Witness Name: Dr Colin Taylor
Statement No.: WITN3088005
Exhibits: None
Dated: 27 August 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR COLIN GEORGE TAYLOR

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 30 July 2020.

I, Dr Colin George Taylor, will say as follows: -

Section 1: Introduction

1. My name is Dr Colin George Taylor and my address is GRO-C GRO-C Kent, GRO-C. My date of birth is GRO-C 1942 and my qualifications are MBBS, LRCS, FRCP, FRCPath.

2. My employment history is as follows:
    a. July 1965 - 1975: King's College Hospital as House Surgeon, House Physician, SHO, Demonstrator Registrar, Lecturer in Haematology;
    b. September 1975 - April 2003: Consultant Clinical Haematologist, Maidstone and Tunbridge Wells NHS Trust;
    c. September 1997 - April 2003: Honorary Lecturer, King's College School of Medicine
3. My position was for the diagnosis and treatment of patients with Haematological problems including haemophilia. The unit was designated as an associate haemophilia centre in the early 1980s. I do not remember the exact date.

4. I was a member of the National Haemophilia Society attending annual meetings in Oxford again from the early 1980s.

5. I was involved in the case of Collette Wintle in 2003. Her complaint was investigated within the Pembury Hospital Trust and by the GMC. In both cases the allegations were not sustained, and the complaint closed

Section 2: Self-Sufficiency

6. *In December 1974 the Department of Health announced additional funding with the primary aim of making the NHS self-sufficient in Factor VIII blood products within two to three years. If you are able to respond, from your own knowledge, to the questions in this section please do so; if you are not, please say so. When did you become aware of this announcement?*
    a. I was unaware of this announcement in 1974.

7. *What did you understand the term "self-sufficiency" to mean? In particular, did you understand it to mean self-sufficiency in providing Factor VIII blood products prophylactically, or solely in response to bleeding incidents?*
    a. The requirements for Factor V111 products varied over time due to the number of patients we were treating. Products were obtained from the Blood Transfusion Centre.

8. *How were annual figures derived for how much Factor VIII blood product had been used over the course of a year?*
    a. As Director figures of usage was supplied by me to Oxford from the department records. The figures were not broken down geographically. The system did not change over time over the best of my recollection.

9. *Were there significant differences between the estimates that were made and actual use? If so, why?*
    a. There were no significant differences between estimates.

10. *To what extent, if at all, did England and Wales (in your view) achieve self-sufficiency of Factor VIII blood products? Why (if this is your view) was self-sufficiency not achieved? Do you consider that more could have been done to achieve self-sufficiency and if so what?*
    a. In my view self-sufficiency was not achieved, I do not know why.

11. *Do you consider that there was a failure by haemophilia clinicians to provide timely and accurate estimates of future demand for Factor VIII blood products and/or a failure by haemophilia clinicians to identify the foreseeable increase in use of such products once they became available?*
    a. Haemophilia clinicians did provide accurate estimates of product needs.

12. *If self-sufficiency had been achieved in Factor VIII products, what, in your view, would have been the effect on the numbers of patients infected with (i) HBV, (ii) HCV, and (iii) HIV. Please comment on when self-sufficiency would have needed to be achieved (in your view) in order for any material difference to have been made in respect of each of these viruses.*
    a. If self-sufficiency using unpaid donors had been achieved, it would have had a positive effect on reducing the number of patients infected.

13. *To the best of your knowledge, did England and Wales achieve self-sufficiency in respect of Factor IX blood products?*
    a. No
14. *If self-sufficiency in respect of Factor IX blood products was achieved, did you nonetheless use commercially produced products in preference to domestically produced products? If so, why?*
    a. If achieved the need for commercial products would not have been necessary.

Section 3: Decisions and actions of the Maidstone and Tunbridge Wells Haemophilia Centre

15. *Please describe the roles, functions and responsibilities of the Centre during the time that you worked there, insofar as the diagnosis, care and treatment of patients with haematological disorders is concerned.*
    a. To provide accurate diagnosis and to select the correct therapeutic agents.

16. *Please identify senior colleagues at the Centre and their roles and responsibilities during the time that you worked there.*
    a. No, only I was involved. We were a small haemophilia centre and I was the one dealing with this sub-group of patients.

17. *Please describe your role and responsibilities at the Centre and how, if applicable, this changed over time, and your work at the Centre insofar as it involved the care of patients with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.*
    a. The responsibility of the centre remained as described on previous question 14. To referrer infected patients to appropriate treatment centres

18. *Approximately how many patients with bleeding disorders were under the care of the Centre when you began your clinics there and over the years that followed? (If you are able to give exact rather than approximate figures, please do so).*
    a. If memory serves, the centre treated approximately 10- 15 patients at any given time.

19. *To the best of your knowledge, what decisions and actions were taken, and what policies were formulated by the Centre, regarding the selection, purchase and use of blood products (in particular factor concentrates) during the time that you worked there?*

a. Policies for treatment and selection of products depended on the severity of the clinical problem and the contemporary knowledge of the risks associated. I do not have copies of any pertinent documents.

20. *What particular products were used for treating patients at the Centre, over what period of time and for which categories of patients?*
    a. The reply to this question is the same as above.

21. *What was the relationship between the Centre and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Centre's decisions and actions?*
    a. No direct relationship to pharmaceutical companies. All products were purchased from the blood transfusion centre.

22. *If the responsibility for the selection and purchase of blood products lay with an organisation other than the Centre, please specify which organisation and provide as much information as you can about its decision-making.*
    a. The reply to this question is the same as above.

23. *How were decisions taken as to which products to use for individual patients? What involvement did you have in such decisions? To what extent, if at all, were patients offered a choice as to which products to use?*
    a. Decisions were taken on the individual patient's problem. Risks for each product were explained to patients to enable them to make the decision.
24. *What alternative treatments to factor concentrates were available in the 1970s and 1980s for people with bleeding disorders?*
    a. Relief of symptoms by use of analgesics.

25. *What were, in your view, the advantages and disadvantages of those alternative treatments? What use did the Centre make of them? Do you consider that they should have been used in preference to factor concentrates so as to reduce the risk of infection? If not, why?*

a. The advantages of analgesia were that if they relieved the symptoms then the patient did not need to have the blood products with associated risks of infection.

26. *What was the Centre's policy and approach as regards the use of cryoprecipitate for the treatment of patients with bleeding disorders?*
    a. If cryoprecipitate worked then there was no need for products with a higher risk of infection.

27. *What was the Centre's policy and approach in relation to home treatment? Did the policy and approach change over time and if so how?*
    a. We encouraged home treatment as it enabled treatment to start at the earliest possible moment providing the best chance early control of the bleed and prevent further joint damage.

28. *What was the Centre's policy and approach in relation to prophylactic treatment? Did the policy and approach change over time and if so how?*
    a. Prophylactic treatment was encouraged in patients with severe bleeding problems and did not change over time.

29. *What was the Centre's policy and approach in relation to the use of factor concentrates for children? Did the policy and approach change over time and if so how?*
    a. Children were treated the same as adults and again did not change over time.

30. *To what extent, and why, were people with mild or moderate bleeding disorders treated with factor concentrates?*
    a. Patients with moderate disorders were only given concentrates if rest or analgesics therapies failed.

31. *What viruses or infections, other than HIV, HCV and HBV, were transmitted to patients at the Centre in consequence of the use of blood products?*
    a. None

Section 4: Knowledge of, and response to, risk

32. *When you were appointed as a Consultant Haematologist at the Centre in 1975, what did you know and understand about the risks of infection associated with blood and/or blood products? What were the sources of your knowledge? How did your knowledge and understanding develop over time?*
    a. My knowledge was obtained from my previous training in haematology units at King's College Hospital and by in depth reading of appropriate literature.

33. *What advisory and decision-making structures were in place, or were put in place at the Haemophilia Centre, to consider and assess the risks of infection associated with the use of blood and/or blood products?*
    a. Risk of infection were assessed by routine screening. Also, when advised that infections had been identified by the Blood Transfusion Service in a batch of products.

34. *What was your understanding of the relative risks of infection from (i) the use of commercially supplied blood products, and (ii) the use of NHS blood products?*
    a. Commercial products had a higher risk than the use of NHS products.
35. *When you were appointed as a Consultant Haematologist at the Centre in 1975, what was your knowledge and understanding of the risks of the transmission of hepatitis (including hepatitis B and NANB hepatitis/hepatitis C) from blood and blood products? What were the sources of your knowledge? How did that knowledge and understanding develop over time?*
    a. I had a general knowledge gained from my training and continued reading of appropriate literature.

36. *What, if any, further enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of the transmission of hepatitis? What information was obtained as a result?*
    a. At all times I was assured that the products used had been screened by Blood Transfusion service.

37. *What, if any, actions did you and/or the Centre take to reduce the risk to patients of being infected with hepatitis (of any kind)?*
    a. Continuing to ensure that screening had been carried out. This screening changed over time as screening processes improved.
38. *What was your understanding of the nature and severity of the different forms of blood borne viral hepatitis and how did that understanding develop over time?*
    a. I had knowledge of the nature and severity of viral hepatitis. This was maintained by reading contemporary literature.

39. *What was your knowledge and understanding of HIV (HTLV-III) and AIDS and in particular of the risks of transmission from blood and blood products during your time working at the Centre? What were the sources of your knowledge? How did your knowledge and understanding develop over time?*
    a. I had knowledge of HIV and ADS again from contemporary literature.

40. *How and when did you first become aware that there might be an association between AIDS and the use of blood products?*
    a. Not known

41. *What, if any, enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of transmission of HIV or AIDS? What information was obtained as a result?*
    a. As soon as testing was available it was used Blood Transfusion Centres from which we obtained our products.

42. *What, if any, actions did you and/or the Centre take to reduce the risk to your patients of being infected with HIV?*
    a. Used products that had been screened for HIV.

43. *Did the Centre continue to use factor concentrates to treat patients, after becoming aware of the possible risks of infection of HIV? If so, why?*
    a. No, until screening was available.

44. *The issue of AIDS was discussed at a meeting of Centre Directors on 17 October 1983 (attended by you) (copy minutes enclosed [PRSE0004440]. Dr Chilsholm suggested that directors could revert to using cryoprecipitate for home therapy in light of the AIDS scare; she also reported that she could get unlimited supplies of cryoprecipitate but had problems in getting large amounts of commercial concentrates. Please set out your recollection of the discussion at that meeting. Did you agree with Dr Chilsholm? Did you agree with the recommendation, following discussion, that patients should continue to receive concentrates rather than cryoprecipitate?*
    a. As you say I did attend the meeting in 1983 but because I have no recollection due to the passage of time of the details. I note you have sent me a copy of the minutes but with no direct memory of the event I cannot and do not wish to comment on the individual items discussed in the minutes.
45. *Did you or your colleagues at the Centre take steps to ensure that patients were informed and educated about the risks of hepatitis and HIV? If so, what steps?*
    a. Do not recollect

46. *When did the Centre begin to use heat treated factor products and for which categories of patients?*
    a. Do not recollect

47. *Do you consider that heat-treated products should have been made available earlier? If not, why?*
    a. Do not recollect

48. *Did you or your colleagues at the Centre revert to treatment with cryoprecipitate for some or all of the patients in response to the risk of infection? If so, how was it determined which patients would be offered a return to cryoprecipitate and which would not? If not, why not?*
    a. Do not recollect

49. *Do you consider that your decisions and actions, and those of the Centre in response to any known or suspected risks of infection were adequate and appropriate? If so, why? If not, please explain what you accept could or should have been done differently.*
    a. Do not recollect

50. *Looking back now, what decisions or actions by you and/or by the Centre could and/or should have avoided, or brought to an end earlier, the use of infected blood products?*
    a. Do not recollect

51. *What actions or decisions or policies of other clinicians or other organisations, within your knowledge, played a part in, or contributed to, the scale of infection in patients with bleeding disorders? What, if anything, do you consider could or should have been done differently by these others?*
    a. Do not recollect

52. *Do you consider that greater efforts could and/or should have been made to inactivate viruses in blood or blood products prior to 1980? If so, who should have made or coordinated those efforts and what steps should have been taken and when? If not, why?*
    a. Do not recollect

Section 5: Treatment of patients at Maidstone and Tunbridge Wells Haemophilia Centre

53. *What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients at the Centre with a bleeding disorder about the risks of infection in consequence of treatment with blood products (in particular, factor concentrates) prior to such treatment commencing? Please detail whether, and if so, how this changed over time.*
    a. At all times patients were provided with information about the risks of all products. The details of the advice changed over time as more information became available.

54. *What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients about alternatives to treatment with factor concentrates? Please detail whether, and if so, how this changed over time.*
    a. Do not recall.

55. *What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients before they began home treatment/home therapy?*
    a. The information proved for home therapy was same as the reply to the previous question about home therapy.

56. *When did you first discuss AIDS or HIV (HTLV-III) with any of your patients? Please describe how and when you learned that patients under your care/the care of the Centre had been infected with HIV. What if any arrangements were made at the Centre for pre-test counselling? How and when and by whom were patients told that they had been, or might have been, infected with HIV? Were they told in person, by letter or by phone? Were they seen individually or in groups? What if any involvement did you have in this process? What information was given to them about the significance of a positive diagnosis? Were patients told to keep their infection a secret? What, if any, information or advice was provided by you or colleagues at the Centre to partners or family members of people who were at risk of infection with HIV or were infected with HIV?*
    a. I personally discussed risks of infection with my patients. The nature of the infections will have changed over time and it is not possible for me now to attach dates to the changes. All patients were informed that HIV was a risk factor in blood products. If the centre was informed that they had received contaminated blood, patients were informed immediately and referred for management at appropriate centres.

57. *How many patients at the Centre were infected with HIV?*
    a. I no longer hold information

58. *Was work undertaken at the Centre to establish the time period during which patients seroconverted? If so, please describe what work was done and what if any conclusions were reached.*
    a. I no longer hold information about this data.

59. *Were patients infected with hepatitis B informed of their infection and if so, how? What information was provided to patients infected with hepatitis B about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?*
    a. All patients were informed that Hepatitis B was a risk factor in blood products. If the centre was informed that they had received contaminated blood, patients were informed immediately and referred for management at appropriate centres.

60. *How many patients at the Centre were infected with hepatitis B?*
    a. I no longer hold information on this data.

61. *Were patients infected with NANB hepatitis informed of their infection and if so, how and by whom? What information was provided to patients infected with NANB hepatitis about the infection, its significance, prognosis, treatment? When did the Centre begin testing patients for hepatitis C? How, when and by whom were patients informed of their diagnosis of hepatitis C? Were they told in person, by letter or by phone? What if any involvement did you have in this process? What information was provided to patients infected with hepatitis C about their infection, its significance, prognosis, treatment options and management? When a test for HCV became available, what if any steps were taken by the Centre and/or by you to ensure that all patients who had received blood products were traced and invited to be tested?*
    a. All patients were informed that Hepatitis NANB/Hepatitis C was a risk factor in blood products. If the centre was informed of that they had received contaminated blood, patients were informed immediately and referred for management at appropriate centres.

62. How many patients at the Centre were infected with hepatitis C?
    a. I no longer hold information on this data.

63. *Were the results of testing for HIV and hepatitis (of all kinds) notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, explain why.*
    a. There was no delay in informing patients with Hepatitis and HIV of their diagnosis.

64. *To what extent, if at all, did you/your colleagues take into account the public health implications of HIV, AIDS, hepatitis B, NANB hepatitis and hepatitis C, when taking decisions as to what information or advice to provide to patients or what treatment to offer patients?*
    a. Patients with any of the infections were told promptly and treated immediately without regard for public health implications.

65. *What information was provided to patients about the risks of other infections?*
    a. Patients were informed of all risks of other infections.

66. *What information was provided to patients about the risks of infecting others?*
    a. Patients were informed of the risks of infecting others.

67. *How often were blood samples taken from patients attending the Centre and for what purposes? What information was given to patients about the purposes for which blood samples were taken? Were patients asked to consent to the storage and use of the samples? Was their consent recorded and if so how and where?*
    a. I no longer hold this information data

68. *Were patients under your care or under the care of your colleagues at the Centre treated with factor concentrates or other blood products without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent to treatment? Was their consent recorded and if so how and where?*

a. Patients were never given blood products without their expressed and informed consent

69. *Were patients under your care tested for HIV or hepatitis or for any other purpose without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent for testing? Was their consent recorded and if so how and where?*
    a. No

70. *Please detail all decisions and actions taken at the Centre by you or with your involvement with regard to a category of people referred to as 'previously untreated patients' (PUPS).*
    a. Previously untreated patients (PUPS) were never offered treatment with blood products unless there was no other means of treating a severe significant bleed. They would have been informed of the advantages and disadvantages and if they refused treatment their views would have been totally respected.
71. *Please list all research studies that you were involved with during your time as a consultant at the Centre.*
    a. I carried out no research related to haemophilia.

72. *How was the care and treatment of patients with HIV/AIDS managed at the Centre?*
    a. Patients with HIV or Hepatitis were referred to appropriate centres for detailed diagnosis, treatments and long term follow up.

73. *What was the Centre's policy with regards to recording information on death certificates when a patient had been infected with HIV or hepatitis? What were the retention policies of the Centre in regards to medical records during the time you were practising there? Did you maintain separate files for some or all patients? If so, why; where were those files located; and where are those files now? Did you keep records or information (e.g. information being used for the purpose of research) about any of your patients at your home or anywhere other than the Centre? If so, why, what information and where is that information held*

now? Do you still hold records or information about any of your patients? If so, explain why and identify the records or information that you still hold.

a. I no longer hold this information data

74. *The issue of high purity blood products was discussed in a letter from you, as Chairman of the South East Thames Haematology Specialist Sub-Committee to the Haemophilia Society (copy of letter enclosed [HSOC0002624]).*

a. *What did your role as Chairman of this Sub-Committee involve? How often did the Sub-Committee meet?*

i. The haematology Sub Committee covered all aspects of haematological practice and met monthly.

b. *How did financial constraints affect decision-making about the type of product purchased?*

i. Decision making had at least to consider financial constraints as part of the remit of the committee.

c. *Why did some consultants feel that high purity products were not the correct choice?*

i. I am unable to remember why some consultants felt high purity was not the correct choice.

d. *What was the relationship between the Sub-Committee and the Haemophilia Society?*

i. The HSC was independent of the Haemophilia Society.

e. *How did the Haemophilia Society try to ensure that the DHSS budget should be adequate for the purchase of correct products?*

i. I am unable to answer this question.

Section 6: UKHCDO

75. *Please describe your involvement with UKHCDO (including any of its working parties, committees or groups).*

a. I was a member of the UKHCDO but not of its working parties or subgroups.

Section 7: Pharmaceutical companies/medical research/clinical trials

76. *Have you ever provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products? If so, please list the names of the companies and give details of the advisory or consultancy services that you provided.*
    a. No

77. *Have you ever received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company? If so, please provide details.*
    a. No

78. What regulations or requirements or guidelines were in place at the time concerning declaratory procedures for involvement with a pharmaceutical company? If you were so involved, did you follow these regulations, requirements and guidelines and what steps did you take?
    a. No

79. *Have you ever undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products? If so, please provide details.*
    a. No

80. *Have you ever provided a pharmaceutical company with results from medical research studies that you have undertaken? If so, please provide details.*
    a. No

81. If you did receive funding from pharmaceutical companies for medical research, did you declare the fact that you were receiving funding and the source of the funding to your employing organisation?
    a. No

Section 8: vCJD

82. Do not know

Section 9: The financial support schemes

83. *What if any involvement did you have with the different trusts or funds (the Macfarlane Trust, the Eileen Trust, the Macfarlane and Eileen Trust, the Caxton Foundation, the Skipton Fund) which were set up to provide financial support to people who had been infected?*
    a. No involvement

84. *To what extent, during your time at the Centre, did staff (including you) inform patients about the different trusts or funds?*
    a. No involvement

85. *Did the Centre have any policy or any guidance for staff members in relation to referring patients to the trusts and funds for support?*
    a. No

86. What kind of information did the Centre provide to the trusts and funds about, or on behalf of, patients who were seeking assistance from the trusts and funds?
    a. None

87. Did the Centre, or any of their staff, act as a gateway for determining whether a particular patient met the eligibility criteria for the receipt of assistance from any of the trusts and funds? If so, please explain who set the criteria, what they were and how they were applied.
    a. No

88. Was the Centre or any of its staff involved in determining applications made by patients for assistance from the trusts or funds? If so, please describe that involvement.
    a. No

89. Based on your own dealings with any of the trusts or funds and/or based on your knowledge of the experiences of your patients in relation to the trusts or funds, do you consider that the trusts and funds were well run? Do you consider that they achieved their purposes? Were there difficulties or shortcomings in the way in which they operated or in their dealings with beneficiaries and applicants for assistance?

a. No knowledge

Section 10: Other issues

90. *Please provide details of any complaints made about you (insofar as relevant to the Inquiry's Terms of Reference) to your employer, to the General Medical Council, to the Health Service Ombudsman or to any other body or organisation which has a responsibility to investigate complaints. (The Inquiry is aware of the complaint made to the GMC by Mrs Colette Wintle).*

a. Apart from the Collette Wintle case of which you are aware there has been no other complaints.

91. *Please explain, in as much detail as you are able to, any other matters that you believe may be of relevance to the Infected Blood Inquiry, having regard to its Terms of Reference and to the current List of Issues.*

a. No comment

Statement of Truth

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

Signed GRO-C

Dated 27.08.2020

This is my statement and I confirm that the contents are true and correct.