

Witness Name: Dr Neil McDougall  
Statement No.: WITN3322012  
Exhibits: WITN3322012-WITN3322018  
Dated: 20 March 2024

## INFECTED BLOOD INQUIRY

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### WRITTEN STATEMENT OF DR NEIL MCDUGALL

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I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 16<sup>th</sup> August 2023.

I, Dr Neil McDougall, will say as follows: -

#### **Section 1: Introduction**

1. My name is Dr Neil Ian McDougall. Date of Birth GRO-C 1965. My professional address is The Liver Unit, 1<sup>st</sup> Floor East Wing, Royal Victoria Hospital, Grosvenor Road, Belfast. My professional qualifications include Bachelor of Medicine and Surgery (MB, BCh, BAO) awarded by Queen's University Belfast in 1989, Membership of the Royal College of Physicians (MRCP) obtained 1992 and Doctorate of Medicine (MD) awarded by Queen's University of Belfast in 1996. I was elected to Fellowship of the Royal College of Physicians (FRCP) in 2002.
2. I took up my current post as Consultant Gastroenterologist and Hepatologist in the Royal Victoria Hospital, Belfast in January 2004. My first consultant post was as Consultant Gastroenterologist in Antrim and Whiteabbey Hospitals from July 1999 until December 2003. Prior to my appointment as a consultant in 1999, I was a registrar and senior registrar in the Northern Ireland Medical and Dental Training Agency gastroenterology training program, obtaining my Certificate of Completion of Specialist Training (CCST) in August 1998. I then completed two consecutive specialty training fellowships in Royal Perth Hospital, Australia (July 1998-Jan 1999) and in The Liver Transplant Unit, Kings College Hospital, London (Feb 1999 – July 1999).

3. My role as a hepatologist in the Royal Victoria Hospital has included taking a lead in the field of viral hepatitis (B and C). I have been the clinical lead for viral hepatitis in the Regional Liver Unit, RVH since 2004. Since 2007 I have been the Clinical Lead for the Northern Ireland Hepatitis C Managed Clinical Network that coordinates initiatives by public health, addictions services, prison service, laboratories services, maternity services and other patient support groups to improve strategies for the management of hepatitis C (and in more recent years hepatitis B). This has included participating in numerous educational events and several annual network events to engage with the public and patient interest groups.
4. I have been responsible for working with the Public Health Agency and Department of Health to try and expedite the approval and introduction of every new therapeutic advance in the field of treatment of hepatitis C since 2004. In recent years since the advent of Direct Acting Antivirals (DAAs) this has resulted in the latest NICE (National Institute of Clinical Excellence) approved hepatitis C treatments being made available to patients in Northern Ireland within a few months.
5. I was the Clinical Lead for the Regional Liver Unit from 2009 until 2018 when I moved to a more senior medical management role in Belfast Health and Social Care Trust (Chair of Division for Medicine and Cardiology). During this time, I have worked tirelessly to expand the service in an effort to meet the growing burden of liver disease on our society. This has included obtaining two hepatitis nurse specialists to augment the hepatitis C treatment program and improve the patient experience.
6. In my work as a hepatologist I have been a strong advocate for two disadvantaged patient groups with stigmatised liver diseases – alcoholic liver disease and chronic viral hepatitis (B and C). I have worked against the well documented discrimination (by the public and the medical profession) against those with alcoholic liver disease, through educating medical students, GPs and hospital colleagues. I have also done media work with the public and work on alcohol minimum pricing with DoH. Similarly, with chronic hepatitis C I have developed initiatives with the prison service (personally providing clinics within the prison) and the homeless (working with community services to improve access for patients) in an effort to provide treatment for difficult to reach patients.

7. I provided the clinical input from hepatology for the Department of Health Hepatitis C Elimination Action Plan published in 2021 and I sit on the steering group for implementation of the Action Plan.
8. In addition to my work as an advocate for disadvantaged patients with liver diseases, I have been an advocate for patients through working with various patient charities. In particular, I have supported the RVH Liver Support Group (a Northern Ireland wide charity) since 2004 and in May 2023 I helped the British Liver Trust to set up a Love your Liver campaign station in Northern Ireland for a few days.
9. I have not been a member of any committees or groups relevant to the Inquiry's terms of reference.
10. I provided a written statement to the Inquiry on 18<sup>th</sup> December 2019 (WITN3322003 – WITN3322006) in response to criticisms made by witness W2778 in 2019. In 2021 witness W2778 made very similar complaints to the GMC about the care I had provided to Mr Conway. The GMC carried out a provisional enquiry and in June 2021 concluded that they found no evidence of any concerns against my practice. This statement includes comments from my original statement in 2019 as well as information relating to events that occurred after my statement in 2019. I have also added comments regarding complaints that witness W2778 included in her latest statement but did not mention in her original statement in 2019.

## **Section 2: Response to criticism in respect of Edward Conway**

11. My clinical meeting with Mr Edward Conway on 28/11/18 was not planned. He attended my colleague Dr Cash at liver outpatient clinic on 28/11/18. Dr Cash had arranged for Mr Conway to go to the Ambulatory Care Centre (ACC) for a Fibroscan after his outpatient consultation was completed. I was speaking to Dr Cash about a separate matter by phone (I was not at the clinic) and he mentioned that he had seen Mr Conway and sent him for a Fibroscan. I know that occasionally Fibroscans can be technically challenging and can require consultant input. Therefore, as lead for the hepatitis treatment program I decided to go to ACC and ensure all was well.

12. When I arrived in ACC, Karen Patterson who is one of our two hepatitis nurse specialists told me that she had been unable to get a successful set of readings from Mr Conway's Fibroscan. I offered to help by attempting a Fibroscan.
13. After completing the Fibroscan I sent K Patterson to get witness W2778 from the waiting area so that I could explain the result to both of them. Mr Conway appeared to be fully engaged with me, but I was aware that he had some memory issues and I wanted to make sure a close family member was present. Karen Patterson was also present for the entire discussion with witness W2778 and Mr Conway.
14. I explained the following about the Fibroscan
- a. It showed a high reading suggestive of cirrhosis. We can grade the level of scarring in a liver as none (normal), mild fibrosis, moderate fibrosis, advanced fibrosis and cirrhosis. It is generally accepted in hepatology that fibrosis is potentially reversible, but cirrhosis implies that there is permanent damage. I did not use the term advanced cirrhosis but I probably used the term advanced fibrosis. I am sure this is where the confusion arose causing witness W2778 to use the term 'advanced cirrhosis'.
  - b. I explained that the ultrasound scan did not show evidence of cirrhosis but that the Fibroscan is a much more accurate device for measuring this. For this reason, we use a Fibroscan to assess all patients before they commence hepatitis C treatment.
  - c. I explained that despite the diagnosis of cirrhosis, he could still receive treatment for his hepatitis C and that the treatment would still have a very high chance (over 95%) of successfully clearing the hepatitis C infection.
  - d. I said that when patients are diagnosed with cirrhosis and are otherwise fairly well, we offer them screening with ultrasound liver and a blood test (alpha fetoprotein) every 6 months. This screening is used to detect small cancerous tumors (hepatocellular cancer or HCC) within the liver. If we detect HCCs when they are small then we have more treatment options.
  - e. I made it very clear on several occasions that his latest ultrasound did not show any evidence of liver cancer. The reason I laboured this point is that I knew they were both anxious because their brother (Mr Seamus Conway) had died from liver cancer in 2018.
  - f. I offered the option of having the follow-up scans and blood tests in Altnagelvin every 6 months for convenience and both Mr E Conway and his sister indicated that they were content with this. Therefore, I sent my letter describing the

consultation to Dr C Ferguson, Consultant Gastroenterologist in Altnagelvin and asked him to arrange the follow-up scans (Exhibit 1). Subsequently, witness W2778 advised us that she wanted her brother to have his follow-up scans in Belfast so I made the necessary arrangements for a follow-up scan in May 2019.

- g. We agreed that he would start on treatment for hepatitis C and I offered to ensure that his case was discussed quickly at our Hepatitis C Multidisciplinary Team Meeting so that he could be started on treatment within a few weeks. Mr Conway was discussed at the meeting on 6 Dec 2018.

15. I have no doubt that both Mr E Conway and his sister found their discussion with me upsetting. I was informing them that he had a diagnosis of cirrhosis and needed to have screening because of the RISK of developing an HCC. This immediately revived memories of the loss of their brother to the same disease. For this reason, I went over what I was saying several times to reinforce it and ensured that the hepatitis nurse was in the room to hear the discussion (as she would be following up Mr E Conway during the treatment).

16. I discovered the following week that witness W2778 and Mr Conway had misinterpreted what I had told them. As soon as I discovered this, I phoned his GP and asked the GP to speak with Mr Conway personally to provide him with reassurances that his ultrasound did not show cancer. I summarised my discussion with the GP in a letter (Exhibit 2).

17. Mr Conway was started on a 12-week course of treatment for hepatitis C in December 2018, finishing on 7<sup>th</sup> March 2019. Follow-up blood tests (HCV PCR) at the end of May 2019 confirmed that the treatment had successfully cleared his hepatitis C infection.

18. In December 2018, Mr Conway's GP Dr McNeill contacted me to ask if it would be acceptable to start Mr Conway on a statin. I wrote back to Dr McNeill on 14 Jan 2019 and advised that I would have no objections to him starting Mr Conway on a statin provided that he monitored the liver function tests in the first 6 weeks or so (Exhibit 3). I also thanked Dr McNeill for his efforts (at my request) to reassure Mr Conway that he did not have liver cancer. The use of statins in patients with compensated cirrhosis has long been known to be acceptable practice. Witness W2778's comments on this matter in paragraphs 110-112 are a misrepresentation of the facts – I did not initiate

the plan to start statins (demonstrated by exhibit 3) and in any case it was certainly safe to consider starting a statin in a patient with compensated cirrhosis.

19. Mr Conway had a follow-up ultrasound on 31 May 2019 as part of his HCC surveillance and I reviewed him at my clinic the same day to give him the scan result. This scan showed a small focal lesion in the liver that was not present on his scan on 28th Nov 2018. I explained that an MRI scan of liver was required to obtain further information and I placed an urgent request for this. Mr Conway indicated that he did not wish to return to my clinic in Belfast if it could be avoided (due to the impact that travelling to Belfast has on him). I advised him that I would refer him to my colleague in Altnagelvin for follow-up. This was all documented in the clinic letter from 31 May 2019 which was copied to Mr Conway for his information and reassurance (Exhibit 4)
20. A follow-up MRI scan was carried out on 7th June 2019 to obtain more detail. The liver lesion did not have the characteristics of a hepatocellular cancer but it required close radiological follow-up. I wrote to Mr Conway on 14 June 2019 to update and reassure him and I spoke with witness W2778 the same day to relay the information (exhibit 5).
21. Despite the fact that Mr Conway had been referred to my colleague Dr Ferguson in Altnagelvin for long term follow-up (at Mr Conway's request), I continued to provide review of his scan results through the Regional hepatopancreobiliary multidisciplinary team meeting. I wrote to Mr Conway in Jan 2020 to reassure him with results. I sent further update letters to Mr Conway in 2021 but I have not been given permission to access his medical records beyond 2020 so I am unable to provide the documents.
22. In March 2021 I was informed by the GMC that witness W2778 had made a formal complaint to GMC about the care I had provided to Mr E Conway. The GMC carried out a provisional enquiry and I provided them with my statement to the Inquiry (WITN3322003 – WITN3322006) from 2019. The GMC concluded that the concerns did not raise questions about my fitness to practice (EXHIBIT 6).
23. To summarise, witness W2778 is correct in stating that I told her and Mr E Conway that his Fibroscan showed cirrhosis even though the ultrasound scan did not show evidence of cirrhosis. I have no doubt that it is extremely distressing to discover that you have cirrhosis as a result of an infection acquired many years ago through no fault of your own. I did not tell Mr Conway that he had liver cancer and I am disappointed that witness W2778 continues to state otherwise despite numerous verbal and written

reassurances to the contrary as detailed above. I do not think that her comments in paragraphs 101-109 are compatible with the documentation I have provided above. Thankfully, Mr Conway's treatment has successfully cleared the hepatitis C infection. However, Mr Conway requires regular radiological follow-up of his liver to look for any evidence of him developing a liver tumour. As demonstrated above, I referred Mr Conway to his local hospital to facilitate this follow-up and encouraged him to attend for follow-up scans.

### **Section 3: Other Issues**

24. There are no other issues that I wish to bring to the inquiry's attention.

### **Statement of Truth**

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

Signed 

**GRO-C**

Dated 20/03/2024

### **Table of exhibits:**

Date	Notes/ Description	Exhibit number
29.11.2018	Letter from Dr McDougall to Dr Ferguson	WITN3322013
07.12.2018	Letter from Dr McDougall to Dr McNeill	WITN3322014
17.01.2019	Letter from Dr McDougall to Dr McNeill	WITN3322015
06.06.2018	Letter from Dr McDougall to Dr Courtney	WITN3322016
17.06.2019	Letter from Dr McDougall to Mr Edward Conway	WITN3322017
17.06.2021	GMC decision Rule 4 (4)	WITN3322018

