Witness Name: Dr Colin Taylor
Statement No.: WITN3088006
Exhibits: none
Dated: 23/02/21

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 01 February 2021.

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

Response to supplementary Rule 9 questions

1. **At paragraph four of your statement, you state that you were a member of the National Haemophilia Society attending annual meetings in Oxford from the early 1980s. Did you have a specific role within the Society? What roles and functions (if any) did you carry out within the Society? Also, please confirm what working relationship (if any) you had with Dr Charles Rizza, the Director of the Oxford Haemophilia Centre in the 1980s.**

   1.1. I did not have a specific role or function within the Haemophilia Society. I had no working relationship with Dr. Charles Rizza.

2. **In your response to question five, you state that the case of Collette Wintle was investigated by both Pembury Hospital Trust ("the Trust") and the GMC. Please confirm the date the investigation by the Trust was**

concluded. If they are in your possession, please also provide a copy of any documents setting out the conclusion of the Trust's investigation.

2.1. I do not have any documentation on the case of Colette Wintle in 2003.

3. **Please elaborate on your answer to question seven in your statement, namely by explaining what you understood 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?**

3.1. I understood self-sufficiency to mean that safe products were available for use both prophylactically and in response to bleeding incidents.

4. **In response to question 24 of your statement, you state that analgesics for the relief of symptoms was the alternative treatment to factor concentrates available in the 1970s and 1980s for people with bleeding disorders. You go on to explain the advantages of analgesics as an alternative treatment in your response to question 25. However, in response to question 26, you explain the Centre's policy around the use of cryoprecipitate. Were you aware at time of other alternatives including Fresh frozen plasma; the synthetic vasopressin analogue desmopressin (DDAVP); antifibrinolytic agents and tranexamic acid? If you did use these products:**

   a. **When did you first use them and on what types of patients were they administered to?**
   b. **What were their advantages and disadvantages?**
   c. **Please explain why in your statement you only make reference to analgesics as an alternative to factor concentrates?**

4.1. I was aware that in addition to analgesics there were alternative treatments that could be combined with pain alleviation. These include Fresh Frozen

Plasma, DDAVP, Antifibrinolytic agents and tranexamic acid. As the products were developed, I used them in patients needing prophylactic infusions or management of acute bleeds. The advantage of some of these agents is that they were not blood products, thus the risk of transmitting infection was reduced.

5. **In response to question 44 you decline to comment on the individual items discussed at the meeting of Centre Directors on 17 October 1983 [PRSE0004440] which you attended as you have no recollection of the meeting itself. Notwithstanding the discussion at this meeting, did you at any point revert to treatment with cryoprecipitate for some or all of your patients in direct 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?**

5.1. As stated, I do not recollect this meeting and therefore, I am unable to say that any change in my clinical policy was connected to the discussions at this meeting.

6. **Please consider the attached letter from Professor Bloom and Dr Rizza regarding the treatment recommendations of the Reference Centre Directors, dated 24 June 1983 and sent to haemophilia centre directors [HCDO0000270_004]. What steps, if any, were taken by you/the Centre to comply with the treatment policy recommended by this letter? Did this letter change the policy approach then in place at the Centre regarding the use of cryoprecipitate, commercial concentrates and alternative treatments? If so, how? If not, why not?**

6.1. Over the years, I no longer remember reading this letter, however, looking at the copy you sent, I note that the paper recommended limiting the use of blood products to those cases where other therapeutic treatments had not worked and at the time there was insufficient evidence to warrant restriction of

imported concentrate. I cannot now say with any certainty what impact it had on our therapeutic policies.

7. **At paragraph 49, you state that children were treated the same as adults and that this position did not change over time. Given the treatment recommendation from the Reference Centre Directors which advised that children should be treated with reserve supplies of NHS concentrates, why did treatment of children remain the same as for adults at the Centre?**

7.1. Regarding the treatment of children. The treatment model is no different from that used in adults. Namely, they require replacement of clotting factors that they do not possess, and these must come from blood products derived from healthy people. In addition, children with severe bleeding problems would have been referred to Great Ormond Street Hospital.

8. **At paragraphs 32, 35 and 38, you state that your knowledge of issues around risk of infection associated with blood and/or blood products came from knowledge gained through your training and reading of the appropriate literature. Which publications in particular did you regularly read?**

8.1. My knowledge of risk infection was taken by reading many papers from contemporary scientific journals and published papers. I cannot recollect names of specific articles or journals.

9. **In your response to question 33, you state that the risk of infection associated with the use of blood and/or blood products was assessed through routine screening. Please explain the policy and procedure governing the follow-up of patients known to be infected. Were you personally involved in the review of infected patients? If so, what was the**

nature of your involvement? What treatment was offered to infected patients?

9.1. Follow up of infected patients depended on the severity of the problem. Where it was in our capability, symptomatic relief was provided locally, however severe cases of Hepatitis would have been referred to King's College Hospital for assessment and recommendations of treatment. Similarly, we had no effective AIDs treatment in our district and again patients were referred to other Hospitals.

10. **At paragraph 34, you state that commercial products had a higher risk of infection compared to NHS products. Please explain how you came to form this understanding. What were your sources of knowledge?**

10.1. I believed that commercial products had a higher risk than NHS products because if people donating could earn money, this financial reward may lead them to disguise their lifestyle and health problems.

11. **In relation to question 36, you state that at all times, you received assurances from the Blood Transfusion Service that products had been screened. Between March and October 1985, a test for HIV was available and whilst used to screen donors in the USA, was not used to screen donors in the UK until October 1985. What specific assurances did you receive from the Blood Transfusion Service prior to October 1985? What form did the assurances from the Blood Transfusion Service take? In answering this question, you may find it helpful to consider DHSC0000509, an article published in the New Scientist in August 1985 which accused the government of delaying a screening test until a UK test was ready.**

11.1. I was unable to carry out additional investigation on site and therefore could only rely on reassurances from the Blood Transfusion Service. At the time

these were the best available sources of information. Though I did realize these reassurances could only be based on what contemporary tests for HIV, AIDS and Hepatitis were available to the Transfusion Centre at a particular time.

12. **At paragraph 43, you state that the Centre did not continue to use factor concentrates to treat patients after becoming aware of the possible risks of HIV until screening was available. Please explain what alternative treatment was given to patients who until that time had been treated with Factor concentrates?**

12.1. Cryoprecipitate and fresh frozen plasma were used because these were single donations from one patient. Though they did potentially carry a risk of infections this was much smaller than with concentrates which came from vast numbers of patient's blood, any one of which could contaminate the whole product.

13. **At paragraph 45, you say that you do not recall whether you or your colleagues at the Centre took steps to ensure that patients were informed and educated about the risk of hepatitis and HIV. Later, you state that "*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*" [paragraph 53]. Please clarify the position regarding information provided to patients and confirm what information, if any, was provided to patients regarding the risk of hepatitis and HIV.**

13.1. At all times myself and members of staff provided patients of the risk of all products as information became available. I am unable to recollect specific information at a particular point of time as this was constantly changing and improving.

14. **In response to questions 50 to 52, you state you have no recollection. These questions in part invite your reflections on past events. Please respond to the following:**

    a. **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?**

    14.1(a) Looking back the actions and decisions would remain the same as at the time they were based on the best contemporary data.

    b. **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?**

    14.1(b) The knowledge base of other clinicians and organisations was always integrated into what patients were told therefore it would not have been done differently.

    c. **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?**

    14.1(c) I do not think greater efforts could have been made as the steps to inactivate viruses in blood products prior to 1980 were already maximal. There was good coordination between all groups involved.

15. **In your response to question 43, you state that you ceased the use of factor concentrates until donor screening became available. However, at paragraph 56, you state that you personally discussed the risks of HIV**

infection with your patients. Please explain your reasons for discussing the infection risk to your patients at this time given that you ceased using blood products until you were confident that they had been screened for HIV?

15.1. See the answer given on question 13. Even when I limited the use of blood products until they could be properly screened, I would have continued discussions with patients to keep them up to date.

Statement of Truth

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

Signed: GRO-C

Dr Colin George Taylor

Dated: 23/02/21

Table of exhibits : None