN0086002 to WITN0086151
Dated: 14th July, 2022

INFECTED BLOOD INQUIRY

WRITTEN WITNESS STATEMENT

OF

DORA STUART

I provide this statement in response to a request under Rule 9 of the Inquiry Rules, 2006 initially dated 2nd November 2018 and reissued on 12th July 2022.

I, Dora Stuart, will say as follows:-

Section One - Introduction

1. My full name is **Dora Stuart** (née Low), and I was born on GRO-C 1954. I am a retired National Health Service (NHS) Staff Nurse currently living alone at an address which is known to the Infected Blood Inquiry.

2. Using this statement, I intend to inform the Inquiry of my late husband, Alastair Stuart, and in particular how, as a patient with Acute Leukaemia, he became infected as a result of him being given contaminated blood by way of transfusion whilst being treated for leukaemia.

3. Alastair contracted Hepatitis C (also referred to within this statement as Hep' C and / or HcV) and subsequently developed directly associated health issues, primarily liver cirrhosis. Hep' C infection was a major contributory factor to his untimely death at the age of just sixty three.

4. I intend to speak of the nature of his illness, how he came to be infected, the impact of that infection upon him, our lives together and across our family and friends, and of the treatment he received.

5. **Alastair Stuart** GRO-C **/1954 to 10/06/2017)** was born in GRO-C GRO-C Scotland where he grew up, courted, married, settled down, worked, and sadly passed away in a house just a short distance from that in which he had been born. He was a hard-working man who trained as a welder.

6. Having trained as a welder, Alastair worked for a few different firms in his local area, starting out making power tools for 'Mitchells,' before moving on to work for Gray's of Fetterangus, making and designing agricultural equipment. They were all difficult, skilled manual jobs each of which he completed to a very high standard. Something of a perfectionist, he was well thought of and respected across his trade in which he became highly skilled and well known. He also worked part-time as a coach driver over weekends, from the late 1980's to the mid-1990's.

7. Prior to our meeting I had trained as a nurse and became a Staff Nurse working at a hospital in Aberdeen. It was a profession which to me was more than just a job, and I found it highly rewarding and enjoyable although at times very hard work.

8. In the early 1970's, I moved from GRO-C where I met Alastair. This would have been in my late teens / early twenties. We fell head over heels in love with one another and married in 1978. We settled down in GRO-C where we had two children, a boy (born in 1980) and a girl (our eldest, born in 1979) who attended the local school – we were very much part-and-parcel of the local community into which Alastair had been born.

9. My daughter has assisted me with providing this statement and was present on the two occasions when I met with members of the Infected Blood Inquiry staff in order to do so. She has also been of great help to me in securing Alastair's medical records, 'to assist' the Inquiry.

10. Throughout this statement I have relied upon these notes for dates and events where my memory, with the passage of time and the fact that there were a large number of significant occurrences, fails me or is unclear.

11. Alastair experienced a couple of problems with kidney stones, besides that he was a fit and healthy man.

Section Two - How Infected

12. Alastair's health first took a turn for the worst in April 1991. On 8th April, 1991 he went to see his General Practitioner (GP), a Dr G. S. Gordon to whom he presented with symptoms of an Upper Respiratory Tract Infection and what appeared to be Pyorrhoea (please see my **Documentary Exhibit WITN0086002**, now attached).

13. Upon examination, the GP told Alastair that he was suffering with Influenza ('the flu') and prescribed two separate medicines to assist him – neither of which had any effect.

14. The following day, Alastair went to see his dentist as his gums were bleeding and had been for several days. Alastair had thought that the problem was related to an ill-fitting dental plate, but his dentist, upon examination, thought differently (again, please see my Documentary Exhibit WITN0086002) and he was referred back to his GP.

15. Seeing Dr Gordon again, the GP referred him to the local hospital, Fraserburgh Hospital for blood tests – he requested a full blood count with a view to establishing what the issue was. The results suggested Acute Leukaemia, something none of us had previously had any cause to suspect.

16. The Aberdeen Royal Infirmary called our home to tell us the results, and spoke to our daughter, telling her that Alastair needed to present himself to the Aberdeen Royal Infirmary (ARI) for examination the following day. I accompanied Alastair to this consultation, and thereafter the ARI became his main source of care.

17. On 11th April, 1991, following examination, Alastair was admitted to the ARI with his 'flu-like' symptoms and despite there being absolutely no known familial history of any such health issue, he was diagnosed as having Acute Myeloid Leukaemia.

18. As an inpatient of the ARI, Alastair received his first course of Chemotherapy but his treatment by this means was complicated by virtue of a number of infections he succumbed to, his immune system having been drastically reduced, but they were all successfully treated with antibiotics.

19. A Hickman Line was inserted, to facilitate the continuation of his treatment, and on 15th May, 1991 he was discharged having undertaken to return to the hospital on 21st May, 1991 for a second round of Chemotherapy treatment. All of this passage of his treatment is summarised, albeit briefly in a medical note of 15th May, 1991 by a Dr Reid (please see my **Documentary Exhibit WITN0086003**).

20. Alastair's flu-like symptoms lasted for about seven days. He had a cough, headache, bleeding gums, nosebleeds and kept shivering. The main clinician of the ARI, treating his leukaemia was a Dr Audrey Dawson and she noted that he had been bleeding into his skin and was at times feverish.

21. As a result, Alastair was given a blood transfusion during the course of his time as an inpatient, and additionally given platelets as well as intravenous antibiotics (please see my **Documentary Exhibit WITH0086004**, a letter dated 20th May, 1991 from Dr Dawson to Alastair's GP).

22. Between April 1991 and 1993, Alastair received platelets and / or blood transfusions, all administered through the ARI. If he was feeling poorly when attending for a routine appointment / check-up, he would receive a transfusion as a day case rather than following admission, and each time was usually given two units of blood, but this was all dependent upon blood tests results, his blood having been tested each time he presented himself.

23. I think that Alastair was given a transfusion of platelets on two or possibly three occasions, which I understand to be quite rare in comparison to the frequency of his being given blood, which was the norm', but whatever he may have been given, Alastair always reported that he felt all the better for it.

24. As can be seen from the letter of Dr Dawson, his Hickman Line both became infected and had fallen out, having to be reinserted under a general anaesthetic on 22nd May, 1991. He also had a Marrow Aspirate, a procedure where bone marrow is taken for examination to determine whether or not a patient may be in remission.

25. I believe that a later NHS 'look-back' exercise identified that Alastair had been infected with HcV via a platelet transfusion given on this date (22nd May, 1991), as later described within this statement (please see paragraphs 101 – 103, 173 – 174 and 193 - 194 of this statement).

26. On 3rd June, 1991 Alastair appeared very pale and was found to have a white cell count of just one with some mild bleeding into his skin. He was admitted overnight into the ARI, directly from a clinic check-up appointment, and where he was then transfused with four units of 'packed cells.'

27. I now refer to a letter of 5th June, 1991 written by Dr Dawson to Dr Gordon (Hospital Consultant to General Practitioner) in which this procedure is described as having passed *"without incident,* and which goes on to state that *"... his platelet count had fallen to 30 with a low MPV, and his white cell count was 1, but he was not infected"* (please see my **Documentary Exhibit WITN0086005**, now attached).

28. By this time, enquiries had been made of Alastair's siblings with a view to finding a suitable bone marrow donor for him as his condition was that poor, and they duly submitted to blood tests with his brother William Stuart having been found compatible. William agreed to become a bone marrow donor for his brother Alastair, and as he was a fisherman was keen to provide his marrow prior to setting out to sea again. Sadly, William has now also passed away.

29. Alastair had to be readmitted to the ARI between 7th June and 10th June, 1991 as he had been found to be *"fairly purpuric,"* and his white cell count had fallen to just 0.4. He was again transfused with platelets, and the procedure was again noted as having passed *"without incident."* He was told that during this episode, he was at the lowest point (re. his white cell count) following the second round of Chemotherapy he had received (this episode is mentioned in my **Documentary Exhibit WITN0086006**, a further letter of Dr Dawson to Alastair's GP, dated 21th June, 1991, now attached).

30. The ARI admitted Alastair for a third course of Chemotherapy Treatment from 20th June, 1991 and 25th June, 1991.

31. Unfortunately, I do not know the exact date, but a short while later, sometime in July, 1991, Alastair had to be readmitted to the ARI when he was found to have a very high temperature and Pneumonia It was an episode described within his medical notes as having been directly attributable to Severe Post-MACE Chemotherapy Aplasia, together with Pneumonia.

32. Between 29th July and 2nd August, 1991 Alastair was again admitted to the ARI, this time for a fourth and final round of Chemotherapy Treatment.

33. I should like to add at this time that the ARI in Aberdeen was / is a 90 mile round trip from GRO-C , and because there was nowhere else nearer (our 'local' hospital not being equipped or staffed to deal with such patients) it was a journey Alastair was having to make on a frequent basis, spending only a short time at home with his wife and children before having to go back into hospital again.

34. Neither of our children had entered their teens by the time of their father having fallen ill, and with him being so poorly and hospitalised so far away, it was a most troubling time for them and took place during their most formative years.

35. On 8th August, 1991 Alastair returned to the ARI for a check-up and was found to have a falling blood count. He had also experienced several bouts of a high temperature and was therefore admitted to the hospital again where he remained until 31st August 1991. As an inpatient, he additionally experienced fevers and episodes of Melaena and as a result was transfused with packed cells, platelets and was additionally given some intravenous antibiotics.

36. On 2nd September, 1991 Dr Dawson wrote to his GP describing the above and actions taken at the hospital (please see my **Documentary Exhibit WITN0086007**, now attached). She told his GP that in so far as his leukaemia was concerned, he had completed chemotherapy treatment, and that the next step would be a bone marrow transplant.

37. His illness and the various rounds of treatment received had, by now, been quite debilitating and the low white blood cell count left him feeling completely exhausted. He was only then in his thirties, but was gravely ill, unable to return to work and had been placed on long-term sick leave as his leukaemia was being treated.

38. As a previously strong, hard-working man with a sound work ethic, Alastair found it very hard to adapt to his new situation, especially as he wasn't returning to a level of fitness where he could return to work or simply enjoy time with his young family.

39. On 6th September, 1991 a two centimetre deep, mobile, non-tender node was found in his groin, very worrying for us all, but a further marrow aspiration procedure was conducted (24th September, 1991) with a result that he appeared to be in remission.

40. All the same, he remained unwell and was due to return for a further clinic appointment on 11th October, 1991. In the week preceding this consultation, he suffered a fall, and his tube became infected with a profuse growth of Staphylococcus Bacteria. He had to be given more antibiotics to address this infection, but being successful the course was discontinued later that same month.

41. On 1st November, 1991 his Gamma GT results were found still to be raised, but were falling and his platelet count had also fallen a little. Dr Dawson said that she did not think that he had an ailment suggestive of a Cytomegalovirus Infection (CMV) as found with some immunosuppressed patients.

42. At a clinic review on 11th November, 1991 his clinicians were concerned that his platelet count had fallen again, and that the Hickman Line was still showing a profuse bacterial growth (Staph Epidermidis Infection), which they swabbed to test.

43. On the 'up-side,' he had put on some weight, having lost a good deal, but he had also developed a brown coloured discharge around the Hickman Line and his platelet count was again a little lower. A Liver Function test was conducted and CMV Titre was checked at a further clinic review on 15th November, 1991.

44. On 19th November 1991, Alastair's care was temporarily moved from the ARI to the Glasgow Royal Infirmary (GRI) where he received radiotherapy and a bone marrow transplant from his brother William before being discharged home to convalesce on 23rd December, just in time for Christmas at home with his family.

45. My **Documentary Exhibit WITH0086008** is a medical record detailing the above admission, albeit in brief as I only rely upon one page of a broader document. It is the GRI record circulated to Dr Dawson and Alastair's GP (shown on the record as having been a Dr Hayworth, but it was a group practise of GP's).

46. The record shows that both brothers, Alastair and William were CMV negative and that Alastair had been given, *"... exclusively negative blood products which were irradiated on each occasion ..."*

47. It strikes me, and by reference to this note I believe I can offer the suggestion, that the clinicians of the GRI knew that they needed to proceed with all due care and attention to infection control measures and requirements, particularly as regards transplant patients. They appear to have used appropriate materials (e.g. 'irradiated' blood products), and Alastair was kept in an isolation room with his visitors having to sit behind screens following this operation – contact was strictly controlled and limited to a 'needs only' basis (i.e. clinical staff only).

48. Returning to a point I have previously raised as to the return trip from GRO-C to Aberdeen, the return trip to and from Glasgow was at least a seven hour round trip, again as there was nowhere any closer to home where these procedures could have been performed.

49. Fortunately, the bone marrow transplant using his brother as a donor was a huge success and Alastair's health improved greatly after Christmas 1991. Check-up results were far more positive, and Alastair was told that although he would need to wait for some five years or so before he could be formally told that he was in remission, his leukaemia appeared to have completely disappeared. All the same, as part of the process towards remission, he was required to return to the ARI at regular intervals for check-ups to monitor his condition.

50. At some time prior to 6th January, 1992 Alastair had been given CMV negative irradiated platelets (please see my **Documentary Exhibit WITN0086009**, now attached).

51. As time passed, and Alastair continued to make good, steady progress, evident from the results of blood test monitoring, his clinic appointments were reduced from monthly, to quarterly, biannually and eventually to just an annual consultation. His doctors (ARI) continued to conduct blood and bone marrow tests, but no further treatment was deemed necessary, albeit that doctors were cautious and would not state that he was 'clear' of leukaemia, it merely appeared that he had it 'well under control.'

52. There were, all the same, a few minor health setbacks, and Alastair did not know, as he had not been told, that he had Hepatitis C.

53. On 13th January, 1992 Alastair was found to have developed Thrush and the wound sites from his marrow transplant were inflamed, although settling down. By 28th January, 1992 he had been 'off of his food,' with little or no appetite. He was also retching and coughing, all of which we attributed to Septrin which he was taking. He had been vomiting most mornings, so his medication had to be changed (as of 4th February, 1992).

54. A couple of weeks later, on or around 25th February, 1992 Alastair was noted as presenting himself 'clinically normal' with a 'normal blood count,' but he had developed a minor rash. It was suggested at the time that this may have been attributable to his having used a particular cream to his face to try to address some dry skin issues he had been experiencing (please see my **Documentary Exhibit WITN0086010,** now attached).

55. By 2nd March, 1992 this rash had increased in size and voracity and he had developed Papules on his face and back. His lips had also swollen. He was prescribed some Piriton and antibiotics, but the latter were subsequently replaced with a skin ointment on 6th March, 1992 once the rash itself had gone (please see my **Documentary Exhibits WITN0086011** and **WITN0086012**, letters despatched between clinician and GP re. these conditions and treatment, now attached).

56. By 13th March, 1992 Alastair was experiencing troublesome 'itching' of the skin and a Dr Bruce Bennett (ARI Haematologist) identified minor purpora, the apparent result of Alastair having been scratching at his irritable skin, but no one had identified or appeared to Alastair or I what may have been causing this irritability (please see my **Documentary Exhibit WITN0086013**, a letter of Dr Bennett to Alastair's GP on this issue).

57. Things got so bad, that between 13th March 1992 and 27th March 1992, Alastair found himself unable to eat an evening meal without vomiting, although he could eat breakfast and then some lunch without issue, which was quite odd.

58. He attended the ARI clinic through which he had been being treated on 27th March, explained what had been happening, and upon examination by a Dr Joanne Currie (ARI Haematology Registrar), it was found that there was some Succussion Splash, so he was booked in for an endoscopy procedure to explore the problem under a Dr Brunt (as evidenced within my **Documentary Exhibit WITN0086014**, now attached).

59. On 30th March, 1992 Alastair's endoscopy took place at the ARI which identified a small Hiatus Hernia, but there was no apparent evidence of any Upper Gastrointestinal Disease which I believe the Succussion Splash may have initially indicated.

60. Alastair had also experienced recurring high temperatures during the course of March, 1992 and this caused further tests to be conducted resulting in his having been given a further blood transfusion, at the ARI on 27th April, 1992.

61. Alastair was due to attend the ARI for a further review on 1st June, 1992 but leading into this he was again suffering with another rash which appeared nightly, although he was otherwise feeling well. His examination on 1st June is detailed in a letter of Dr Marcia Ratcliffe (ARI Haematology Research Registrar) to his GP, Dr Hayworth (please see my **Documentary Exhibit WITN0086015**, now attached).

62. A further review took place at the ARI on 24th June where he reported that his rash had remained and had become irritably 'itchy' when he had tried to cope without taking antihistamines he had been previously prescribed. Upon taking this medication again, the irritability of the rash appeared to reduce (please see my **Documentary Exhibit WITN0086016**, a further letter from Dr Ratcliffe to Dr Hayworth, keeping the GP informed).

63. After some fifteen months of it having initially been fitted, Alastair was admitted to the ARI (between 26th and 27th July 1992) and had the Hickman Line removed (in a procedure conducted under a local anaesthetic). This appeared to be 'good news,' and a major step in the right direction in so far as his improving health condition and care requirements were concerned, but just a short while later he had to be admitted again.

64. My husband was admitted to the ARI where he remained an inpatient between 11th August 1992 and 14th August 1992 suffering with a florid Acute Herpes Infection which had affected his left thigh and buttock. The rash was still growing when he had been admitted, and it is quite possible, in my view, that Shingles had lain dormant within him until such time as his health declined, as once he start feeling unwell, it appeared.

65. The clinicians wanted Alastair to remain in hospital beyond his discharge date (i.e. 14th August), but he had been adamant that he wanted to get out to attend a family wedding, a wish that his doctors bowed to, but only on the proviso that he adhered to strict guidelines he was given as to caring for himself – basically he was told to *'behave himself'* and not overdo it (please see my **Documentary Exhibit WITN0086017** in this regard).

66. A subsequent clinical review of his condition conducted on 17th August, 1992 which was immediately following the wedding, revealed that there was no evidence of generalised shingles and that the shingles he had was clearly receding (please see my **Documentary Exhibit WITN0086018**) but, returning to the clinic on 3rd September, 1992 it was still quite evident – the region of his shingles was painful, particularly so at night and despite blisters within the rash having faded his skin was still broken, so he had to be prescribed suitable medication to assist him dealing with it (please see my **Documentary Exhibit WITN0086019**).

67. I now produce as my **Documentary Exhibit WITH0086020**, a letter of Bruce Bennett (ARI Consultant Haematologist) to Alastair's GP, dated 21st September, 1992. This shows that on this date, the only apparent problem which Alastair faced were episodic itchy skin blisters which those treating him were trying to stop him scratching, nothing else was disclosed or apparent. The leukaemia was now 'behind him' (albeit that he awaited a formal finding that he was in full remission) and according to Dr Bennett Alastair was *"very well."*

68. Dr Audrey Dawson wrote to Alastair's GP on 17th November, 1992 following a review of Alastair in clinic the previous day which itself followed a check-up regarding his marrow that had taken place the previous week at the GRI. She wrote to suggest that Alastair be encouraged to contact his employer, as a matter of some urgency, as regards his returning to work, the overall tenet of the letter being that he was 'on the mend' and could return to work albeit in a lighter capacity than welding – although that may be something he could achieve, given time (please see my **Documentary Exhibit WITN0086021**, now attached).

69. My husband gradually regained his strength and physical capabilities, at least in so much as returning to work was concerned and within two years of his initial leukaemia diagnosis he was able to return to the workplace and as time progressed he returned to what appeared to be full strength and good health – as fit as he was prior to leukaemia and its treatment.

70. All the same, a few issues arose as his condition improved. On 10th November, 1992 Alastair attended the GRI for a review of his bone marrow condition and had marrow aspirate and trephine. This revealed an abnormality in so much as there was an excess of lymphoid cells with reduced myeloid. A Dr Franklin (GRI) subsequently advised Dr Dawson (ARI) that the tests needed to be repeated a month or two later. The above was reported to Alastair's GP, by Dr Dawson on 23rd November, 1992 with a comment that his tests would be repeated sometime around Christmas, 1992 (please see my **Documentary Exhibit WITN0086022**, now attached).

71. The main content of the letter was that Dr Audrey Dawson suggested to Dr Hayworth that it would not be advisable for Alastair to be told of the apparent anomaly that had been revealed, saying, *"I think it would not be in Alastair's interests for this bit of information to be given to him at this moment – it is only a tentative abnormality and will upset him very considerably."* A decision had been taken by a hospital consultant *not* to tell the patient of their condition, and that decision had then been passed to the patient's GP, presumably with a view to the GP following their apparent directive.

72. Neither Alastair, or I as his wife and next of kin, were ever told of the abnormal test result from 10th November, 1992.

73. The bone marrow aspirate test was repeated by the ARI on 14th December, 1992, but fortunately the results showed that Alastair remained in remission, so perhaps the previous decision *not* to tell us of the abnormal test result was a positive course of action, as it avoided any undue concern, but all the same I believe a patient has the right to know what their condition may be, even if it may only be suspected.

74. At various times, from 1993 onwards, Alastair would complain of tiredness and he was found, upon examination and blood testing, to be anaemic. He was told by the clinicians treating him (ARI) that he'd need a 'top-up' of blood and at times he also required platelets, so he received transfusions of both with an explanation being given as regards the platelet transfusions that they would help his blood to clot.

75. By January 1993 Alastair found that he could go without the antihistamines he had been taking and had returned to work, initially completing just a four-day week over the period of a month, to see how he coped rather than returning full time (as had been suggested by Dr Dawson).

76. By 15th February, 1993 Alastair was only experiencing some skin irritability in small areas of his upper back, but his blood count was 'normal.' This was an improvement, but by 25th March 1993 he was experiencing some discomfort over the site of his earlier Herpes infection.

77. On 25th March, 1993 Alastair was seen in clinic by the GRI Consultant Haematologist, I.M. Franklin PhD FRCP FRCPath who subsequently wrote to both Dr Dawson (ARI) and Dr Hayworth (GP). The letter, dated 30th March, 1993 I now produce as my **Documentary Exhibit WITN0086023**.

78. The consultant provides both doctors with an update as to Alastair's health position post-marrow transplant, which is positive and notes that he had by then returned to full time employment and was back welding.

79. The above aside, the consultant haematologist also states that, *"He was tested negtive for Hepatitis C at the end of 1992 and his liver and renal function appeared to be normal."* The word 'negative' had been misspelt within this letter (it appears as shown above), and I believe in light of what subsequently took place, that this should actually have been 'positive.'

80. Neither Alastair or I had been made aware of the apparent fact that he had been specifically tested for Hepatitis C. As such we did not know *why* any such test would have been required, but having said that, considering the content of the letter as at my Documentary Exhibit WITN0086022, it is apparent that we may not have always been told what was happening or in particular what may have been suspected at any given time.

81. I believe that it was at some time in the Spring of 1993 that Alastair heard of HIV, Hepatitis, and their links to Haemophilia from a television news article. This was the first occasion when either of us had become aware of a problem with contaminated blood supplies, as it hadn't previously been made apparent, it simply wasn't being openly discussed.

82. HIV was known, and subject to considerable public attention in the media, but it had not been related to any form of health-setting blood use. As Alastair had an appointment for a check-up the following Monday, he decided that he would discuss the matter with his doctors, but in the interim we worried whether or not he may have been infected.

83. Attending the ARI for a consultation with Dr Dawson, Alastair brought the subject up, and she simply stated, *"Yes, you are unfortunately one of those,"* and went on to tell him that he was, *"one of the victims."*

84. I believe that Alastair, hearing this news, and not really understanding too well its implications, did not ask at that time, what he may have been infected with (be that HIV, HcV or anything else), and I do not believe that he was told that he had contracted Hep' C at that time either, just that he had been infected.

85. I felt really disappointed in Dr Dawson. If she had known that Alastair had been given contaminated blood or blood products, why had he not been told? I wondered when she had known and for how long telling him had been avoided, and why? Was it because of his having been undergoing leukaemia treatment and her not wanting to tell him to avoid his becoming upset (as had occurred before)?

86. His blood had been tested so often, that had an HcV test been performed, she would have known of his infection a considerable time before, and he was only told when he asked her, there appeared to have been no intention on her art to have told him at any time beforehand.

87. In any event, Dr Dawson subsequently told Alastair that he had contracted Hepatitis C, by virtue of his having been given contaminated blood during the course of his leukaemia treatment. His medical notes reveal that he had Hepatitis C of Genotype 1.

88. Throughout 1993, Alastair had been working and outwardly appeared to have returned to good health, but was nevertheless still being regularly monitored as he progressed towards full remission – through regular blood tests and reviews conducted in clinic. All the same, he developed another rash.

89. As a nurse myself, I always tried to diagnose what may have been happening each and every time something new occurred, before he went to see a doctor. With the benefit of hindsight, as it had never entered my mind previously, I believe that a lot of the conditions he experienced whilst recovering from his leukaemia and its treatment were symptoms of Hepatitis C infection, in particular the recurrent skin rashes he had.

90. At no time during the course of his treatment were Alastair or I made aware of any risks associated with the clinical use of whole blood transfusions, platelet transfusions or blood product use. Nothing had been said to us, and there was no printed material exposing any 'risk' provided.

91. Equally, neither of us were ever told of the origins of any of the blood or blood products he had been given, and at the time there appeared to have been no alternative to their use – at least, no alternatives were ever offered, it was blood, platelets, both or nothing, with the inevitable consequences if he had opted for the latter.

92. Dr Dawson, upon telling Alastair that he had HcV, did not explain to him what the symptoms were, that is, what he needed to look out for, and didn't provide any form of information as to how it may impact upon him as time progressed.

93. No printed information was made available to him, and I personally think that, as a nurse, there was an assumption that I would tell him all about Hep' C, not her. I may have been a nurse, but I did not have a lot of knowledge or any experience of hepatitis, be that Hep' C or any other variant.

94. Between 15th November, 1993 and 4th March 1996, the levels of Ferritin in Alastair's blood were considered to be too high, so he had to endure regular venesections to remove blood and thus control the iron levels within his blood stream. On 8th February, 1994 Dr Franklin (GRI Consultant Haematologist) wrote to Dr Dawson having seen Alastair, in clinic at the ARI on 3rd February.

95. He explained that the Ferritin level abnormality could reflect some degree of liver inflammation, explaining that liver biopsies conducted on other patients had shown a heavy iron overload in patients of his nature. Unfortunately, his letter does not make it clear if the higher iron level is directly the result of Hepatitis C Infection, although I believe this to be the case, or because he had had leukaemia and / or a bone marrow transplant.

96. On a more helpful note, whereas he advised that the venesections be conducted weekly, efforts were being made to have this done at our local hospital in Fraserburgh, rather than Alastair having to travel to Aberdeen all of the time (please see my **Documentary Exhibit WITN0086024**, now attached).

97. On 28th February, 1994 Alastair had to be seen at the ARI where he was finding himself becoming rather tired at work of an afternoon and blood tests were conducted as a result of which a further venesection was conducted, but due to a drop in his haemoglobin levels, the weekly venesections he was having were suspended until he returned to the ARI for further consideration of his condition later the following month (28th March). A letter of Dr Marcia Ratcliffe (ARI, Staff Grade Doctor in General Medicine and Haematology) to his GP, dated 3rd March 1994 details this situation (please see my **Documentary Exhibit WITN0086025**, now attached).

98. In May, 1994 Alastair had some skin lesions (please see my **Documentary Exhibit WITN0086026**), but by July these were reasonably clear.

99. My husband was found to be doing well, and returned 'normal' liver function tests when seen at the ARI on 4th August, 1994 (as is apparent within a letter from the GRI Consultant Haematologist, I.M. Franklin to Dr Dawson, dated 8th August, 1994, now my **Documentary Exhibit WITN0086027**, now attached).

100. In September, 1995 he experienced a sore throat which was initially regarded as being part-and-parcel of a flu-like illness he had (please see my **Documentary Exhibit WITN0086028**), but he went on to develop a cough in the October and in November his liver function tests were found to be over the normal range of that which had been expected. He was found to have a herpes Simplex Virus, Type 1 (please see my **Documentary Exhibit WITN0086029**, now attached) and it was unclear as to whether or not Alastair would then have to be re-immunised following his earlier marrow transplant.

101. On 9th April, 1996 Dr Dawson wrote to Alastair's GP having seen Alastair, in clinic, the previous day (please see my **Documentary Exhibit WITN0086030**, now attached). It was during the course of this consultation that Alastair first received any information as to the original source of the Hep' C infection he had, and came at least two years after he had been told that he had been 'one of the victims.'

102. She provided the GP with blood test readings, and a general, albeit brief, overall health update for Alastair, and added that she had discussed the likelihood that a donor whose blood had provided platelets he had been given in 1991 had been the source of his HcV infection as the donor had been found to have tested positive for Hepatitis C.

103. HcV infection was outlined as being the likely cause of his adverse liver function test results and Alastair had been told that he may be suitable for Hep' C treatment using the drug Interferon, and his blood had been forwarded on to Edinburgh (I know not where, but can only assume that it was to a public health laboratory or some form of register where details of patients with HcV were held).

104. Dr Dawson also stated that a liver ultrasound scan was a possibility, in about a month's time (depending upon requirement and possible scheduling issues due to a bank holiday).

105. At the time of his consultation, Alastair was considered to have been 'clinically normal,' which I find quite odd, as he clearly had Hepatitis C – I can only imagine that she was relying upon the fact that he had few, if any, overt symptoms of HcV at that time - but he was nevertheless suffering with the repeated rashes and tiredness.

106. A subsequent letter of Dr Dawson, dated 17th April, 1996 written for the information of Alastair's GP, Dr Hayworth confirmed that Alastair had HcV (confirmed through blood testing following his previous consultation), and that his blood had been forwarded to a reference library (I believe to be of similarly infected patients) in Edinburgh as had previously been suggested (please see my **Documentary Exhibit WITN0086031**, now attached).

107. Alastair and I had been a clean-living couple who had never exposed themselves to any of the known risk factors associated with Hepatitis infection, such as intravenous controlled drug use or promiscuous sexual conduct. There was no other possible source of his infection with HcV other then by way of the transfusions he received.

Section Three - Other Infections

108. I do not believe that Alastair became infected with anything other than Hepatitis C as a result of his having been given contaminated blood, platelets or products as a patient of the NHS.

Section Four - Consent

109. Alastair was treated with his consent in so far as his having had leukaemia was concerned, and was knowingly given whole blood and platelet transfusions as an integral part of that treatment. However, on occasions his condition meant that he felt so tired and unable to cope, that he would have consented to anything being given to him and in any manner of delivery, if he felt that it would have helped.

110. Transfusions not only served to stabilise his condition, and ease his discomfort and lethargy, but offered some hope in what may otherwise have been seen as a rather impossible situation for him. With no alternatives offered, or possibly even available, he had to consent.

111. Having said that, the issue of what can be described as 'informed consent' arises where neither Alastair or I were ever made aware of any risks associated with the blood and / or platelets being used – we didn't even know where they had come from. He could not be considered to have provided informed consent *if* risks were already known to his clinicians *before* he was given blood and / or platelets. If they knew of any risk, he should have been told, but he wasn't.

112. The marrow transplant was conducted with his full consent (and that of his late brother, William) and he also subsequently gave his consent for a liver transplant as he had been told that facing probable death, as he was at that time, it could add some ten years to his overall life expectancy.

Section Five - Impact

113. Following Alastair's HcV diagnosis confirmation, his clinicians continued to administer blood and platelet transfusions. Over time, his liver function began to decline and as it did so, so his overall general health went into decline. He was told that this was all due to his having Hepatitis C, although the main health issue he faced was apparently the leukaemia, which was apparently prioritised over HcV treatment.

114. On 7th May, 1996 Dr Dawson again wrote to his GP, following his having been seen in clinic that day. She provided a general update on his health and suggested that Interferon treatment may be of benefit (please see my **Documentary Exhibit WITN0086032**, now attached).

115. The following month, on 4th June, 1996 Dr Dawson wrote to say that his liver function test results were showing an improvement (having initially worsened towards the end of 1995). A Hepatic PCR test had been negative and a liver scan conducted the same day had shown a small, but normal liver (please see my **Documentary Exhibit WITN0086033**, now attached).

116. By then, Alastair had become aware of his having a simple cyst in his right kidney, but his blood count was considered satisfactory at the time. Dr Dawson appeared somewhat comforted with his condition following the liver scan result as his ALT and alphafetoprotein levels were both raised and at that time she no longer considered it necessary to subject him to a liver biopsy. Her letter to the GP was also copied to Professor P.W. Brunt (ARI, Physician / Gastroenterologist) Dr P. Molyneux (ARI, Consultant Virologist) and Dr P. Yates (ARI, Blood Transfusion Service) - so it would appear that his ongoing care was very much a multi-disciplinary affair, led through Dr Dawson and her Haematology Department.

117. Dr Dawson followed up the above letter with a further note on his condition following receipt of test results (please see my **Documentary Exhibit WITN0086034**, now attached). The only notable entry over and above a near repetition of the above was that Alastair had returned, *"... quite deranged liver function tests ..."*

118. A letter of Dr Dawson, dated 24th June 1996 followed analysis of samples taken from Alastair being tested in Edinburgh. These seem to have altered Dr Dawson's initial treatment plan as they suggested that a liver biopsy *was* necessary. Whilst writing to his GP, Dr Dawson referred to Alastair as *"... this poor man ..."* and stated that he had been *"... messed about quite a bit as a result of the alarming results from Edinburgh"* (please see my **Documentary Exhibit WITN0086035**, now attached).

119. Notes in Alastair's medical records show that Dr Dawson was being advised on certain aspects of his care by Dr P. Brunt and that the latter was in favour of a liver biopsy being undertaken.

120. Alastair visited the ARI again on 7th August, 1996 where he was seen in clinic by Dr Dawson. She subsequently wrote to his GP stating that as a result of his having Hepatitis C Viraemia, problems were being posed for his having a liver biopsy, but that they should still proceed with the same, all of which she was having difficulty explaining to him (please see my **Documentary Exhibit WITN0086036**, now attached).

121. This was a most confusing time for all of us, especially Alastair who had absolutely no medical training or background, but who felt that he was expected to take it all in, understand everything and make decisions on his health and overall care 'there-and-then,' which at times was simply too much for him. Rarely a week went by without him needing to go here or there for something or another, and he was repeatedly tested and examined – he was both worried and at times confused by what was happening as he had often been since his initial leukaemia diagnosis.

122. On 19th August, 1996 Alastair was admitted to the ARI for the liver biopsy and remained an inpatient there until 21st August. During this time there were two unsuccessful biopsy attempts made on the ward, and only a third procedure using ultrasound for guidance was successful.

123. Dr Richard Soutar was a Senior Registrar in the Haematology Department of the ARI. He saw Alastair on 9th September, 1996 and subsequently wrote to his GP, Dr Hayworth (please now see my **Documentary Exhibit WITN0086037**, as attached). His letter was headed with the apparent biopsy result, *"Chronic Hepatitis On Liver Biopsy"* together with Hepatitis C Positive and AML – Post Allergenic BMT (apparently, from 1991).

124. Dr Soutar had seen Alastair in lieu of Dr Dawson under whose care he remained, but who had been on leave from the hospital at that time. Her Senior Registrar stated that Alastair required Interferon treatment in which regard he had taught him how to self-administer the drug, and had started him on a course of treatment – 3 mega units (of Interferon), 3 times per week.

125. Apparently, at least in so far as can be seen in the letter, my husband had been made aware of the possible side-effects of Interferon use and how he could act to minimise the same. His treatment was to be monitored, and as such arrangements had been made for him to return to the clinic the following week. I describe his experience of the Interferon treatment later within this statement, but suffice to say at this point, that it was not positive.

126. Dr Dawson had referred Alastair to the ARI Outpatient Department (Eye Clinic) which he attended on 1st October where I believe that he saw a Dr C. Rees (ARI, Registrar, Opthamology). Dr Rees subsequently wrote to Dr Dawson, informing her of the outcome of this consultation which saw my husband being seen and examined by both the registrar and a Professor Forrester whom I believe to have been the Opthalmic Consultant.

127. They diagnosed that Alastair had developed mild Cataracts in both eyes, and complained of *glare* in certain lighting conditions. Apparently his eye problems were discussed with him, and a decision taken not to operate, at least not for the time-being, as there was no apparent guarantee that surgery would have been guaranteed to improve his sight, all the same, were his situation to get any worse, Dr Dawson was invited to refer him back to them (please see my **Documentary Exhibit WITN0086038**, as attached).

128. Another Consultant Haematologist, Jane Tighe (ARI, Haematology Department) saw Alastair when he returned to the ARI for a clinic appointment on 21st October, 1996. By this date he had had to stop taking the Interferon, as a result of him having had a bout of Thrombocytopenia (an abnormally low platelet count). When seen, he was asymptomatic but was experiencing issues with his vision brought about by the cataracts. He had also had flu, or at least flu-like symptoms leading up to this consultation.

129. On the basis of his blood count at the time, Jane Tighe decided not to return to his Interferon treatment plan, deciding to keep him off of them for a further two weeks following which this position would be revisited (please see my **Documentary Exhibit WITN0086039**, now attached).

130. Alastair was again seen in the ARI Haematology Clinic, by way of a review, this time by a Mr Henry G. Watson (ARI Consultant Haematologist) who had not previously had any dealings with my husband. In a letter to his GP, Mr Watson remarked that the use of Alpha Interferon had been related to the Thrombocytopenia Alastair had experienced.

131. Referring back to previous clinical notes, this consultant remarked that a fresh abdominal ultrasound would be required *"fairly quickly"* in view of *"... the possible association of the rise in alphafetoprotein with an otherwise undetected hepatocellular carcinoma as a complication of his Hepatitis C infection ..."* Alastair was at the very least now suspected of having developed liver cancer, an issue the consultant wanted to explore further through an ultrasound scan (please see my **Documentary Exhibit WITN0086040** a letter of Mr Watson to Dr Hayworth, dated 11th February, 1997).

132. A few days later, after the above had been sent, Dr P.W. Brunt (ARI, Gastrointestinal and Liver Department) wrote to Dr Watson on 15th February 1997 (in a letter dictated on this date but not typed up and presumably despatched until 17th), with a copy also being sent to Alastair's GP.

133. Mr Howard had earlier commented (as per WITN0086040) that Liver cancer would have been unlikely in Alastair's case as he had only then been infected for some five years. Dr Brunt agreed with this viewpoint, and in his letter to Dr Watson repeated this stating that the source of Alastair's Hepatitis C infection could be pinpointed to approximately five years before (i.e. at some time in 1992).

134. It was noted that Alastair had necessarily had to stop taking Interferon as a result of the adverse impact it was having in terms of thrombocytopenia and the doctor suggested that a non-invasive MRI scan may prove to be 'interesting,' but that an ultrasound scan had been arranged in any event.

135. At this stage therefore, the clinicians did not appear to think that any liver cancer was attributable to his HcV, due to the short period of time that had elapsed since his infection, but in so far as I could tell, or knew, or subsequently learned, there was no other possible source and it is always possible that he was infected at some point in time during 1991, over five years before (please now refer to my **Documentary Exhibit WITN0086041**, now attached). The doctor was nevertheless sure that a notable rise in Alastair's alphafetoprotein was due to Hepatitis C.

136. On 19th March, 1997 an abdominal ultrasound was undertaken where everything appears to have been found to be 'normal,' save for a tiny stone which was apparent within his right kidney; in particular, his liver was noted as appearing 'normal' on the scan. All the same, his medical records note that further investigation was necessary to assess *why* his alphafetoprotein levels were elevated, suggesting by way of example, the possible existence of a germ cell tumour.

137. On 6th May, 1997 Alastair was again admitted to the ARI, this time for a testicular ultrasound and a CT scan, but these again showed no abnormalities, so a treatment plan, of sorts, was put in place which meant that his general health would be observed, but by May 19th he had already developed a persistent cough.

138. On 18th August, 1997 a Dr Marcia Ratcliffe (ARI, Staff Grade Haematologist / Oncologist) wrote to Alastair's GP, now a Dr R. Duthie (but at the same surgery, a group practise in Fraserburgh), with an update. She had seen Alastair at a Haematology Department clinic appointment earlier that day. She identified a 'sweat-rash' across his back and under each arm, but noted that his blood count had remained satisfactory, although his platelet count remained low and alphafetoprotein level continued to fall.

139. As a result, a further, non-urgent liver ultrasound scan had been undertaken but the results appeared normal, apart from the apparent cyst in his right kidney (please see my **Documentary Exhibit WITN0086042**, now attached).

140. Alastair then had a heavy upper respiratory tract infection before attending the clinic for another review on 17th November, 1997 with the observations of this day, again conducted by Dr Ratcliffe being reported to his GP (please see my **Documentary Exhibit WITN0086043**, now attached). Moving into 1998, medical records show that he had an abdominal scan in January, the results of which all appeared satisfactory, with no liver abnormalities being apparent.

141. Jane Tighe (ARI, Consultant Haematologist) wrote to Alastair's GP on 16th February, 1998 to state that he had appeared normal on an ultrasound scan, but that he still had a low platelet count but that aside, his other blood test results had been satisfactory. She had proposed a plan that they monitor his condition through liver function tests (LFT's) and alphafetoprotein levels quarterly thereafter, but he had not then had an alphafetoprotein test conducted since May of the previous year (please see my **Documentary Exhibit WITN0086044**, now attached).

142. By May, 1998 the problems in his upper respiratory tract appeared to be settling and there were no longer any markers for chronic liver disease. He now wanted to be reviewed afresh by an Ophthalmologist, to see what could be done regarding his cataracts and his eyesight in general as he had been developing an ever more uncomfortable sensitivity to light.

143. Unfortunately, Alastair was not in good health and suffered something of a relapse with episodes of his having a chest infection, pneumonia, herpes and other conditions as a direct result of his immune system having been seriously compromised, often requiring hospital admission for assistance, some of which was evidenced by Dr Duthie in medical notes of 2nd August, 1998 (please see my **Documentary Exhibit WITN0086045**, now attached).

144. A further extract from his medical notes (now produced as my **Documentary Exhibit WITN0086046**, now attached), and again dated 2nd August, 1998 notes Alastair as having been infected with the Hepatitis C virus as a result of platelets he had been given in 1991 having originated from an HcV infected donor.

145. On 8th August, 1998 having been troubled by glare during periods of strong sunlight, due to the cataracts which had remained, unchecked, he returned to hospital for one of his regular check-ups where it was found that his liver could not be felt upon physical examination.

146. During the course of a further clinical review, conducted on 9th November 1998, it was noted that a further abdominal ultrasound had revealed a small calculus in the upper pole calyces of his left kidney. From this date onwards, abdominal ultrasound scans were undertaken annually, as a matter of course and an integral part of the monitoring process, rather than 'on demand' as and when any given clinician may have requested one.

147. Scrutiny of his medical records has revealed that by February, 1999 despite earlier consideration of doing so, Alastair had not entered into any form of re-vaccination programme following the transplant of bone marrow from his brother.

148. He then received (26th February, 1999) a tetanus toxoid inoculation in anticipation of our going on a Mediterranean cruise and on 28th May, 1999 an imovax polio vaccination.

149. Henry Watson (ARI, Consultant Haematologist) wrote to Alastair's GP, Dr Duthie, on 26th April, 1998 following his having seen him that day in clinic. He remarked that Alastair was then *"... asymptomatic, capable of a good hard day's work ..."* and enjoyed a *"... good quality of life."* He went on to state that he also showed distinct signs of HcV infection but displayed no clinical signs of chronic liver disease. Unfortunately, or fortunately as the case may be (in light of its side effects), he also noted that Alastair was unable to tolerate treatment with Interferon.

150. Mr Watson explained that his treatment plan consisted of keeping Alastair under continuing review, using annual ultrasound scans and quarterly alphafetoprotein tests and that *"... when, as is likely, alternative therapies for Hepatitis C which spare him the platelet count become available, we should consider treating him."* It is quite clear to me, that Interferon aside, at that time the clinicians had no other means of treating his Hepatitis C at their disposal, and he'd simply just have to wait until something he could take (unlike Interferon) became available (please see my **Documentary Exhibit WITN0086047**, now attached).

151. His eyesight continued to be an issue for him, as did the condition of his kidneys. On 1st November, 1999 he was reviewed in clinic where it was noted, perhaps in confirmation of separate earlier reports, that he had calculi in both kidneys.

152. Alastair returned to the ARI for a further ultrasound scan of his abdomen which the ARI Staff Grade Haematologist / Oncologist, Dr Marcia Ratcliffe described in a letter of 8th November, 1999 sent to Alastair's GP. Within the letter she described how his liver had reduced in size since the time of his previous scan and that this was consistent with the development of Cirrhosis of the liver. This was bad news, but at least there did not appear to have been any noticeable change in the condition of his kidneys, and Dr Ratcliffe had told Alastair of the results during an outpatient appointment (please see my **Documentary Exhibit WITN0086048**, now attached).

153. In the early 2000's, although I cannot now recall exactly when, Alastair became septic which made him act completely irrationally for a period of time. He was so unwell, and his conduct was so out of character and strange (I though initially that he'd gone 'doo-lally'), that I called for an ambulance. The ambulance crew took him straight to the ARI where he was admitted as an emergency case through Accident & Emergency (A&E) – here it was found that the sepsis had been caused by the deterioration of his liver, and we were told that his situation was 'touch and go.' I was worried sick and thought that he was going to die, as in my eyes, there was nothing that could be done.

154. However, Alastair rallied, and after a week as an inpatient he was able to be released home, our daughter having driven him back from the hospital. Whilst he had been an inpatient, he was kept in what I considered to be rather frightening conditions, where anyone visiting had to wear masks and take other protective measures (such as those which we would now recognise from the Covid-10 Pandemic), as a result of an unrelated outbreak of bird-flu.

155. I cannot now recall what he was treated with, and / or whether or not he was given any more blood, platelets or any other blood products, but it is possible in light of his treatment means before, that he received transfusions. In so far as the chronology of events in Alastair's life are concerned, this event may appear slightly out of place, but as I am unsure of the date(s), I mention it now.

156. Henry Watson (ARI, Consultant Haematologist) wrote on 17th January, 2000 to Alastair's GP following him having been reviewed in clinic earlier that day. He stated that Alastair was continuing to do reasonably well, that there were no clinically obvious signs of chronic liver disease, and that he had no significant symptoms.

157. Mr Watson stated that it would be pertinent for Alastair to have another endoscopy procedure performed, as none had taken place for some years (not since the early 1990's) as this measure would be an important part of the management of his health should he go on to develop portal hypertension as a result of cirrhosis (please see my **Documentary Exhibit WITN0086049**, now attached).

158. In April, 2000 Mr Watson speculated as to whether Alastair's slowly rising alphafetoprotein levels may herald the development of Cirrhosis but stated that in this regard there were then no obvious therapeutic options (for treating the Hep' C infection, echoing previous comment made on this subject).

159. An endoscopy was performed on 23rd August, 2000 following which Alastair was reviewed by Jane Tighe (ARI, Consultant Haematologist) as an outpatient of Dr Watson's clinic on 20th November, 2000. Ms. Tighe stated that low-tension oesophageal varices were apparent but that his weight appeared to be increasing and there was no need at that time for any beta-blocker use.

160. Encouragingly, there was no stigmata of liver disease and no palpable hepatosplenomegaly. But unfortunately, she stated that Alastair remained persistently thrombocytopenic although there was no evidence of haemorrhage resulting from this. An additional abdominal ultrasound was performed that day, but the results were unknown when she wrote, and she added test results as regards alphafetoprotein and transaminase (please see my **Documentary Exhibit WITN0086050**, now attached).

161. By March, 2001 Alastair's platelet count was found to be slightly lower, and he also went in for a lumbar x-ray which revealed a slight straightening of the normal curvature of the lumbar section of his spine, an issue which I do not know to be necessarily related to Hep' C, or not, but it was simply yet another hospital trip, another examination, another finding and another condition he had to deal with.

162. In July 2001, Alastair suffered with both a cold and a sore throat and there were additionally two episodes of pain being experienced in his right loin and an incident of haematuria in the November which may have necessitated a referral from his GP to Urology, but I cannot now recall if this necessarily took place, or not.

163. On 26th November, 2001 Dr Ratcliffe (ARI, Staff Grade Haematologist / Oncologist) wrote to Alastair's GP following a review in clinic which had taken place on 12th November, 2001. She provided the results of the abdominal ultrasound he underwent on 12th, and the hospital doctor, in writing to the GP, appears to quote directly from a report, *"The liver is small, coarse and irregular and typical of cirrhosis but has not changed since the previous examinations. Calculi remain in the left kidney with a 5.5cm cyst projecting from the upper pole of the right kidney. The lower calyces on the right are also slightly distended though no cause is apparent. No other abnormality was demonstrated."*

164. The doctor went on to comment that the calculi in both kidneys had been noted before, and hinted that the right sided loin discomfort Alastair had been experiencing may well have been directly related to the problems of the right kidney (please see my **Documentary Exhibit WITN0086051**).

165. In December, 2001 Alastair attended Fraserburgh Hospital's A&E Department suffering with kidney stones. In January, 2002 he had another chest infection which only settled with antibiotic treatment and then in March he found himself suffering with intermittent cramp in his thighs. It was then decided that he'd have to have bi-annual ultrasound scans rather than annual, with a view to the clinicians being able to identify any early changes in his condition.

166. On 5th April, 2002 Alastair went to the ARI. It was not one of his now fairly routine clinic appointments, but because he had suffered with a sharp stabbing pain in his right hip (in the iliac fossa) and had been advised to go there by his GP should he encounter any health issues as they were fully aware and better placed to deal with whatever may be occurring.

167. A Gastrointestinal Endoscopy Report from the ARI is my next **Documentary Exhibit, WITN0086052**. Within the report, dated 20th May, 2002, it is noted that he had by then been infected with Hepatitis C for some 13 years and that the last endoscopy had been undertaken in August 2000 which had revealed one low tension varix. It stated that he had thrombocytopenia and had an intolerance to Interferon (as a result of the thrombocytopenia).

168. Its author, an A. Fraser, sent a copy to both Alastair's GP and Consultant (Jane Tighe), stating that in so far as the oesophagus was concerned, the new scan had revealed a small hiatus hernia, at least five variceal trunks, the largest of which had extended into the stomach and that there was evidence of generalised, yet mild, gastritis in the stomach.

169. A recommendation was made that Alastair be placed on Propanolol (to reduce his heart rate) by 25% as it had been measured at 81. He also suggested that a repeat endoscopy be performed in some three years time, but that in the interim he would be happy to see him as and when it was deemed necessary.

170. Henry Watson (ARI, Consultant Haematologist) wrote to Alastair' GP following a clinical review of my husband's condition on 15th July, 2002. His general diagnosis was noted as having been Post Allo BMT, Hepatitis C, Cirrhosis and Portal Hypertension.

171. Mr Watson stated that Alastair's platelet count was indicative of hypersplenism and that recent scans (as I have detailed above), showed no evidence of hepatocellular carcinoma.

172. He described problems Alastair had experienced whilst taking Propanolol, where the dosage had left him feeling light headed, so his daily dosage regime had been reduced.

173. The consultant also reflects on the fact that he had discussed a compensation claim with Alastair. He states in the letter that his understanding of the situation (as regards his HcV infection) was that he had been identified as part of a look-back exercise, and that as such was a suitable candidate for compensation, *"... under the conditions of The Burton Agreement ..."* and that he had encouraged a solicitor acting on Alastair's behalf to send details of his claim to the Central Legal Office.

174. He then added that, *"For documentation, Alastair's identified transfusion episode happened on 22.4.1991 at Aberdeen Royal Infirmary. The donation was number 1066900 and the cellular component involved was platelets."* I do not know the origins of the information upon which Mr Watson relied, but clearly detailed information as to how and when he had become HcV infected were by this time available. The letter to which I have referred to above is now produced as my **Documentary Exhibit WITN0086053**, now attached.

175. In an unrelated incident, in October 2002, one of Alastair's legs was splashed with hydrofluoric acid for which he had to attend the Fraserburgh Hospital A&E.

176. Dr Deepak Sadani (ARI, Specialist Registrar, Haematology Department) wrote to Alastair's GP following a review of Alastair's condition in clinic in 4th November, 2002. This was a quarterly review I attended with my husband.

177. The doctor reported Alastair's blood test results and then spoke of his compensation claim. He stated that his claim, having been lodged with the Central Legal Office, had been forwarded to his solicitor and that subsequently his GP should have received a letter telling him that the matter was being considered. He then continued with more clinical information, and it appears odd to me that a compensation claim would be 'sandwiched in' between medical information in a letter between doctors.

178. Dr Sadani stated that Alastair had then (4th November, 2002) been well, but that he had experienced problems of a colic pain, and trapped wind. He detailed his medication, such as it was at the time, and went on to state that Alastair had no pallor or oedematous feet but that he did have a few visibly dilated veins over his face. There were no spider naevi and no palmar erythema. Abdominal examination had revealed no liver or spleen palpable. His chest was clear and he presented with normal heart sounds.

179. The doctor states that tests related to CMV, PCR and HcV antibody levels were repeated and that he'd been given something for his trapped wind (please see my **Documentary Exhibit WITN0086054**).

180. On 2nd December, 2002 Henry Watson (ARI, Consultant Haematologist) wrote to Alastair's GP, then a Dr Tweedie (but at the same group practise in Fraserburgh), as Alastair had presented himself at the ARI with a five day history of Melaena, describing his having produced 'black stools' two or three times per day. The consultant reported that there was evidence of a degree of liver failure with gynaecomastia as a result of which Mr Watson had undertaken to have Alastair admitted to the GI Bleeding Unit for further investigation (please see my **Documentary Exhibit WITN0086055**).

181. Alastair remained an inpatient of the ARI until 5th December, 2002 and whilst there underwent another endoscopy procedure to determine what was happening within him. Whilst there, he received a further transfusion, noted in his medical record as *"... transfused 2U as Hb 89 ..."* (please see my **Documentary Exhibit WITN0086056**).

182. His admission and treatment within the GI Emergency Bleeding Unit at the ARI was documented in a letter of Dr Aileen Smith (ARI, Senior House Officer, Gastrointestinal and Liver Department) to Alastair's GP written on 6th December, 2002 (typed and presumably despatched on 12th December) which I now produce as my **Documentary Exhibit WITN0086057**.

183. In addition to the symptoms noted by Mr Watson, Dr Smith reported that Alastair had complained of having been lethargic for around three weeks prior to his admission, of becoming breathless on exertion and having a reduced exercise tolerance. She noted that as his haemoglobin level had been found to be 89, he had been transfused, receiving two units, but I do not know if this was a transfusion of blood or platelets.

184. Whilst an inpatient, a further endoscopy was performed which showed portal gastropathy and low-tension varices. Two varices were noted as having been protruding into half of the oesophageal lumen with cherry red spots, both being banded at that time.

185. A GP of the group practise Alistair used in Fraserburgh, a Dr Helen Fowler noted a hospital admission between 2nd December 2002 and 4th December 2002 and shows Alastair as having had oesophageal varices banded. This is believed to be identical to the information provided above and reflects the same incident (please see my **Documentary Exhibit WITN0086058**), but it does not appear to take matters any further, the SHO's report being the far more detailed explanation of the two. I believe that he may initially have gone to his GP's practise and then been referred on to the ARI.

186. A short time after his hospital discharge, on 26th January 2003, Alastair went to the A&E Department at Fraserburgh Hospital with renal colic. A short time later, in February 2003, a blood test revealed that he had become anaemic once again.

187. On 24th February, 2003 Alastair returned to the ARI Haematology Clinic for a review and was again seen by his consultant, Mr Watson. The consultation, examination and test results were reported by Mr Watson in a letter of the same date to Alastair's GP (please see my **Documentary Exhibit WITN0086059**).

188. Interestingly, for the first time a doctor (Watson) noted that Alastair was now *"... struggling a little bit."* He was finding himself more tired and had become short of breath under exercise. Providing blood test results he highlighted the fact that his anaemia was worsening, there'd been an increase in his MCV (to 116) and his platelet count had been 61.

189. There were one or two spider naevi (as previously noted by another clinician) and he appeared slightly pale but there were no other signs of liver disease and no evidence of gynaecomastia. A suggested treatment plan, primarily using Folic Acid was proposed and he remarked that he'd review him afresh in eight weeks time – although in saying that he also stated that, *"... we need to keep a closer eye on Alastair ..."* so, in my view, to see him again two months later was not exactly keeping a close eye on him.

190. In April 2003 Alastair suffered with worsening swelling in his ankles, his lethargy had and also worsened, his liver function tests were showing a notable decline and he continued to experience anaemia and have a lower than desirable platelet count.

191. By now, Alastair had been placed under the care of a Dr A. Fraser at the ARI as regards his liver condition and he in turn had placed my husband on the liver transplant register – the waiting list for a donor organ, should one become available. It was explained to Alastair and I that were he to be called for a liver transplant, it would happen at another hospital, not at the ARI, as they were ill equipped and staffed to perform such complex surgery 'in house.'

192. I now rely upon my **Documentary Exhibit WITN0086060**, a letter of A. Fraser (ARI, Consultant Physician / Gastroenterologist) to Dr A. Bathgate (Consultant Physician) of the Scottish Liver Transplant Unit at the Royal Infirmary of Edinburgh dated 18th April, 2003 (typed and presumably despatched on 22nd April, 2003).

193. The letter detailed Alastair's health position in so far as his liver was concerned, explaining that he had acquired HcV of Genotype 1 Liver Cirrhosis, having initially contracted Hep' C from a platelet transfusion he had been given in 1991. One consultant asked the other to review Alastair with a view to his being considered a suitable candidate for a liver transplant.

194. In so doing, Fraser told Bathgate that Alastair had deranged liver enzymes, portal track inflammation with early fibrosis and interface hepatitis. He had ascites with palpable swelling on the left lobe of the liver and swollen ankles.

195. Fraser states that Alastair contracted Hepatitis C as a result of a transfusion given to facilitate his bone marrow transplant and that his infection was identified through a look-back enquiry undertaken in 1996.

196. His earlier leukaemia was mentioned, but it was noted that it had not returned following treatment (which included the bone marrow transplant).

197. His attempts to clear himself of HcV were mentioned, against the use of Interferon with comments that although tried several times, each was unsuccessful due to thrombocytopenia. In so far as other possible causes of his Cirrhosis were concerned, the consultant proposing Alastair for a transplant remarked that, *"... he has not been a drinker."* As I have already stated, Alastair and I were clean living individuals who had not placed ourselves at risk – his medical problems all stemmed from leukaemia, which was unavoidable, but then Hepatitis infection, which was, and the only source of that infection was from the blood or platelets he had been given, as later confirmed in the look-back exercise.

198. On 16th May, 2003 Alastair underwent another endoscopy procedure during the course of which two oesophageal varices were seen together and three or four variceal bands were applied to address this. Apparently, there were two columns of grade two oesophageal varices with at least two columns having red spots. They found no large gastric varices in his stomach but there was very prominent portal hypertension gastropathy with red spots.

199. A Doctor Dhiraj Tripathi, the Medical Registrar to Dr Alastair MacGilchrist wrote to Mr Fraser (ARI) in a letter also copied to Alastair's GP and dated 4th July 2003. It was a letter detailing the findings of a liver transplant suitability assessment which had taken place between 23rd June 2003 and 27th June 2003 during which time Alastair had been an inpatient (of the transplant assessment unit) at the Royal Infirmary of Edinburgh.

200. This report I now produce as my **Documentary Exhibit WITN0086061**. His overall diagnosis was shown, as a form of header to the document, as was the fact that he had acquired HcV from a transfusion in 1991 whilst being treated for acute myeloid leukaemia. Other 'background medical information' was provided by way of an introduction, including the fact that he had been identified as having HcV in 1996.

201. His steadily deteriorating health situation was then described leading to his being referred for assessment in March, 2003. The results of examination and tests conducted, including yet another endoscopy procedure and CT scan were provided. In conclusion, the doctor reported that Alastair was a suitable candidate for a liver transplant, and in that regard an MRI scan would be required approximately two weeks later.

202. Finally, Dr Tripathi stated that Alastair *"... himself was keen to have a bit more time to think about the liver transplant ..."* and that dependent upon his views and the results of the later MRI scan(s) he would be 'listed' in about a month's time (which I believe meant that if he were willing, and the MRI result was favourable he'd join the register of patients awaiting a donor organ at some time in August, 2003).

203. A further endoscopy was conducted on or around 18th July 2003 when three varices were evident and two variceal bands were deployed to deal with them. Not surprisingly in my opinion, after so many endoscopy procedures, it was noted that Alastair *"... tolerates this procedure poorly"* (please see my **Documentary Exhibit WITN0086062**).

204. Between 21st and 25th July 2003, Alastair had to be admitted to the ARI again, this time having been found to be slightly anaemic and dehydrated. To help him, he was given intravenous fluids and two units of blood. I found that within his medical records, his admission had been attributed to his having presented with Encephalopathy with Alastair having been described at the time as pale, drowsy but rousable, and without fever. He was found to have a mild hepatic flap and crepitations to the base of his left lung.

205. On 31st July, 2003 Alastair attended an appointment at the Edinburgh Royal Infirmary to be given a pager or bleeper device which was an integral part of his having been accepted for transplant and added to the list – it would alert him as and when a donor organ became available.

206. I have previously mentioned the travelling distances between our home and Aberdeen, and the home and Glasgow. Edinburgh was 175 miles away, a return car trip of some seven hours.

207. On 4th August, 2003 Doctor K. Simpson (Consultant Physician, Scottish Liver Transplant Unit, Edinburgh Royal Infirmary) wrote to Dr Fraser (ARI, Renal Consultant) following a review of Alastair in the transplant clinic which had taken place on 31st July 2003.

208. The doctor noted that Alastair had been assessed for transplant but that since that particular admission, he had needed to be both scoped and banded, and had additionally been admitted to the ARI (as I have previously mentioned re. his having been anaemic and dehydrated).

209. Dr Simpson detailed the medication Alastair was then taking and remarked that upon examination he had appeared slow to answer questions and appeared mildly jaundiced although there was no hepatic flap. He had been found to have a soft abdomen with no ascites and mild peripheral oedema.

210. Blood test results were provided, and it was noted that he had returned a reduced sodium level and an abnormal liver function test result (elevated bilirubin amongst other readings). Dr Simpson stated that he would be placed on the active transplant list and until transplant he would be reviewed at monthly intervals in clinic in Edinburgh, albeit that some visits may have been able to be accommodated in Aberdeen, closer to home, in conjunction with Mr Bathgate. His letter was copied to Dr Tweedie (GP) and Andrew Bathgate the Liver Transplant Unit Consultant Physician (please now see my **Documentary Exhibit WITN0086063**).

211. His medical records appear to show that he may have been taking some form of beta-blocker in September, 2003, but I do not know the full details of this and I may not have completely understood the entry I have seen.

212. Completely out of the blue, the telephone rang one night in early September, in the middle of the night, and Alastair was told that a donor liver had become available for him. Since he had been placed on the list, we had kept a bag packed for him, so that he could have travelled at a moments notice, and such was the case here, an ambulance was already on its way, to collect him and take him to Edinburgh.

213. Because of the distances involved and an apparent need for speed, we had been told that we'd be taken to the hospital by helicopter, but on the day this had been cancelled, so we had to go by ambulance.

214. None of the doctors treating Alastair had ever said that a replacement liver would clear him of Hepatitis C, but it was believed to be a distinct possibility as his Hep' C infection had not appeared aggressive or particularly noticeable as he approached the time of his transplant – apparently, there was a good chance that it would work, but no guarantee. I do not think that the doctors would have conducted the transplant if the virus had been aggressive at the time.

215. The transplant, conducted on 6th September 2003 went well, and was apparently successful and despite Alastair and I having been told that he would most probably have to remain in hospital for two to three months post-operatively, he was discharged within a month of surgery, having initially been on an isolation ward and then later transferred as a step-down measure to a High Dependency Unit. He made a good recovery.

216. Having been discharged, Alastair had to return to the Edinburgh Royal Infirmary for assessment by the transplant team, but he was progressing well, looking much better, and was referred back to the ARI for his ongoing care and monitoring. After a while, the consultant from Edinburgh travelled to Aberdeen to see him in clinic there, so Alastair didn't have to travel so far whilst he was still convalescing.

217. Alastair's health appeared much better from the moment he had been discharged, and continued improving for a while although we noticed that he still could not walk any appreciable distance. The repeat problems he had been experiencing through the Hepatitis C infection didn't appear to be anything as bad, and following his transplant Mr Fraser (ARI, Renal Consultant) said that the health improvements he was having were all attributable to the transplant. His doctors at the ARI continued to monitor his progress until about a year before he passed away in June, 2017.

218. On 8th October, 2003 Dr Colin Noble (Registrar, Scottish Liver Transplant Unit, Edinburgh Royal Infirmary) wrote to Alastair's GP and Mr Fraser (ARI, Renal Consultant) following a review of Alastair in clinic. He noted that Alastair was doing well, and slowly but surely mobilising himself around his garden, walking, but commented on a few issues he was still facing, notably including the fact that his liver function had not 'settled down' following his transplant, as a result of which a further ultrasound scan had been requested (please see my **Documentary Exhibit WITN0086064**).

219. Unfortunately, Alastair experienced other issues post-transplant. He used to experience breathlessness, at times struggled to walk and had lost his physical strength. He continued to suffer from fatigue and couldn't walk too far without having to stop. At one point in time he told me that his whole body ached, just as if he had a the flu' or a cough or heavy cold, yet he had none of these things. He was prescribed some steroids at one point, in an effort to help with his breathlessness.

220. Between 9th and 16th October, 2003 Alastair had to be readmitted to the Edinburgh Royal Infirmary with Varicella Zoster Infection for which he was given intravenous medication and a further ultrasound scan was undertaken whilst he was an inpatient. A letter of Dr A. Convery (Senior House Officer to Dr Alastair MacGilchrist, Edinburgh Royal Infirmary) to his GP, and copied to Mr Fraser refers (dated 21st October, 2003, please see my **Documentary Exhibit WITN0086065**).

221. Later that month, upon my husband having attended hospital to sign consent forms for his receipt of flu and pneumonia vaccinations, testing revealed that he had become B12 Vitamin Deficient.

222. He was further reviewed in Edinburgh on 11th November, 2003 where his liver function tests were found to have returned to a satisfactory position although his blood pressure had been noted as being a little high (please see my **Documentary Exhibit WITN0086066**).

223. On 27th November, 2003 Alastair was again reviewed in clinic and symptoms had actually improved following his transplant, albeit that his eyesight had worsened (please see my **Documentary Exhibit WITN0086067**).

224. On 9th January 2004 Mr Fraser wrote to his GP to state that in spite of the transplant, Alastair's Hepatitis C viral load had remained high. The letter was copied to Dr Bathgate in Edinburgh, but all that Mr Fraser could offer at the time was that his department would continue to monitor the situation by 'keeping an eye on him' when he returned to clinic (please see my **Documentary Exhibit WITN0086068**).

225. Whilst all of this had been going on, a change of personnel at our local GP's practise had seen Alastair's former doctor (Dr Duthie) leave and as a result he appeared to have been left without a doctor. He received a letter from the surgery asking him to register afresh, which at that time in his life, and having experienced such health turmoil over what had become many years, was the last thing he needed.

226. Alastair wrote to the surgery on 31st January, 2004 in desperation. He wrote to Dr Tweedie, someone he had seen as his GP on a number of previous occasions, and asked if he would be prepared to 'take him on,' as he felt *unwanted* by the surgery, something he attributed to the difficult nature of his condition(s), possible costs being associated to it, and the departure of Dr Duthie having provided an opportunity for them to discard him. When a patient is having a number of battles with his health, this was the last thing he needed to have to be dealing with (please see my **Documentary Exhibit WITN0086069**, a copy of his letter).

227. Following an outpatient appointment in the transplant clinic on 11th March, 2004 Mr Fraser wrote to Alastair's GP to inform him that a post-transplant liver biopsy at twelve months was necessary and suggesting that dependent upon the outcome, my husband may require a trial of a combination therapy to treat his Hepatitis C (please see my **Documentary Exhibit WITN0086070**).

228. On 2nd August, 2004 my husband had another abdominal ultrasound scan which showed his 'new' liver to have been of the normal size with no focal abnormalities apparent. A cyst on his right kidney and a calculus on the left kidney were both visible and noted.

229. On 7th September, 2004 he was admitted to the Edinburgh Royal Infirmary for a liver biopsy, kept in overnight and then discharged the following day. The biopsy passed without incident and his liver histology appeared almost normal, which was encouraging but Alastair reported some Paraesthesia in his left arm, but he did not have any objective, motor or sensory loss.

230. A subsequent outpatient appointment letter for his GP, dated 18th October, 2004 from a review conducted at the Edinburgh Royal Infirmary recorded some fatigue in his left arm but otherwise he appeared to be recovering well (please see my **Documentary Exhibit WITN0086071**).

231. On 5th May, 2005 Alastair's GP, Dr A.G. Beattie (a new doctor, but at the same practise as he had always used), wrote to the liver transplant unit as Alastair had been attending the surgery where he had been diagnosed as having a mild depressive illness for which he had been placed on medication which appeared to be having a positive effect (please see my **Documentary Exhibit WITN0086072**).

232. On 7th June, 2005 Alastair was seen in Mr Fraser's clinic at the ARI by a Dr Shirley English. Alastair's main complaint to her at that time was of lethargy, supported by the fact that he had not returned to work and didn't feel as if he could do so, at least not full-time. He also made mention of having been depressed, for which he was receiving treatment, a situation not made any the better form the continual yapping of a neighbour's dog. On the treatment side for his depression, he stated that the medication prescribed had never been taken, but that his situation was improving (please see my **Documentary Exhibit WITN0086073**).

233. A further abdominal ultrasound scan was conducted in October, 2005 but nothing new was revealed. His medical records from that time include both flu and pneumonia vaccination questionnaires and a consent form re. these inoculations dated 20th October of that year. He continued to complain of breathlessness upon exertion, and his blood pressure was found to be slightly high in December of that year, but nothing else that was particularly untoward.

234. In 2006 and then into 2007, my husband's general health went into a noticeable decline and he developed high blood pressure, gout and eventually some skin cancer on his nose and right-hand side of the body from which he had to go to Dundee for surgery to have this removed.

235. On 11th January, 2006 Mr Fraser (ARI) saw Alastair in clinic and subsequently wrote reporting his findings to Alastair's GP commenting amongst other matters that, *"Not surprisingly, this mans Hepatitis C PCR is positive ..."* (please see my **Documentary Exhibit WITN0086074**).

236. By now, Alastair's health issues were such that he was able to apply for a concessionary parking permit (a blue badge for the disabled), a matter in which he was fully supported by his GP, Dr Tweedie who countersigned the necessary application on 22nd April. 2006.

237. In June 2006 he still had high blood pressure and high potassium levels were also found through blood testing and he had his flu inoculation in November, 2006. In January 2007, medication he had been on with a view to addressing his blood pressure issues was reduced and Mr Bathgate (Consultant, Scottish Liver Transplant Unit, Edinburgh) suggested that he could be prescribed an ACE inhibitor or an Angiotensin II blocker, as angiotensin blockade reduces fibrosis in Hepatitis C patients (please see letter of 8th January, 2007 from Mr Bathgate to Dr Tweedie, now produced as my **Documentary Exhibit WITN0086075**).

238. The ARI again wrote to Alastair's GP on 11th January, 2007 to inform him that Alastair had needed to attend their clinic as a matter of some urgency when he had felt particularly unwell and developed a rash. Whilst there, his renal function was found to have significantly deteriorated although an ultrasound scan had revealed his urinary tract to have been 'normal' (please see my **Documentary Exhibit WITN0086076**).

239. Mr Bathgate of the Liver Transplant Unit, Edinburgh wrote a letter to Alastair's GP on 23rd March, 2007 to state that during the course of a clinical review, Alastair's renal dysfunction, as he described it, was giving his doctors cause for concern although in more general terms he appeared to be 'doing well' (please see my **Documentary Exhibit WITN0086077**).

240. On 27th July, 2007 Alastair had to be admitted to the ARI where he remained an inpatient until discharge on 7th August. He was suspected of having a form of bronchiolitis and a high-resolution CT scan was arranged, to better assess his condition, but could not be undertaken whilst he was there.

241. Shortly before, Alastair and I had taken a short holiday in the Orkney Islands, which may or may not have been related, but he had not experienced any significant respiratory issues leading into this episode (please see my **Documentary Exhibit WITN0086078**).

242. On 17th August, 2007 my husband attended the ARI for his CT scan. Later that day, Dr Currie called our home and spoke with me stating that he believed Alastair's respiratory problem to be a case of bronchitis, and advised as to changes to his medication which would be appropriate. I subsequently wrote a short note for our GP (then Dr Francesca Lee-Mason, but at the same surgery in Fraserburgh those before him), asking her to note the advice I had been given whilst at the same time making the required medication available. I added that Dr Currie (ARI) would call the surgery himself, at some point, to outline the position with Alastair as it was at that time (please see my **Documentary Exhibit WITN0086079**).

243. Dr Currie followed up the above with a letter addressed to Dr Tweedie at Alastair's GP's surgery, dated 23rd August 2007, in which he discussed the outcome of the HRCT Scan and Alastair's case having been discussed in a hospital multi-disciplinary meeting of that date.

244. One suggestion put forward for Alastair's respiratory issues (described as being bronchiolitis with mild bronchiectasis, possibly resulting from obliterative bronchiolitis), was that it was due to a manifestation of 'Graft-Versus-Host-Disease,' in other words, directly related to his liver transplant.

245. It was proposed that a lung biopsy be performed to confirm / refute this diagnosis which would be arranged by a Mr Remmen (ARI Consultant) in liaison with Alastair, something Dr Currie had told Alastair himself in a 'phone call, so he was fully aware of what had been planned (please see my **Documentary Exhibit WITN0086080**).

246. Within Alastair's medical notes from this time (27th August, 2007) is a note of Dr Currie stating that Alastair's health had declined following his having been admitted on this occasion. On 28th August, just a day later, Alastair was readmitted to the ARI with high blood sugar levels. He was Hyperglycaemic Hyperosmolar Non-Ketotic Coma and remained an inpatient until 3rd September, 2007.

247. He returned to the ARI where he was an inpatient between 17th and 20th September, 2007 when the lung biopsy was performed. The results showed no signs of bronchiolitis, but abnormalities of the pulmonary vasculature were apparently evident.

248. A microbiology report of the ARI, referring to a sample taken on 25th September, 2007 states that Alastair had been found to have MRSA, something which he had apparently had before, on at least one prior occasion of his being hospitalised (please see my **Documentary Exhibit WITN0086081**).

249. A further ARI Microbiology Report, dated 15th October, 2007 shows that Alastair had again been found to have a Meth' (Methicillin) Resistant Staph' Aureus – again, MRSA (please see my **Documentary Exhibit WITN0086082**).

250. In January, 2008 Alastair's liver was found to be of a normal size and was producing a normal echo pattern when examined. His renal impairment was responding well to fluids, which suggested that he was or had been dehydrated again, and his elevated glucose levels were being treated with insulin.

251. Mr B. Vijayan (Consultant Gastroenterologist, ARI) wrote on 26th February, 2008 (typed and presumably despatched on 10th March) to Alastair's GP, in a letter copied to Mr Bathgate (Scottish Liver Transplant Unit, Edinburgh) to say that Alastair had been reviewed in clinic on 26th February, and that he found he had been keeping well and presented with no particular complaints.

252. The episode of severe bronchiolitis was referred to, as having been treated with high dose steroids, and that as a result of high blood sugar levels he had been put onto Gliclazide. Other medications he was taking were also described. A liver ultrasound scan had been performed on 16th January with no adverse findings save for a 1cm lesion showing features of haemangioma which had been present from the time of transplantation (please see my **Documentary Exhibit WITN0086083**).

253. In March, 2008 Alastair was put onto the Thyroid Register.

254. On 22nd June, 2008 Alastair had to be taken to the Fraserburgh Hospital A&E Department by ambulance. He had been suffering with considerable pain that was radiating down his left arm and he had absolutely no power or use of the left hand. I now produce as my **Documentary Exhibits WITN0086084 and WITN0086085** the call log regarding this incident and a subsequent discharge letter.

255. These show that he presented in an anxious state, and unable to properly answer questions put to him by the medical staff. He was suffering with pain in his upper back, shoulder and arm, a pain that had been worsening over two days. He was also clammy, and agitated and analgesics taken did not appear to have had any affect. On this occasion he was given painkillers.

256. On 21st July, 2008 Alastair had a scan of his right shoulder and spine conducted at the ARI. Mr M.H.I. Kamel (ARI, Consultant Neurosurgeon) subsequently wrote to Dr Lee-Mason (GP) with the findings of this and a physical examination he had conducted, but no abnormalities were apparent. His letter also outlined Alastair's background medical history (please see my **Documentary Exhibit WITN0086086**).

257. The same Consultant (Mr Kamel) reported on an MRI scan performed on 18th September, 2008 which revealed evidence of disc protrusion and osteophytosis. Writing to Alastair's GP on 9th October, 2008 (in a letter typed and presumably despatched on 13th October), Mr Kamel suggested that the protruding discs be removed. Mr Kamel also wrote separately to Alastair, outlining his findings and how he suggested they be tackled (please see my **Documentary Exhibits WITN0086087 and WITN0086088**).

258. On 6th November, 2008 Alastair was admitted to the ARI for a further liver biopsy, being kept in overnight and then discharged. The results were given to his GP by way of a letter from Mr Fraser to Dr Lee-Mason (GP), but with no adverse findings, they were recorded as having been, *"... very encouraging"* (please see my **Documentary Exhibit WITN0086089**).

259. Whilst this had been taking place, Alastair was also attending our local hospital for physiotherapy (to help with his back and arm issues), being discharged by them on 17th November, 2008.

260. Following the liver biopsy, everything appeared to be moving in the right direction, the transplant appeared to be working and to have settled well, and his aches and pains were being attended to, but due to a succession of different ailments he succumbed to, Alastair's health rapidly declined in 2009 / 2010, and continued to go downhill throughout the remaining six to seven years of his life.

261. On 4th January, 2009 my husband was admitted to the ARI under Mr Kamel and remained an inpatient there until 6th January during which time problems with his spine were attended to – he had surgery consisting of ACD & Fusion using a Rabea Cage, and Slimloc Anterior Cervical Plating (on 5th January) all of which was reported to his GP in a letter of 9th January 2009 (typed and presumably despatched on 12th January) a copy of which is now produced as my **Documentary Exhibit WITN0086090**.

262. Mr Fraser wrote to Alastair's GP on 10th March 2009 stating that recent spinal surgery (as above) had served to address some neurological issues Alastair had been experiencing and that his most recent liver biopsy (again as reported above) had not shown any evidence of scarring or cirrhosis (please see my **Documentary Exhibit WITN0086091**).

263. By the time of a further clinical review held on 12th May, 2009 Alastair's neck and shoulder problems had both improved following the surgical intervention of Mr Kamel.

264. Notes within Alastair's medical records include a letter from a Sue Hay of the Family Health Services Team at Woodend Hospital in Aberdeen to his GP regarding the supply, monitoring and management of domiciliary oxygen therapy.

265. Alastair had oxygen provided for his use at home and had been in receipt and using the same for some time, all of which this letter serves to confirm, but it was written not as regards his medical condition but as a management tool of NHS Grampian, Family Health Services (please see my **Documentary Exhibit WITN0086092**).

266. On 11th November, 2009 Alastair was again admitted to the ARI, on this occasion for a further liver biopsy. He was again detained overnight and discharged the following day following the procedure. The results showed no progression and revealed mild necro-inflammatory change and minimal fatty change. There was no evidence of cirrhosis or fibrosis and I understood that the test results meant that there had been no further progression of Hepatitis C. A further biopsy was arranged to take place twelve months later.

267. All of the above was reported in a letter to his GP from Dr Shirley English from the ARI Gastrointestinal and Liver Services Department led by Mr Fraser (please see my **Documentary Exhibit WITN0086093**).

268. Mr Fraser again wrote to Alastair's GP, following a clinical review conducted on 9th March, 2010. Within his letter, Mr Fraser states that Alastair had experienced 'a couple of episodes' since the New Year, and detailed the medication Alastair had been taking and continued to have.

269. He stated that the liver biopsy of 9th November 2009 had revealed very mild disease as a result of which he did not think that there was any need to 'jump in' with antiviral therapy at that time.

270. Notably, the consultant referred to Alastair's diabetes, stating that, *"There is fairly good evidence that the combination of diabetes and hepatitis c is associated with progression of liver disease and therefore we would be keen to try and control his diabetes as much as we can"* (please see my **Documentary Exhibit WITN0086094**).

271. Further thyroid investigations were conducted in April, 2010 including some as regards his placement on the Thyroid Register. Between February and May, 2011 Alastair was assessed and advised as regards the personal management of his Type 2 Diabetes, but investigations had shown that his high blood-glucose levels were not attributable to his dietary intake. Apparently, the steroids he had been prescribed to help with his breathlessness may have caused the diabetes and he had had to be prescribed insulin.

272. Between 18th and 20th May, 2011 Alastair was an inpatient of the ARI where a further (his pre-arranged annual) liver biopsy was performed. The results did not show any evidence of fibrosis but there was peri-portal lymphocytic inflammation and mild macrovesicular fatty change. In reporting these findings in a letter to Alastair's GP, Mr Fraser commented that he believed the results to be encouraging, and that no clinical intervention was required (please see my **Documentary Exhibit WITN0086095**).

273. Around March, 2012 Alastair's blood sugar levels were not good and he had by then had to be placed on minimal immunosuppression due to his renal impairment all of which is revealed in a letter of Mr Bathgate (Consultant, Scottish Liver Transplant Unit, Edinburgh) to Alastair's GP (Dr Tweedie) of 21st March, 2012 (please see my **Documentary Exhibit WITN0086096**).

274. On 10th May, 2012 Alastair went back into the ARI for a further liver biopsy but on this occasion was not detained there overnight, but was discharged the same day. Mr Fraser subsequently wrote to Alastair's GP reporting on the procedure undertaken and his findings, stating that it had revealed mild portal tract and minimal lobular inflammation. There was apparently no fibrosis or any indication that antiviral therapy was necessary (please see my **Documentary Exhibit WITN0086097**).

275. In August, 2012 Alastair had a lesion on the right side of his nose for which he was referred to a dermatologist. It was noted in his medical records that he was then taking Tacrolimus (amongst other medications) which can, apparently, predispose a person to skin cancer. The lesion was later identified as a possible basal cell carcinoma in September, 2012 (please see Paragraph 277, below).

276. On 10th November, 2012 Alastair spent a short time as a hospital inpatient for an operation to address the cataract in his left eye, to assist him as his eyesight had continued to worsen.

277. On 27th November, 2012 Mr Fawad Hussain (ARI, Consultant Locum Dermatologist) wrote to Alastair's GP (then a Dr Jayappa, but again at the same practise in Fraserburgh) with an update as regards the lesion on his nose.

278. Mr Hussain told Dr Jayappa that Alastair had undergone a punch biopsy of a non-pigmented ulcerated lesion on the right ala of his nose on 27th November, 2012 and reported that over the preceding six months the lesion had been increasing in size. He stated that the lesion appeared to be basal cell carcinoma for which he was going to refer my husband to hospital in Dundee for Mohs' Micrographic Surgery, to which Alastair had consented (please see my **Documentary Exhibit WITN0086098**). A subsequent letter (of 23rd January, 2013 confirmed the above, a copy now being exhibited as my **Documentary Exhibit WITN0086099**).

279. In January, 2013 the cataract in his right eye was surgically addressed, again to help improve Alastair's vision which had been failing when both eyes had been affected.

280. By February, 2013 Alastair was found to have been struggling to adequately control his Type 2 Diabetes. Following a diabetes clinic review at Fraserburgh Hospital, on 6th March, 2013 Dr Wendy Watson wrote to his GP to state that his HBA1C was steadily increasing and that by introducing insulin his glycamic control may be improved. She also stated that a reduction of Sitasgilptin was necessary due to Alastair's high EGFR (please see my **Documentary Exhibit WITN0086100**).

281. The nose issue he was facing was further reported in a letter of 11th March, 2013 following Alastair having been reviewed in a dermatology clinic. Dr Sanjay Rajpara (ARI) reported that Alastair had consented to Moh's Micrographic Surgery on his nose which would be conducted to address his basal cell carcinoma at the Ninewells Hospital in Dundee.

282. A liver biopsy was performed at the ARI where Alastair was an inpatient for the procedure between 8th and 9th May, 2013. At the same time, biochemical assessment of his thyroid revealed satisfactory results. A letter from a Mr Ashis Mukhopadhya (ARI, Consultant Gastroenterologist) to Alastair's GP provided a report on the findings of the biopsy histology which showed that there had been a slight increase in fibrosis and also periportal inflammation.

283. His clinical condition and liver function tests all presented as normal, so no further change in his clinical management was suggested (please see my **Documentary Exhibit WITN0086101**). There is a note within his medical records that he had a further liver biopsy performed on 3rd July, 2013 and that the procedure was 'uncomplicated.' I can only imagine that this took place to re-evaluate the findings of the earlier histology report.

284. On 16th July, 2013 Alastair went to Dundee (a four hour round trip) for the micrographic surgery on his nose. Unfortunately the skin graft which had been an integral part of the process subsequently bled and in late July had to be redressed

285. At Fraserburgh Hospital on 24th July, 2013 Alastair was found to have Late Onset Type 1 Diabetes and was placed on daily insulin.

286. In early August, 2013 Alastair started to experience some left side abdominal pain which worsened as the day went on and by 3rd August he'd been suffering with it for at least ten hours, the pain extending into his back and abdomen and he appeared slightly bloated. Taken into hospital, via A&E, he was diagnosed as having possible renal colic and given Tramadol and Buscopan then referred to his GP for further assistance.

287. Alastair returned to the ARI on 20th August, 2013 and was reviewed by Mr Mukhopadhya. His findings were subsequently reported to Dr Lee-Mason (GP) by letter (typed and presumably despatched on 22nd March). A brief past diagnosis history was provided as were details of the various medications he was then taking.

288. The consultant confirmed the removal of his basal cell cancer (from the nose) for which Alastair awaited a follow-up dermatology appointment at the time of being seen.

289. Some sort of error would appear to have been made, wherein apparently some blood for testing under Alastair's name was available from the day before, but Alastair hadn't been there or given this blood. As a result he gave blood to / through Mr Mukhopadhya for testing at the time of his appointment. Detailed results arising from this blood test were provided (please see my **Documentary Exhibit WITN0086102**).

290. Dr Lee-Mason (GP) referred Alastair for a kidney ultrasound scan on 1st October, 2013 as he had experienced renal colic with resultant discomfort and pain (please see my **Documentary Exhibit WITN0086103**). Within the referral letter, the doctor provided a potted history of his past health issues, current health issues and detailed his medication.

291. By the end of October, 2013 Alastair's blood sugar levels were showing improvement, but his medical records show that his HBA1C should have been lower than was being found, given that he was taking insulin.

292. On 4th November, 2013 Maria K. Rossi (Consultant in Public Health Medicine, Public Health Directorate) wrote to Alastair's GP (then a Dr Andrew Watt, but again at the same surgery in Fraserburgh) re. a Hepatitis C Follow-Up Project and a related individual patient letter. The letter reported Alastair to the GP and a person with Hep' C, referred to previous material with which the surgery had been provided, and offered advice as to the reduction of risk of infection with HcV for both surgery staff and the patient (please see my **Documentary Exhibit WITN0086104**).

293. A radiology report of 7th November 2013 from Peterhead Community Hospital noted that Alastair had simple cysts in his right kidney and evidence of a loss on cortico-medullary differentiation and cortical thinning. In February, 2014 his blood pressure was again found to have been raised and his renal function was impaired. On a better note, his glycaemic control was found to have improved.

294. By now, in the eyes of his liver specialist, he was stable and had been for some years, so the frequency of his liver biopsies was reduced from annually to bi-annually following a clinical review in Edinburgh on 11th March, 2014 as reported in a letter of Maureen Cunningham, the Liver Recipient Transplant Coordinator for Mr Bathgate (Scottish Liver Transplant Unit, Edinburgh) which is now produced as my **Documentary Exhibit WITN0086105**).

295. On 10th April, 2014 Alastair was tested and returned an abnormal ECG result as a result of which, on 29th April an 'SCI Gateway Electronic Referral' was conducted by his GP, Dr Francesca Lee-Mason within which she outlined his past and current medical condition and treatment(s) for the same (please see my **Documentary Exhibit WITN0086106**). The doctor raised concerns for what she termed to be a 'silent heart attack' or the first stages of heart failure in Alastair's case.

296. In deteriorating health, Alastair and I discussed a power of attorney, and on 17th June, through our solicitors, Alastair signed a Continuing and Welfare Power of Attorney agreement in which he appointed our children and myself as his attorneys with power to act on his behalf (please see my **Documentary Exhibit WITN00860107**).

297. Alastair's GP, Dr Francesca Lee-Mason had referred him to the ARI for further investigation of his renal issues. On or around 1st July 2014 Alastair was seen in the ARI Medical Renal Unit by Laura E. Clark, a Consultant Nephrologist. His past history was taken, as were details of his concerns, and what appears to have been a very thorough examination conducted, supported by tests, all of which is reported in a six-page report sent to his GP by Ms Clark (please see my **Documentary Exhibit WITN0086108**). Ms Clark suggested that one way forward was to perform a kidney biopsy, which Alastair had agreed to, in order to establish exactly what his renal situation was at that time.

298. In July, 2014 a chest x-ray revealed that Alastair's heart and mediastinal outlines to be normal and his lungs to have been 'clear.'

299. On 5th August, 2014 Alastair signed a document allowing his daughter and I to access his medical records and to seek information on his condition on his behalf, such as test results and allied matters.

300. A further detailed report from Ms Clark (ARI, Consultant Nephrologist) to Alastair's GP, dated 19th August, 2014 followed a kidney biopsy performed as previously agreed, following which he experienced a little post-biopsy haematoma but no other issues. The biopsy results were indicative of diabetic nephropathy which he was told at the time was likely to progress to end stage renal failure (please see my **Documentary Exhibit WITN0086109**).

301. In contrast to the kidney results, Alastair's liver function remained relatively stable across this time and fortunately by the time of a clinical review on 30th September, 2014 his renal function had stabilised.

302. Following the referral of his GP, Alastair had been placed under the care of Mr Andrew Hannah (ARI, Consultant Cardiologist) who wrote to the GP on 17th December, 2014 (typed and presumably despatched on 18th December) to report his assessment of Alistair's position.

303. He had provided reassurance to Alastair and I that he did not have a failing heart, but within his report noted an inferior perfusion defective suggestive of coronary artery disease, albeit that that would not have explained Alastair's continuing breathlessness (please see my **Documentary Exhibit WITN0086110**).

304. On 17th February, 2015 Alastair was reviewed in clinic by Ms Clark (ARI, Consultant Nephrologist) who, in a letter to his GP on the outcome of her examination stated that he had been suffering with an Upper Respiratory Tract Infection over the preceding Christmas period (2014 – 2015) and had by then been told (as stated above) that he had Coronary Heart Disease which Ms Clark confirmed (please see my **Documentary Exhibit WITN0086111**). A suggested treatment / management plan was discussed.

305. Attending a diabetes clinic review at Fraserburgh Hospital on 17th February, 2015 Alastair reported that he had not been feeling well and a month later (17th March) he was reviewed in clinic by a Dr B. Vijayan at the ARI who subsequently told his GP that Alastair had been keeping reasonably well apart from feeling tired. He also commented that his kidney function had remained stable.

306. On 27th March, 2015 a Professor Bob Steele of the Scottish Bowel Screening Centre reported to Alastair and his GP's practise that Alastair had tested positive on a kit he had used and returned – blood was apparent in his stool and although not cancer itself it was nevertheless indicative of bowel cancer and advice was provided including recommendation that a colonoscopy be undertaken (please see my **Documentary Exhibit WITN0086112**).

307. The Bowel Screening Programme again wrote to our GP (2nd February, 2015) stating that Alastair had tested positive but at the relevant time had, *"... significant co-morbid disease having had a liver transplant and also has CKD Stage 4 due to diabetic nephropathy."* The letter was written by Perminder Singh Phull, ARI, Consultant Gastroenterologist who stated that he / she was, *"... uncertain as to his fitness for colonoscopy"* in which regard he was seeking further views of clinical colleagues (please see my **Documentary Exhibit WITN0086113**).

308. My understanding is that whilst Alastair was attending the hospital in Dundee, Alastair's bowel cancer was suspected as they had initially discovered blood in a stool sample, so it may not have been uncovered as a result of a kit having been used, but I am unsure on this matter, not that I think it matters a great deal, had it been found in Dundee, that was only a relatively short period of time from Bowel Screening Service having become involved.

309. Ms Clark (ARI, Consultant Nephrologist) again wrote to his GP, having reviewed Alastair in her clinic on 21st April, 2015. She again provided a detailed report (now attached as my **Documentary Exhibit WITN0086114**) within which she stated that Alastair looked remarkably well despite a recent injury to his right eye. He appeared to her to be well enough to undergo the questioned colonoscopy provided he did so as an inpatient, as she had concerns for his bowel preparation and how the associated medication may impact upon his deteriorating kidneys.

310. On 27th May, 2015 my husband had to be admitted to the ARI, renal ward as a result of what can best be described as having been a general malaise, he was really feeling unwell and lacked all energy to look after himself adequately, he was tired, didn't really want to eat and became breathless very easily.

311. He remained an inpatient until discharge on 3rd June and I have managed to secure his discharge record, although many of its pages are missing (1, 2, 4, 7 and 8 out of a total of ten). Of these I now produce an extract (four pages) as my **Documentary Exhibit WITN0086115**).

312. Apart from the symptoms I have described, itchy skin was additionally noted by the staff treating him on the ward as something he had been experiencing. His medical investigations, such as they were at that time, together with medication he was taking are all detailed.

313. Alastair attended a bowel screening clinic on 8th June 2015 and elected to have the proposed colonoscopy. He also attended a pre-dialysis clinic review on 15th June and on 18th June, Mr Fraser confirmed in a letter to Alastair's GP that a decision as to dialysis, or not, was then awaited. At that point in time Mr Fraser did not think that Alastair could be given antiviral therapy, remarking that, *"I think his hepatitis c is the least of his problems at present"* (please see my **Documentary Exhibit WITN0086116**).

314. Between 20th and 22nd July 2015 Alastair was an inpatient of the ARI where he underwent a colonoscopy procedure. The subsequent report showed that he had Diverticulosis and a Malignant Colonic Tumour. In a clinic review held on 3rd August, 2015 it was noted that Alastair had been pleased with the cosmetic outcome of the Moh's surgery on his nose of about eighteen months before.

315. His case was discussed at a colorectal multi-disciplinary team meeting with a view to his being operated upon. Histology following his colonoscopy had revealed a tubular adenoma with low and high-grade dysplasia and macroscopic appearances were of a malignancy

316. On 12th August, 2015, Alastair and I met with Mr Shayanthan Nanthakumaran, a Consultant General Surgeon at the ARI. Also present was a Karen Gow, a Colorectal Cancer Nurse Specialist who had been assigned to Alastair re. his bowel cancer.

317. He explained to us a suggested treatment option which consisted of a right hemicolectomy. This surgery meant that Alastair would thereafter most likely have had to be given permanent renal replacement therapy. The surgery was risky and this risk included a high mortality rate, but the alternative was to seek to manage the tumour conservatively which, given time, would almost inevitably have led to small bowel obstruction. There wasn't much of a choice but at least it was all laid out before us.

318. Mr Nanthakumaran subsequently detailed our consultatiuon in a letter to our GP which I now produce as my **Documentary Exhibit WITN0086117**).

319. Between 19th and 21st August, 2015 my husband was admitted to the ARI having had to be taken there by ambulance following some four hours of rectal bleeding. Upon admission, through A&E, he was transfused and given some iron, intravenously.

320. Alastair had, by that time, been subject to a number of pre-dialysis reviews and a treatment plan which involved a left brachicephalic fistula had been agreed upon. On 31st August, 2015 his clinicians confirmed that his kidney function remained poor.

321. Dr Jacqueline Furnace, Clinical Research Fellow Manager from the Diabetic Clinic of the North Aberdeenshire Local Community Health Partnership, wrote to his GP on 2nd September, 2015. She had seen Alastair earlier that day in clinic at Fraserburgh Hospital as part of his ongoing diabetes management and reported her findings in her letter (please see my **Documentary Exhibit WITN0086118**).

322. On 4th September, 2015 my husband Alastair was again admitted to the ARI, this time suffering from hyperkalaemia. He was not detained but discharged later the same day having been attended to by a Dr Ben Dobb of the ARI Acute Medical Initial Assessment Unit who wrote to Alastair's GP regarding his admission, in a letter of 21st September, 2015 (please see my **Documentary Exhibit WITN0086119**).

323. Alastair's medical records hold information regarding his taking 'Pro-Source Liquid,' in order to boost his daily protein and calorie intake at around this time.

324. In order to commence with dialysis treatment, Alastair had to be admitted to the ARI for a permanent catheter to be fitted, which took place on 21st September, 2015. As Alastair had to commence dialysis to address his failing kidney function before he could have any bowel surgery, he was placed into a single room on a ward in which he could begin his renal treatment. He was isolated, to protect him from any ailments others may have had, and anyone entering his room had to be covered head-to-toe in gowns and such like as a preventative measure.

325. Between 16th October and 30th October, 2015 my husband was an inpatient of the ARI where he underwent a right hemicolectomy operation during the course of which a growth of about the same size as a tennis ball was removed from his bowel. He was also fitted with a stoma bag. His bowel surgery included some involvement of his renal clinicians.

326. Mr Nanthakumaran wrote to our GP following the surgery, describing what had occurred in a letter dated 11th November, 2015, but importantly for Alastair, noted that no further surgical intervention would be required after this procedure (please see my **Documentary Exhibit WITN0086120**).

327. Alastair's doctors told him that they had managed to remove all of the bowel cancer so there was no need for him to have to endure anything else, such as chemotherapy, although he told me that he would most probably have refused to have been given chemotherapy as it had made him so unwell before.

328. Ms Clark (ARI, Consultant Nephrologist) wrote to Alastair's GP on 12th November, 2015 providing details of a Hepatitis B Immunisation Protocol in use with dialysis patients, suggesting that Alastair be inoculated. This appeared to be the sort of generic form / letter that may have been sent to any patient meeting the dialysis criteria, and although it had Alastair's patient details and was written with him in mind, did not as such appear to have been bespoke – personally I wonder how effective it may have been considering that he had Hepatitis C in any event (please see my **Documentary Exhibit WITN0086121**).

329. Alastair again entered the ARI as an inpatient between 21st and 23rd December, 2015 where he had surgery for the construction of a left arm brachio-cephalic a-v fistula.

330. At a review in clinic held on 14th January, 2016 which we attended together, both Alastair and I expressed concerns about a rash that he suffered from, especially at night. Dr Anedin, whom we met with on that occasion believed it to be no more than a heat rash or some form of contact dermatitis.

331. On 10th February, 2016 Ms Clark wrote to Alastair's GP following on from her letter of 12th November, 2015 and expressing a concern that my husband had no Hepatitis B antibodies and required a vaccine or booster (please see my **Documentary Exhibit WITN0086122**). I believe that Dr Tweedie (GP) responded, but merely confirmed that they held no record of his ever having been vaccinated against Hep' B.

332. In a letter from Mr Fraser to Alastair's GP, dated 15th March, 2016, which followed a review of Alastair in his clinic earlier that day, the consultant stated that Alastair had complained of a nocturnal itching. He stated that he didn't think there was a need to 'rush into' antiviral therapy in order to address what he clearly thought to be an HcV related symptom, although in saying this he added that there were some, *" ... promising developments that may be used in the future ..."* alluding to the fact that a new treatment or treatments may become available in the near future (please see my **Documentary Exhibit WITN0086123**).

333. Alastair was prescribed some Hydroxyzine, a drug used in renal failure cases, but in this case used to combat his nightly itchiness and had to be advised of its associated side effect, i.e. drowsiness (please see my **Documentary Exhibit WITN0086124**).

334. In April, 2016 it was noted that Alastair was doing well on dialysis, and as such he had been transferred to a unit in Peterhead, much closer to home, as he had been driving to and fro each time. Just a couple of months later, in June, 2016 Alastair was found to have a Staph' Aurous infection (which I believe is / was MRSA again), in his upper respiratory culture. At a dialysis clinic appointment on 13th July, 2016 he was found to be clinically euvolemic, so all in all, his health was very much 'up and down' and changeable at very short notice.

335. On 16th August, Mr Fraser wrote to our GP following another review of Alastair in clinic. He remarked that the itch was major issue, athough on a more positive note his liver was doing very well. The consultant added that, *"I have not suggested any intervention with regard to his hepatitis c as his last Fibroscan revealed only mild disease and any treatment would be complicated by his dialysis. There are some new treatments on the horizon and this may be of benefit to him in a couple of years time"* (please see my **Documentary Exhibit WITN0086125**).

336. Alastair had a duplex scan of his left upper arm fistula in October, 2016.

337. On 26th October, 2016 Ms Clark wrote to Alastair's GP having reviewed Alastair at the Peterhead Dialysis Clinic (please see my **Documentary Exhibit WITN0086126**). Her letter discussed his food diary, with a view to identifying the source of hyperkalaemia as, although not having identified the precise cause, Werther's Original sweets were suspected and Alastair was advised accordingly.

338. Alastair had been put back onto intravenous iron therapy as a result of renal anaemia. Ms Clark stated that she believed his itch was due to hyperphosphataemia.

339. The consultant summarised how Alastair's stoma was working well, but that he found it uncomfortable and occasionally passed a jelly-like substance. His heart sounds had revealed a mild ejection systolic murmur, which may have radiated from his fistula. Ms Clark had asked the Urology Department of the ARI to consider him for a cystoscopy, in light of the frank haematuria on his small amounts of urine.

340. In December, 2016 Alastair was reviewed through a diabetic retinopathy eye screening programme. He was found to be asymptomatic with his diabetes retinopathy graded as 'mild.'

341. On 20th December, 2016 Alastair was admitted and then discharged from the ARI having gone in with a visible haematuria. He had a flexible cystoscopy performed at the time (please see my **Documentary Exhibit WITN0086127**, extracts from his patient record of this date and as regards the events now detailed below).

342. The very next day, 21st December 2016 we had to call the A&E Department as we believed Alastair to have developed a urinary tract infection, and we needed advice on what to do from the renal unit. He had initially become unwell, suffering with high-grade pyrexia whilst undergoing dialysis treatment in Peterhead. He had to be admitted to the ARI again, but only remained an inpatient overnight. As once before, not all of the medical record of this admission is available, the bulk of its pages being missing (1-4, 9, and 10) as a consequence of which I only produce an extract (4 pages).

343. An abdominal ultrasound scan was undertaken on 4th January, 2017 following which his case was discussed at a Bladder multi-disciplinary team meeting held on 17th January, under the stewardship of Justine Royle (ARI, Consultant Urological Surgeon).

344. I now produce a copy of the resultant patient treatment plan for Alastair as my **Documentary Exhibit WITN0086128**. The summary shows that both of his kidneys at that time had been found to be ill-defined (on the scan) with a lack of cortical medullary differentiation and thinning of the cortex. There were also two large soft subtle soft-tissue masses in the right lobe of his liver.

345. A Speciality Registrar in Diabetes and Endocrinology at the Fraserburgh Hospital, Dr Asha Hesarghatta Shyamasunder, wrote to Alastair's GP on 25th January 2017 following a review conducted in the diabetes clinic. Two of the seven pages of this letter are also to be found within Alastair's medical notes (please see my **Documentary Exhibit WITN0086129**).

346. The doctor reported that an abdominal ultrasound had revealed a solitary left renal calculus and new focal lesions in the right lobe of his liver. At the time of writing, Alastair had been unaware of the ultrasound results, but had been told that there was an issue with his liver, but the broader detail had not been given to him.

347. Ms Royle (ARI, Consultant Urological Surgeon) wrote to Alastair on 25th January 2017, telling him that she had discussed his scan results in a multidisciplinary team meeting (as I have previously divulged, above), and that they had concluded that they (i.e. the MDT) were *"... happy enough at this stage with your kidneys but they have shown an area within your liver for which we will ask the Hepato-Biliary Team to re-evaluate you ..."* In short, whereas the clinicians appeared content that his kidneys could continue as they were and being managed as they were, there were concerns as to the condition of his liver and further enquiry was required (please see my **Documentary Exhibit WITN0086130**).

348. The lesions noted on Alastair's liver was a development picked up by Dr Shyamasunder (Speciality Registrar in Diabetes and Endocrinology). He / she wrote to Mr Fraser on 26th January, 2017 discussing the lesions and how he (Alastair) was as yet unaware of the ultrasound results, only having been told that there had been an abnormality found through a scan of his liver, which he (Alistair) would later discuss with him (Mr Fraser). In other words, Alastair hadn't been given any detailed information (please see my **Documentary Exhibit WITN0086131**).

349. Alastair was told that he had liver cancer in January 2017. He was told that his condition was terminal in February, 2017 when he was advised that he had a life expectancy of about a year, but this subsequently became six months and was then reduced even further and he was given just weeks to live, and eventually just days.

350. Following a review in clinic on 21st February, 2021 Mr Fraser told Alastair's GP that Alastair had been losing weight, although none of the symptoms he was then presenting with appeared due to his past bowel issues. All the same, Mr Fraser wanted his case to be discussed further at a colorectal MDT as he suspected that an issue with the bowel may have been the root cause (please see my **Documentary Exhibit WITN0086132**).

351. Sadly, Alastair's health continued to decline. One factor in this is that despite what they may have thought at the time, the clinicians *had not* removed all of the bowel cancer as had earlier been thought, and cancer had spread around his body including in his new liver. As a result, Alastair became visibly jaundiced and his liver began to shut down as he moved towards the end of his life.

352. Ms Clark wrote to Alastair's GP on 22nd February, 2017 following a review of his case in the dialysis clinic at Peterhead. A CT Scan had confirmed that Alastair had multiple liver and lung lesions consistent with metastases, news which Mr Fraser had given to Alastair the previous day. Alastair had been both shocked and upset, particularly as he had been feeling quite well and had been eating normally leading into this.

353. Ms Clark reported that Alastair may have needed some form of anxiolytic to help him sleep given that this was an upsetting and anxious time for him – it was for us all (please see my **Documentary Exhibit WITN0086133**).

354. As Alastair had lost a considerable amount of weight, a plan was developed to reduce his dry weight on dialysis. It was noted that his liver function tests had shown a deterioration since October, 2016 although his dialysis results had been stable.

355. Ms Clark's letter showed Mr Fraser to have been considering treatment options, but Alastair, having been considering his position and having been in such ill health on and off over so many years, had already made a decision as to what he thought was best for him – he didn't want to spend weeks in hospital or having chemotherapy, which he considered would probably have killed him on its own, he wanted to be at home and to enjoy as much of an active life as he could, with a decent quality of life.

356. Angharad Marks (ARI, Honorary Consultant Nephrologist) wrote to Alastair's GP on 24th February, 2017 providing advice regarding Hepatitis B vaccination, attaching a protocol re. the same as he had previously tested negative for the HbV surface antibody. Clearly, some of the clinicians were wholly unaware of his position and hadn't taken the time to fully appraise themselves by referral to his notes before sending out a well intentioned but ultimately worthless, letter.

357. Dana Kidder (ARI, Consultant Nephrologist) wrote to Alastair on 1st March 2017 to ask if he would consider helping with a medical study being undertaken regarding markers for kidney injury in patients with diabetes mellitus, a study which would involve using tissue from Alastair's previous kidney biopsy (please see my **Documentary Exhibit WITN0086134**).

358. A colorectal screening service MDT meeting resulted in a treatment plan for Alastair having been created on 3rd February, 2017 following on from a CT scan which had revealed new liver and lung metastases together with lymphadenopathy, non-obstructive urinary tract calculi and that Alastair's urine bladder was 'thick-walled.'

359. On 8th March, 2017 Mr Fraser wrote to Alastair's GP following a telephone call with Alastair regarding the outcome of the colorectal MDT meeting. There were then no treatment options available as regards his lung or liver metastases, and Alastair had told Mr Fraser that he no longer wanted cancer treatment, having previously had chemotherapy (please see my **Documentary Exhibit WITN0086135**).

360. Dr Fraser told Alastair that he could speak to Laura Gunn, a Colorectal Cancer Specialist Nurse, if he needed someone to discuss his situation with, but that otherwise the consultant would see him again a couple of months thereafter, which Alastair was happy to accept.

361. Alastair asked the consultant how long he thought he had left to live? He was told that his cancer would likely progress within a period of months rather than years

362. At the Peterhead Dialysis Unit, Ms Clark met with Alastair and completed a 'Do Not Attempt Cardiopulmonary Resuscitation' form, which he signed on 19th April, 2017. This had already been discussed by Alastair with his GP, so it was expected to come up at some point in time or another. It appeared to Alastair that although CPR could prove to be successful, the outcome would not be of any overall benefit to Alastair, so he did not want CPR to be undertaken.

363. On 19th April, 2017 a review showed that his liver function had continued to worsen. Alastair described having been feeling 'twinges' of pain around his liver and Ms Clark noted that he would likely develop some 'liver capsule pain.'

364. He reiterated that he did not want to be admitted to hospital if he was dying, and it was agreed that efforts would be made to make him as comfortable as possible / practicable, at home in his final days. Ms Clark noted that his dialysis continued to be going well and stated that it would not be reduced at that time as he was keeping active and quite well with it (please see my **Documentary Exhibit WITN0086136**).

365. Ms Clark wrote to Alastair's GP on 24th May, 2017 following another review conducted in Peterhead when Alastair had attended for a dialysis session. She noted that Alastair had rapidly declined over the four weeks leading into their meeting, and appeared significantly jaundiced with a severe itch and upper back pain (please see my **Documentary Exhibit WITN0086137**).

366. Within her letter, this consultant continued that, *"... they were looking at just a few weeks given the rapidity of decline in the past few weeks."* All the same, Alastair was keen to continue dialysis treatment as he felt that he would only live for a matter of days, not weeks, without it, and he wasn't yet prepared for that eventuality.

367. Alastair discussed his position regarding dialysis with the consultant at this review and it was agreed that should he become too unwell to travel to the unit to receive dialysis treatment, then it would have to be accepted that he was then entering the terminal stages of his illness and that from that time onwards every effort should be made to keep him comfortable, at home, in accordance with his wishes.

368. Alastair didn't think that I was fully accepting of the situation and was keen for Ms Clark to speak to me over the 'phone. She believed that a face-to-face meeting may have been better and so asked our GP to meet with us, in person and at home, to discuss the future – *"... given the difficulties that he is facing with his wife's reactions I have suggested that he may wish to consider going to the local hospital in Fraserburgh, and I think he is going to consider this seriously."*

369. Nurses from MacMillan met with my husband and I, and having visited the house ordered some equipment to make some adaptations for Alastair.

370. On 8th June, 2017 we had to call for an ambulance. Alastair had woken up feeling agitated and found that he was unable to swallow. He said that he could see animals and funny people in the room. Please see my **Documentary Exhibit WITN0086138** which is a copy of the emergency services log of the incident.

371. Alastair had calmed down a lot by the time help arrived, but had woken up really agitated, confused and panicking. Interestingly, the call log records that we did not have a 'just in case' box at home – sadly, we simply weren't prepared for his inevitable decline.

372. Alastair was then bedbound with me acting as his main carer. His medical records note that I was 'coping well' at the time, but I needed ongoing support of an evening and a nightly 'phone call was requested.

373. Alastair died at 7.25p.m. on 10th June, 2017. His passing was duly registered, and a copy of the relevant forms are now produced as my **Documentary Exhibit WITN0086139**. The certifying doctor was our GP, Dr Francesca Lee-Mason.

374. His cause of death was given as having been:

I(a) Cachexia due to metastatic adenocarcinoma of the colon

I(b) Pulmonary and liver metastatic disease due to adeno-carcinoma of the colon

With secondary issues being recorded as:

II Renal failure due to diabetic nephropathy
Diabetes Mellitus Type II
Liver Transplant

375. Hepatitis C, which had been acquired from an NHS transfusion, and which had been a major contributory factor, in my view, to the demise of his natural liver, wasn't mentioned.

376. I wish to emphasise that when Alastair had first been told of the damage to his liver, he was 'tea-total' and never drank any alcohol. Later, having received a donor organ and not wishing to damage it, he remained tea-total. I can recall an occasion when he had a small sip of someone's lager, it made him feel ill and that aside, he never drank.

377. As a nurse, I recognised that Alastair had Hepatitis C, that it was there, within him, and was never going to go away, especially as he couldn't be treated. I believe that Hep' C directly led to many of his other medical problems, or was at the very least a contributory factor with them. One only has to look at the various ailments he succumbed to, from aches and pains, flu-like symptoms and lethargy through to liver cancer and deteriorating kidneys, and in my view the evidence is there.

378. Interferon therapy to treat his HcV infection was first mentioned by Audrey Dawson on 7th May, 1996 (WITN0086032). On 9th September 1996 Richard Soutar had advised that Alastair had been found to need Interferon treatment for Hepatitis C, that a course of treatment had commenced, and that he had been shown how to self-administer the drug (WITN0086037). He stated, in reporting this that Alastair had been appraised of the side effects which came with using Interferon and had been advised how to minimise them.

379. Alastair started his first course of Interferon before his liver transplant and I think that initially he responded to it well, but I did not notice any appreciable difference in him whilst he was taking it, but it was unsuccessful and did not clear him of the infection.

380. During the course of his treatment, Marcia Ratcliffe (writing on 5th November, 1996) recorded that Alastair had been unable to recommence taking Interferon due to poor blood test results (in particular, low platelet levels), which can be seen in my **Documentary Exhibit WITN0086140**. Basically, his taking Interferon had reduced his blood count, so he was taken off of it for a fortnight, to recover and was then going to be returned to the treatment but on a lower dose.

381. Jane Tighe, on 21st October 1996 had written to say that Alastair had been compelled to take a break from Interferon treatment as a result of thrombocytopenia (WITN0086039) and that having been off of the drug for some two weeks was going to take a further two week 'break' before he returned to the treatment.

382. On 7th October, 1996 (in what I believe may have been the review upon which Jane Tighe had relied, as above, it was noted that Alastair had been coping with his Interferon treatment with *"... little in the way of problems ..."* but his platelet count had dropped so his treatment had to be suspended.

383. Then, on 18th November, 1996 following a review, a clinical decision was taken to reintroduce Interferon Therapy and give Alastair three mega units of Alpha Interferon, with a view to the dosage being increased if he were able to tolerate it (please see my **Documentary Exhibit WITN0086141**).

384. On 2nd December, 1996 Jane Tighe reported that Alastair was tolerating Interferon and that his treatment was to continue. Some side effects were noted, a little tiredness and anorexia, but otherwise he was, 'tolerating it well' and was to be seen a short while thereafter with a view to the dosage being increased (please see my **Documentary Exhibit WITN0086142**).

385. On 23rd December, 1996 his platelet count was found to have fallen further as a direct result of the Interferon treatment for Hepatitis C and there was some speculation that the course of treatment he was on might have had to be abandoned albeit that he complained of no overt, adverse side effects (please see my **Documentary Exhibit WITN0086143**).

386. As Alastair's liver function tests had remained unchanged and his platelet count had dropped further, at a clinical review of 13th January 1997 a decision was finally taken to stop this form of treatment – this was on medical grounds, not at Alastair's request, and sadly he was never offered any other form of treatment, albeit that a combination drug therapy was once mentioned, but not pursued, and 'new' treatments were hinted at but never delivered or arrived (please see my **Documentary Exhibit WITN0086144**).

387. On 27th February 1997, unknown to Alastair, an R. Chopra (Glasgow Royal Infirmary (GRI), Consultant Haematologist) contacted Mr Watson (ARI, Consultant) to offer a place on a trial of Interferon Beta *if* Alastair met the criteria required. Clearly, he did not as he was never put on an Interferon Beta course, but the inquiry may be interested to know that the GRI was then the only place in the country (U.K.) offering HcV treatment with Interferon Beta (please see my **Documentary Exhibit WITN0086145**).

388. I can remember that Alastair was offered a second course of Interferon, again prior to his liver transplant, but I cannot now remember when. It was on this second occasion that he found his body was unable to complete the course, and he felt dreadful whilst taking it, nauseated, light-headed and generally awful with a combination of the side effects, a further lowering of his platelet count and the fact that it did not appear to be working, he was taken off of the course.

389. Alastair had been against intravenous drug use and personally hated needles, unless they were for his treatment. He had no tattoos, save for five small dots which was a medical tattoo on his back, so it had been placed there in clinically sterile conditions (it had been to help doctors with the dosage and sizing of his treatment). He had never been sexually promiscuous.

390. Alastair felt angry and frustrated that he had been given a disease (Hepatitis C) by the very people who are there to help you with health issues – in his view it should never have happened, should never have been allowed to happen, all products the NHS were using should have been safe.

391. Unfortunately, having unsuccessfully tried Interferon, and with no alternative treatments available for him, he had to learn to live with Hep' C infection, which as time progressed he did, but that doesn't mean he accepted it.

392. When Alastair had first been diagnosed as having HcV, or at least when he was first told that he had Hep' C, as there was a clear delay before he was informed, he was unwell and consequently quite frail. I wonder how much information he may have been given regarding HcV, and how much he may have actually taken in.

393. Alastair understood that his liver had been slowly but surely failing as time went on, and the longer he waited for a resolution, so the poorer his condition became, and at times came to believe that he'd not live long enough to receive a donor organ.

394. Prior to his transplant, as he was waiting for the ambulance to take him in, having already prepared for the worse, just in case the operation wasn't successful, he told our daughter of all of our important documents, where he kept them and how they could be accessed. I didn't know this at the time as I was sorting out his bag for him, but I learned of it later.

395. When Alastair had first been diagnosed as having bowel and liver cancer, he broke down emotionally and found it extremely hard when he told us of his fate when in February 2017 he let us all know that his condition was terminal.

396. He'd already faced a great deal, and had 'bounced back' from bad news, really bad news, on a number of occasions but this was just too much for him, but we supported him, especially our daughter who would not let him give in to the disease or give up, so he'd faced up to what was happening and tried to get on with things as best as he could and in any event, 'giving up' had never been in his nature.

397. Our daughter had a son in 2005 and Alastair was devoted to him; he lived for his Grandson, it gave him impetus in his life, and he was grateful for every additional day her had.

398. As with our important paperwork, Alastair was a very organised man and this extended into his actions as his health declined, as demonstrated by the conversation he had with our daughter – but he also made all of the arrangements for his own burial, to ensure that things went as he had wanted them to, whilst at the same time saving my daughter and I this onerous task which he must have known we would have found extremely difficult ourselves.

399. Alastair and I never spoke of his hepatitis infection with anyone outside of the house, outside of the immediate family, not even with other family members or close friends, with the sole exception of medical personnel. We both felt that lots of people have Leukaemia, but they don't all die, with treatment most live lengthy lives and enjoy a good quality of life – but they don't all get HcV because of it.

400. Alastair was given Hep' C as a means of treatment for Leukaemia, and as a result his health worsened as opposed to improved – it destroyed his liver, then attacked his replacement liver and impacted upon other organs such as his kidneys in an equally damaging manner.

401. The Hepatitis C virus Alastair received because of the NHS use of contaminated blood and / or contaminated blood products directly led to his death and saw an otherwise fit and healthy, hard-working, active, responsible and loving family man suffer at a time when he should have been able to enjoy himself, his family and friends and the company of his grandson – it took all of that away from him and him away from me.

402. All the same, Alastair never once blamed the people who had been treating him for his ill health – he placed the blame for what happened with the health authorities, not the clinicians who had to work with the materials they had been given. He always wanted it known that the various doctors who had cared for him had done their level best to make him better, and when that couldn't be done anymore, tried to make his life, and its end, as comfortable as was possible. They also deserved better in his eyes.

403. The whole situation, from the time of Alastair's first major illness (i.e. Acute Myeloid Leukaemia) was extremely hard for me to deal with, but like him in later years, I just had to get on with things no matter how difficult life was proving to be.

404. I was a married woman with two young children who needed support, especially as they each witnessed their fathers decline from such an early age. He needed my support too, but the children had to be put first, so it all became quite challenging for us all, especially as I still had to work to help support us all.

405. Emotionally, it became a great strain, none more so than when it was suggested that I submit myself for HcV testing– the thought of us both having it was extremely worrying for me and I worried as to our future and for that of the children, and Alastair felt guilty for having exposed me to the virus, even though it had not been his fault. To date, I have never been tested

406. Working, running the household, looking after the two children and caring for Alastair meant that I was very, very busy all of the time and never really had time to stop and take stock of what was happening around me. Whenever bad news arrived, like Alastair, I just had to get on with it, so I did for the family's sake, but there was no support. Alastair and I met some fantastic clinicians across the years, but there was never even the slightest whiff of any support for me whilst this was all going on, or for Alastair as he battled with his ailments and treatment(s).

407. Alastair and I had always enjoyed travelling, holidays, cruises, breaks we took all over the world together prior to his liver having started to decline (i.e. his natural liver). These were then limited to just holidaying in and around Scotland (like the trip to the Orkneys which I have mentioned), as he was too ill to have been taken overseas. He was also quite reluctant, following the bowel surgery, to lay on a beach as he didn't want anyone to see, or worst still to touch, his stoma bag, it was a matter of great privacy to him and he had wanted to keep it that way.

408. We had also enjoyed visiting friends and family, going out to different places and attending dinner parties, that sort of thing, but once his liver began to fail he simply wasn't fit enough for any of those activities. He'd loved walking, and used it as a part of his therapy whilst trying to get better, but again it was something he simply couldn't do. In the end, as all of the things we used to do together as a couple were lost to us, we'd end up at home, alone, drinking tea together, and as such became a little reclusive beyond folks who'd come to visit us.

409. Alastair and I had always enjoyed a healthy life together and intimacy was an integral part of that loving bond, but as we learned that Hepatitis C could be sexually transmitted, we took the difficult yet fully conscious decision *not* to have sex anymore, and passed up any thoughts we may have harboured for having a larger family.

410. As a nurse, I had always known what Alastair faced in so far as Hep' C was concerned, and knew that given the passage of time, he'd need a liver transplant. Sometimes, having some medical knowledge is helpful, sometimes not, and it was not at all helpful for me, emotionally, to know what this infection threatened to do to Alastair if it continued unchecked, as it did. In some respects I wish that I'd not known as it played on my mind, caused worry, made me anxious for him, for us and for us all as a family.

411. We rather got used to not having Alastair around the house during his frequent spells as a hospital inpatient, and then when he started going in for regular dialysis, as he had to stay overnight each time. As time went on, he spent more time in hospital than he did at home – his death was not 'sudden' but gradual and over a most protracted period of time. It may have come fairly swiftly in the end, but that end had been a long time coming which had a terrible impact on my children and I.

412. As mentioned, we were never offered any help, but equally we never sought any ourselves prior to Alastair's death. We had been in touch with MacMillan Nurses, and one was present over the last few days of Alastair's life, but otherwise I hadn't wanted any help with his care, I did that and our daughter stepped in to help as well. A MacMillan Nurse first visited us in May, 2017 and told us that he'd come back, regularly, but he never did.

413. In spite of the health circumstances, I consider Alastair's death to have been untimely, he could and should have lived for a lot longer than he did, and we should have enjoyed more time together as a couple, especially once the children had grown up and moved on with their own lives, but we never had that chance.

414. Our daughter found her father's ill health and untimely death particularly impactive. From around 1991 onwards, she had to step up and help bring up her younger brother as I couldn't do everything – she was just eleven, but because I worked night shifts, she would have to get him up of a morning, collect him from school and do all manner of things for and / or with him whilst at the same time also sharing the role of full time carer for her father, with me, especially as he deteriorated as at times he was wholly unable to feed or bathe himself. It was not how she should have spent such formative years.

415. From seventeen (at which age she passed her driving test), she took on the responsibility for ferrying her father around – she would always take her dad out in the car, sometimes just for long drives to 'get him out of the house,' but also dealing with the necessary things, like getting him to and from appointments.

416. I knew too much about his conditions, and she learned too much of them and saw at close quarters what was happening to him. A great deal of worry, responsibility and concern was placed on her shoulders from a very early age, but she remained strong and would never break down before her father, no matter how emotionally distressing she may have been finding things. I am, as her father was, immensely proud of her and how she conducted herself, but she should never, ever have been in that position.

417. I do not doubt that her schooling suffered as a result of her having acted as she did, but she would not have had it any other way and simply did what she did, when she did, for her father.

418. I should add that my brother-in-law also helped us, but he wasn't 'on site' as our children were, nevertheless we needed him and he proved very helpful with Alastair for which I am very grateful.

419. Our daughter is employed in the oil and gas industry. Alastair's declining health and care needs meant that her employment choices were rather limited, as despite having been offered a good, well paid and interesting job with prospects overseas, something she had earlier enjoyed during something of a respite with his needs, she later opted to remain in GRO-C so that she could be on hand to help with her father.

420. This had a detrimental impact upon her career, career prospects as they were at that time, and income. This wasn't helped by the fact that whilst she had previously working abroad (in Australia) she had flown home to help when her father had fallen ill with Sepsis, cutting short the time she should have spent working there.

421. It was to our daughter that Alastair turned when it came to him settling his affairs, and she sat down with him to sort out the funeral arrangements, in such detail that even the type of coffin was discussed, and it was she, not I or our son, who had to tell his brothers when Alastair finally passed away.

422. Sadly, her son, in whom Alastair took such a keen interest and whom he loved dearly, only ever knew his Grandfather when he had been in ill health.

423. I do not think that Alastair was ever treated or regarded differently by those treating him because he had HcV. At times he was even given a private room (which he enjoyed). HcV had no detrimental impact on his securing dental support. His main problem in so far as his securing care is concerned was with him sourcing a donor liver as he had a rare blood type.

424. Travel insurance was an issue and in the end he decided *not* to tell travel insurers of his Hepatitis C status as otherwise it was a major issue. Later in life, telling them that he had diabetes and / or had had a liver transplant saw quoted premiums going 'sky-high' and as such they were unachievable. As someone in his position, he would have had to have health care cover, but the prices quoted meant that we couldn't go overseas, it was just another factor of our having to stop living life as we always had.

425. A history of cancer, from the time of his leukaemia treatment, meant that life insurance was equally unachievable. I can recall a time (in July 1998), when Alastair applied for Life Insurance, and know that his medical records contain a letter from The Brittanic Assurance Co. to his GP. It shows the type of questions doctors were being asked, off the back of which some quite ridiculous premium payments were sought or life insurance simply was not made available (please see my **Documentary Exhibit WITN0086146**).

426. Alastair made a conscious decision not to tell anyone outside of his immediate family who may have *needed to know,* about his having Hepatitis C. We never told any friends and the children were barred from telling theirs. Hep' C was kept within the house. I do not know why Alastair took this stance, but believe it to have been rooted in the stigma which was associated to Hepatitis at the time of his having become infected – media scares and adverse publicity. As none of our friends knew, no one else learned of it, but we didn't prevent visitors from calling at the house, so we weren't cut adrift from society or became reclusive, we were just 'careful.'

427. In around 2000, Alastair had been made redundant – the company he last worked for ceased trading. Despite his best efforts to return to the workplace, as he had before, ever worsening ill health meant that he was unable to do so, as a result of which he effectively 'retired early,' but he kept himself busy and active, making things from home.

428. The access society now enjoys to sickness and / or welfare support or grants to assist were not available to us at that time. As a result, I became the family breadwinner, working nights and additional shifts where possible, to make ends meet, and in particular as we had to travel all over Scotland for his treatment, which became a considerable expense in its own right.

429. As much as was possible, I manipulated my working shift pattern to accommodate whatever may have been necessary at any given time, making myself available to accompany Alastair to and from his various appointments. Fortunately, going to the GRI or ERI for a regular consultation or treatment worked well with my 'days off' and my employers were brilliant, very understanding, extremely caring and overall very accommodating with our needs.

430. As his health worsened and his needs increased, I gave up working in order to offer him the full time care he required. I had a career, a job I loved, but retired aged just 58 to care for him. This has a lasting impact for me, financially, as not only was I not entitled to my pension until I turned 66 (due to a change in pension rules), but it would necessarily be reduced as I would not have paid in as much as I would otherwise have done.

Section Six - Treatment / Care / Support

431. Alastair had been allergic to Interferon which was a major obstacle to his Hepatitis C having been adequately tackled. He took on two courses of treatment, but ultimately both failed, but it wasn't for want of trying on his part or that of his doctors. I believe that he actually completed the first course, but had to be taken off of the second.

432. I have already mentioned the lack of emotional support during his lifetime – there was equally none available or at least made available to my family and I when he passed away. I always thought, and still do looking back, that we coped, and coped well under the circumstances. I do not know if some form of counselling would have helped, maybe yes, maybe no, but I do not think that it would be of any benefit to us now.

Section Seven - Financial Assistance

433. I do not believe that we suffered any particular financial hardship beyond that already mentioned – my early retirement, Alastair having to retire early on health grounds and our daughter having lost employment opportunity. Fortunately, Alastair and I had always put a little away for a rainy day, so we always had savings, which we could rely upon when necessary, which we did. Our daughter used to good-naturedly poke fun at us in this regard, but I am glad that we did.

434. I believe that Alastair applied for some sort of compensation when he was told of his Hepatitis C, but he dealt with this himself, instructing solicitors (Messrs. Brown & MacRae) who in turn sought relevant medical records in order to pursue a claim.

435. I believe that both Dr Fraser and Dr Tweedie supported his claim and as a result he was given two lump-sum payments, one of £30,000 and another of £10,000, but I cannot now remember the exact figures, who paid them, or whether this was from a specific trust or fund established to help people who had been infected like Alastair or following a court order for compensation – until his sad demise and taking our daughter into his confidence, Alastair kept everything like that (financial matters) to himself.

436. Having said that, in the late 2000's I know that Alastair received a letter from someone telling him that he'd receive monthly payments of £1,000. I now received monthly payments of £1,700- as his widow, from a scheme established to help which *I am* aware of, and which I believe to be the successor to the earlier scheme through which he got £1,000 p.m.

437. I cannot help but think that Alastair should have received some compensation and suitable financial assistance from the outset. HcV infection, which was absolutely no fault of his, meant that he was unable to work over a very long time, and came at a time when he had a trade, was well thought of in that profession, and could have earned a great deal of money – instead he had to rely upon savings and his private pension once he stopped working. All the same, money isn't everything and no amount will adequately compensate for what he, and we, went through or perhaps more importantly, bring him back.

Section Eight - Other Issues

438. Despite all that has happened, I do not *condemn* the NHS. We are privileged to have a good health service and it is something we all need to look after. It has been good to me, and I am proud to have worked for it. I support what Alastair said, this wasn't anything to do with the people who treated him, it was a management failing – his doctors *had* to give him what they had, it is just unfortunate that it was contaminated, and neither Alastair or I believe any of them knew that.

439. I would very much like the Infected Blood Inquiry to determine:

i). Why Alastair had to approach his consultant to see whether or not he had been given any contaminated blood / a contaminated blood product,

ii). Why he hadn't been told of any suspected or even merely possible HcV infection before he actually was,

iii). What were the origins of the contaminated material Alastair had been given, and in that regard what records had been maintained showing its origins, and,

iv). How long had it been known or suspected that Alastair had Hep' C *before* he was actually told – and in the event of a delay, *why* had there been a delay?

Statement Of Truth

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

Signed: GRO-C

Dated: 14 July '22