

Tuesday, 12 January 2021

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Dr Bevan. Can you hear me?

A. Yes, I certainly can.

SIR BRIAN LANGSTAFF: And you can see me, can you?

THE WITNESS: I can.

SIR BRIAN LANGSTAFF: Good morning.

Just before we start, I have a few words to say

to others who are listening, so excuse me for

a moment.

THE WITNESS: Of course.

SIR BRIAN LANGSTAFF: The people I'm speaking to now are the hundred or so, maybe more, who are listening remotely to what I have to say.

This is our first day of hearings in the new year. Already in 2021 Covid has affected our plans, as it has affected the plans of so many others. It is important to make progress with the hearings but it is vital to stay safe. The way those two considerations fit together means that we cannot do things as we would have wished.

When I last spoke to you, early before Christmas, I had hoped we might be able to hear more evidence in person in 2021. All our witnesses this

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you're looking at, you are only seeing part of it, you are seeing me I think at the moment, in the hearing room there are three members of counsel's team, socially distanced to the extent of being almost remote from each other, across the room from me. There are three members of the Inquiry staff in the room, at the far corners of it. It's a room capable of holding 200. It holds at the moment less than ten.

One of those members of staff, Mary, will ask you to take the oath in a moment or two, and we have Soumik, whose job it is to make sure that if documents are referred to you can see them and so can those who are following remotely.

You are talking not only to us here in the room, Dr Bevan, but you're talking to everyone out there who is watching remotely. The number varies from time to time, understandably, but it will be, as I said, in the 100 or so, maybe more, people who are keen to hear what you have to say.

With that introduction, Mary, may we ask Dr Bevan to take the oath, please.

DR DAVID HUW BEVAN, affirmed

Questions by MS RICHARDS

MS RICHARDS: Dr Bevan, good morning. Can you see and hear me?

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week would have wished to be here in person.

Participants in the Inquiry who wish to do so would have been able to come to Fleetbank House. Unfortunately, this is not to be.

You will, I trust, understand, why. Why, in these days of the new lockdown, this is the price of our making progress: safety, yours, ours, and mine, requires it.

You are, of course, listening remotely to me as I say this. It goes without saying that we will continue with the live broadcast, YouTube, and update meetings for Inquiry participants. I trust you will understand there may have to be further changes to the timetable until the siege imposed by Covid is lifted but I can assure you that, though more witnesses will be obliged to give evidence remotely, just as these week's witnesses will, the Inquiry's approach will be just as thorough as if witnesses were with us here in the hearing room.

Now, Dr Bevan, you are at home, are you?

THE WITNESS: I am, yes.

SIR BRIAN LANGSTAFF: And you are on your own, I think?

THE WITNESS: I think my daughter is somewhere in the house but essentially on my own.

SIR BRIAN LANGSTAFF: We, here, so I can tell you what

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A. I can. Good morning.

Q. I'm going to start just by asking you to provide us with an outline of your career.

As I understand it from your witness statement, you had various general junior medical posts in the mid-70s, 1973 to 1976?

A. I did, yes.

Q. And --

A. Mostly in the North of England.

Q. Then you took up a senior house officer post in medical oncology at the Royal Marsden Hospital from late '76 into May of '77?

A. That's it, yes. That's right.

Q. Then from July of 1977 to December of 1978, you were a registrar in haematology at St George's Hospital.

A. Yes, and the rotation around local hospitals, which was the training regime there.

Q. Was this the beginning of your career in haematology?

A. It was.

Q. You've described in your statement this being, this first period, the 18 months or so from mid '77 to late '78, as being a rapid introductory period for the novel cohort of trainees who had no prior experience of laboratory work and who were recruited for their acute medical experience and MRCP in order to care for

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1 patients with blood diseases.
 2 Could you just outline a little what you meant
 3 by that?
 4 **A.** Okay. Hitherto, haematology had been very much
 5 a laboratory specialty and part of the clinical
 6 pathology orbit in the NHS, and so the trainees who
 7 ended up in haematology had usually commenced by
 8 doing, soon after registration, a rota of jobs in the
 9 various aspects of pathology. So they would do some
 10 time in histopathology and autopsy work, they would do
 11 some time in bacteriology, microbiology, and they'd do
 12 haematology and also chemical pathology. So there was
 13 a rotation through the various laboratory disciplines
 14 in clinical pathology, and then they would choose
 15 which one of those disciplines they would
 16 specialise in, end up in, and then haematologists
 17 would come from that, that arena.
 18 Haematologists began to realise that people
 19 with blood diseases, who at that time were clinically
 20 under the care of general physicians, some of whom
 21 supposedly were said to have an interest in
 22 haematology, some of which had no real interest in
 23 haematology, and the colleges -- joint committee
 24 between the College of Pathologists and the College of
 25 Physicians came to the conclusion that haematologists

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1 control and, eventually, also that of the coagulation
 2 laboratory and its special tests, and there was a kind
 3 of internal rotation that accomplished this as well as
 4 possible.
 5 **Q.** And then in December of --
 6 **A.** Yes -- sorry.
 7 **Q.** Carry on.
 8 **A.** The other aspect was it was -- at that time, on-call
 9 work in laboratory overnight and at weekends was
 10 shared between professional technical staff, who were
 11 able to do it with great expertise, and haematologists
 12 and other pathologists in training as a kind of
 13 baptism of fire, having to cross-match, you know,
 14 blood for people in life-threatening emergencies, when
 15 one's experience and knowledge and technical skills
 16 were simply not up to it. So that was, I think,
 17 a period of considerable error, but I remember doing
 18 that. And while doing that, one was also on-call for
 19 the haemophilia patients of the unit, who used to gain
 20 entrance for treatment by battering on an outside door
 21 of the laboratory -- which in that time was in
 22 a series of sheds, basically -- to get in and to be
 23 administered usually cryoprecipitate.
 24 I could manage that but my skills as
 25 a laboratory technician were minimal. I'm very glad

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1 where possible should look after their own patients
 2 clinically and that therefore they needed to recruit
 3 a new cohort of individuals into the subject who had
 4 general medical experience and therefore -- and the
 5 membership of the Royal College of Physicians, and
 6 therefore would have a decent basis to enter such
 7 a profession as a clinical haematologist is in the
 8 NHS. And basically, from then on, that became the
 9 approved mechanism for generating consultant
 10 haematologists.
 11 **Q.** In that first 18 months or so, before your appointment
 12 as a senior registrar at the end of 1978, you
 13 described you spent your time first of all learning
 14 laboratory work without any haemophilia contact and
 15 then laboratory work for the purposes of haemophilia.
 16 Is that broadly correct?
 17 **A.** Yes. They obviously had to give us a crash course in
 18 the laboratory aspects of the subject. So, for
 19 example, absolutely typical of a consultant
 20 haematologist, he's looking down a microscope at blood
 21 cells and deciding whether someone has leukaemia or
 22 another blood disease. So we had to be taught from
 23 scratch how to do that. In addition, we had to be
 24 taught about the semi-automated and automated
 25 machinery in the laboratory, methods of quality

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1 to say that whole system was abandoned very soon
 2 afterwards and on-call work was then done entirely by
 3 fully trained technical staff.
 4 **Q.** Now, December 1978 you were appointed as Lecturer and
 5 Honorary Senior Registrar in Haematology at
 6 St George's Hospital Medical School, and that was an
 7 appointment that you fulfilled from December '78 until
 8 1984; is that correct?
 9 **A.** Yes. Yes, that's correct. It was a lecturer job --
 10 technically it was a lectureship with the St George's
 11 Hospital Medical School -- sorry, honorary senior
 12 registrar role with the hospital. In fact, it was
 13 almost entirely a service job. At that stage, there
 14 was hardly any lecturing or teaching duties to do.
 15 One assisted at practical teaching but "lecturer"
 16 was -- it was a way to find the funding from
 17 a different source, basically.
 18 **Q.** You have said during this period of five years or so
 19 it was part of the South-west Thames senior registrar
 20 training rotation and you worked in a number of
 21 different hospitals and locations over that period of
 22 time?
 23 **A.** Yes, that was the official training rotation of the
 24 South West Thames region which was held with
 25 St George's as the teaching hospital base and then

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a number of other hospitals which -- where one gained experience of specialist haematology. So one was -- part of it was spent at St George's but an equal part, a year I think, was spent in a district general hospital. At that time, I was at St James' Hospital Balham, which is very close to St George's but was, you know, a separate institution at that time. And then the specialised training was at the Royal Marsden Hospital, in haemato-oncology, because at that time it was -- and I think has always been the case, the majority of people training in haematology went into what's called haemato-oncology, treatment of leukaemia, lymphoma, myeloma. So there was a considerable amount of time spent at the Royal Marsden Hospital. Then also one had formal attachments to the National Blood Transfusion Service at Tooting.

So that was the rotation. So for most of that time I was outside St George's. But when I was in St George's obviously that was when I began to learn a bit more about the patients with haemophilia.

Q. Throughout that period, Professor Flute, and I'll come back to him in a few minutes, but Professor Flute was a consultant haematologist and the centre director for the purposes of the St George's Haemophilia Centre?

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them out on the bench on blood and plasma and other substances, and then one analysed the results oneself and came to a conclusion and, once again, because we were not fundamentally trained in laboratory haematology the wet practical part could go badly wrong.

I remember at Oxford, at one stage during my blood transfusion practicals, I was faced with a water bath with all the tubes floating upside down in it. The other thing that happened in the coagulation practical, which has a strange bearing on it, was that the sample tubes with standard preparations of blood factors in them would go off during the actual hour or two of the practical, so you'd end up with something that had much less of substance X in it than there was at the beginning.

So the practical was a lottery, a lottery, and at some centres all the candidates would fail and they were notorious for this. Thankfully, I went to Oxford, which was one of the more civilised centres, as one would hope, and I managed to get through. But it was an ordeal and I was very glad I never had to sit it twice.

Q. Now, in 1984, having successfully passed the MRCPPath exam, you were appointed senior lecturer and honorary

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A. Yes, he was a professor of haematology at the medical school, an honorary consultant haematologist and Haemophilia Centre Director.

Q. In the course of this period you took your MRCPPath exam?

A. Yes, at the end. I mean, the whole rotation was geared towards equipping someone to be able to take that exam and hopefully pass it, and that was done then towards the end, in 1983, in I think the autumn of 1983.

Q. You have observed -- sorry?

A. It's okay. That's it.

Q. You have observed in your statement that the two parts of that exam that were most frequently failed at that time were the practical exams in coagulation and blood transfusion. You didn't fail --

A. Yes.

Q. -- you passed --

A. More by the (*unclear*), yes.

Q. Do you have any understanding as to why those two areas were the most frequently failed?

A. Well, they were wet practicals. This was abandoned several years afterwards but, at that time, one was expected to actually do a practical examination where one chose the test one was going to do, one carried

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consultant in haematology at St George's and you remained in that post from 1984 until -- in reality, I think until 2008, although the titles and the contractual arrangements changed in 2004?

A. Yes.

Q. Initially, Professor Flute remained the centre director and head of department, but he took early retirement some time in 1985. Can you recall when?

A. Sorry, exactly what do you want me to --

Q. When Professor Flute took early retirement.

A. Yes. That was in '85. Up until then, St George's was more than just St George's still, the consultant staff were responsible for running the laboratory at St James'. I think my first year as a consultant was spent mainly there because the sitting consultant there had gone off with severe health reasons, and it was a bit of a surprise to the other two consultants in the department because, by losing that colleague through ill health, there were just the three of us, Professor Flute, Dr John Parker-Williams and myself, and it came as somewhat of a shock that Peter Flute left quite suddenly to become -- he didn't actually retire at that point, he became South-west Thames Postgraduate Dean. So he moved into a part-time training and academic role outside St George's and it

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basically left the entire menu of haematologists at St George's to be run by myself and Dr John Parker-Williams.

Among the -- my half of the responsibility, before I took most of the responsibility for the clinical side of the operation, because John was excellent at the laboratory side -- haemophilia became a part of it and by becoming the consultant responsible for haemophilia, one sort of automatically became the centre director in relation to the UKHCDO and the national system.

Q. That was in the summer of 1985?

A. July, yes.

Q. Now, just following through your career before we come back to look at St George's in more detail, you described in your statement how in 1987 a professor of haematology, Professor Gordon-Smith, was appointed at St George's and that brought with it, in due course, more funding which allowed the employment of more staff or appointment of more staff, including, for the first time, a haemophilia nurse?

A. Yes. I think that was in the very early '90s that we managed to get our first haemophilia nurse and, from then on, we were allowed to -- as the funding became more channelled from the -- via the *Pan-Thames*

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before leaving my sickle cell practice but I worked on the basis that new blood was needed to look after that part of things and that things I'd wanted to do in terms of I wanted to accomplish something in the research line in one of the subjects I did, and this only seemed to be able to be facilitated through going into this very specialised role as a Haemophilia Centre Director.

Of course, because, throughout one's tenure as a haemophilia doctor at St George's, the centre at St Thomas' -- Guy's and St Thomas' Hospital had been, you know, very large in our lives and it was a considerable challenge to go and take over that centre. But, luckily, they suggested it to me so I -- eventually I decided to go there. In fact, it did turn out that way with the research, but I was able to participate in proper research there.

Q. You remained as director until 2016 when you relinquished your director role to Dr Dolan, but you remained a consultant full time, and then part time, until March 2018 when you retired but then you came back as a locum consultant, I think, until March 2019?

A. Yes, I was one of the senior consultants that was in a position of possibly being caught in a retirement trap. Basically, one took retirement when it was

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Haemophilia Consortium, which was a specialised commissioning group as part of NHS London, things were put on a much better basis, in that our needs, if we made a good case that we needed, say a second nurse or paediatric nurse, or we needed a centre organiser, administrator, then funding was released from the Pan-Thames Haemophilia Consortium to cover that.

So the appointment of Ted Gordon-Smith completely transformed the department from something that was becoming an extreme backwater, understaffed, into, you know, a major centre.

Q. Then in 2008, you moved to St Thomas' Hospital as consultant haematologist and the Haemophilia Centre Director for Guy's and St Thomas' NHS trust?

A. Yes, I did. I mean, I had -- at the beginning, I'd done everything including leukemic treatment, and so on, at St George's and then, as we appointed new younger consultants, most of them had a haemato-oncological bent, and so I moved out of that area and my patient base became -- it still remained multidisciplinary, but it became restricted mainly to haemophilia, bleeding disorders and thrombotic disorders, and sickle cell disease and other haemoglobinopathies.

Yes, so I was -- I had to think very carefully

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available on the understanding that one would retire and return to work, first of all, in a general capacity to support Dr Dolan during his initial years, and then, as I said, a tragedy which affected a close colleague at St Thomas' unexpectedly, I was called back from retirement to help out for a further year. So my retirement was somewhat delayed but eventually happened.

Q. Throughout the period from 1985 to your eventual retirement in 2019 you were a member of UKHCDO?

A. Yes.

Q. We'll come back to UKHCDO in a little more detail later but you were not, for the most part and for most of that time, involved with its working parties or its committees?

A. Not at all. I think the haemophilia directors of smaller centres -- we were a kind of medium-sized centre -- as Mark Winter's study showed in the south of England there were haemophilia centres with directors who attended regular meetings who had no actual patients or very few or mild patients only. But we did have a substantial number at St George's. Nonetheless, at UKHCDO, the roles on special working parties and their special committees were reserved for major centre directors, so-called Reference Centre

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1 Directors, and later comprehensive care centre
 2 directors. No doubt, if I had specifically asked to
 3 be included on such a working party, I would have
 4 been, but because haemophilia was still only, I would
 5 say, even at the height of involvement, about
 6 10 per cent of my workload at St George's, I never
 7 quite had the time to devote to such working parties.

8 **Q.** Now, if I can turn to the physical facilities of the
 9 haemophilia centre at St George's, when you first
 10 arrived there and over the following few years through
 11 into the mid-and late 1980s, what was the centre?
 12 What physically did it comprise?

13 **A.** When I joined, the Haematology Department of
 14 St George's in Tooting was accommodated within -- and
 15 in fact the entire haematology laboratories -- were
 16 accommodated within a strange improvised structure
 17 between several of the Victorian hospital blocks with
 18 wooden walls and a ceiling, which was bit like
 19 a rabbit warren, and then, at one stage, it had
 20 an external door and inside that external door was
 21 a series of little clinical rooms, which were used for
 22 every conceivable purpose for patients. The
 23 haemophilia patients came in and were treated in one
 24 of those rooms, where there was a bedstead and
 25 a chair, where intravenous therapy could be

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1 suitable for a clinical facility, since it was
 2 actually removed from the clinical facilities of the
 3 hospital. You would have to set up your own kind of
 4 crash trolley and emergency system there.

5 So we kept appealing for a proper clinical
 6 space and the hospital never decided that it was one
 7 of its priorities. Instead, of course, our patients
 8 were treated in an increasingly sophisticated day unit
 9 but they shared that unit with all other haematology
 10 patients. But the day unit was well equipped, well
 11 staffed and safe, and the children used to go to the
 12 Pinckney Children's Ward, which already ran a kind of
 13 out-patient for children. So, in that way, it
 14 complied with the preferred model for children, which
 15 was it was in the paediatric part of the hospital.

16 So things worked but we never had that single
 17 haemophilia centre, where all the patients knew they
 18 could go.

19 **Q.** Now, in terms of the numbers of patients, we'll look
 20 at a couple of annual returns in a moment but your
 21 recollection in your statement was that there were --
 22 in the late 1970s, early 1980s there were around
 23 25 severely affected patients, haemophilia A and B --

24 **A.** Yes.

25 **Q.** -- including approximately eight children, and that

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1 administered and people could be examined.

2 There was no specific haemophilia office or
 3 centre in the way in which, you know, anybody
 4 understood it, what that might mean. A specific
 5 clinical space devoted entirely to haemophilia and
 6 with special facilities for children, and so on, were
 7 simply not there. Then there was the laboratory and
 8 all the treatment product was stored in refrigerators
 9 and freezers in the haemophilia laboratory, and the
 10 telephones that patients accessed were in the
 11 haemophilia laboratory or the haemostasis laboratory,
 12 haemostasis blood clotting laboratory.

13 So it was -- it didn't fulfil any of the
 14 definitions which centres were supposed to fulfil. So
 15 that's about it.

16 **Q.** Did you get the sense that laboratory facilities were
 17 prioritised over clinical facilities for any available
 18 funding?

19 **A.** I think we -- we made various efforts to establish
 20 a clinical haemophilia centre, somewhere in the
 21 building. That Jerry-built haematology complex was
 22 itself left within my period of time as a senior
 23 registrar and re-established within the medical school
 24 block, in a kind of large functional hanger-like
 25 space, absolutely fine for a laboratory but not very

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1 those numbers increased over the years that you were
 2 at St George's until the number was in the region of
 3 about 35?

4 **A.** Yes. One was at least sensitive to these numbers
 5 because, certainly during my time as consultant, the
 6 UKHCDO was looking at definitions of various grades of
 7 centre, and they were looking at a definition for
 8 a comprehensive care centre and, for one reason or
 9 another, they settled on the number of 40 severely
 10 affected patients treated in a year, on a consistent
 11 basis, and one was always aware that one was just
 12 underneath that. Sometimes one might have had
 13 40 severes but they weren't all treated in a year.
 14 The others, the numbers just came slightly under. So
 15 we never quite reached that 40 patient mark. But
 16 I remember that at the end we were certainly very
 17 close to it.

18 **Q.** Again, in that period, late 1970s, first half of the
 19 1980s, do you have any recollection as to how many
 20 patients not severely affected but mild or moderate
 21 were patients of the centre?

22 **A.** This is where, I'm afraid, my memory begins to fail me
 23 in the fact of being retired I have no access to any
 24 kind of electronic database but, by definition, it's
 25 normally assumed that someone -- a certain number of

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severely affected haemophilia patients were accompanied by a slightly greater number of moderately affected and very great number of mild. In fact, it's not like that at all with haemophilia.

Moderate haemophilia is perhaps slightly rarer and the mild haemophilia group is a somewhat amorphous -- it changes from time to time. So my feeling would be there would be about another 50 or so in those two categories, mild and moderate, and then, of course, one was responsible for a considerable number of people with von Willebrand's disease and other bleeding disorders, and von Willebrand's disease was about equivalent to the number of severe haemophiliacs. That, again, the definitions changed, so mild von Willebrand's disease you might be looking at up to 100 people with von Willebrand's disease who were attached to the centre.

A lot of the clinical work, clinic work, out-patient clinics, involved seeing people on a routine basis with mild bleeding disorders and looking after them then when perhaps they needed surgical operations, and so on. So you had to be always ready for that. In surgery, the adage is there's no such thing as a mild bleeding disorder, if they are having surgery; take it all seriously.

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Professor Ilsley Ingram there was definitely a change. As, again, this was only by kind of hearsay and from Professor Flute himself, I think he found Professor Savidge a somewhat rebarbative colleague, not afraid in any way to criticise the actions of a smaller centre or people he considered to be less expert in the treatment of haemophilia, and at one early stage, I think something must have been said that offended Peter Flute deeply and so he came and said "Oh, there's a chap new chap at St Thomas', very difficult man". So there was just a feeling that there was a possible conflict there.

Now, in myself as a Haemophilia Centre Director, I find that if I needed advice on a particularly difficult or a case that wasn't going quite as planned, I would ring Geoff Savidge at St Thomas', and he was always very helpful, on a personal level he was always perfectly helpful. But one knew at the same time that he was attempting to take over the care of patients from the smaller centres in the region and he did this out of a principled stance that they would get better care at St Thomas', which of course when I eventually came to St Thomas' I saw was possibly the case.

Certainly, before we had a haemophilia nurse he

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Q. I just wanted to come back to your relationship with St Thomas', which was the reference centre certainly geographically closest to St George's. To what extent was there any kind of relationship between St George's haemophilia centre and St Thomas' haemophilia centre in the late 1970s or in the course of the 1980s?

A. When I started out, Professor Flute had, I think, a good relationship with Professor Ilsley Ingram, who had started the St Thomas' haemophilia centre and was an extremely multi-talented and senior individual, and Ilsley Ingram ran this thing called the Coagulation Club, Clotters --

Q. Haemostasis club?

A. Haemostasis club, that's right, sorry. He ran this thing called the haemostasis club, which was like on the British model of genteel academia where enthusiasts for a certain subject would gather and hear presentations and chat and discuss the presentations and generally form a community.

So, as a registrar, I was encouraged by Professor Flute to attend the haemostasis club, if I could, to get a flavour of this and I did, not that I comprehended much of the presentations.

So it was all good in that, and then when Geoffrey Savidge took over from

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had haemophilia nurses and they were very good. There's absolutely no doubt that the care of an individual with haemophilia in a centre is -- the role of a haemophilia nurse is absolutely critical. It's the reason why a centre exists. I don't think now that I would say that anybody could have a haemophilia centre, in a meaningful term of the word, without a haemophilia nurse to look after patients because the consultant, who will have many other concerns, is a very variable presence and focus, whereas a haemophilia nurse will look after patients.

So, in that way, he was completely right, completely right.

Q. Some witnesses who have provided statements to the Inquiry have described being treated at both St George's and St Thomas'. Did that happen during this period? Might there be a patient who might be treated at St George's for one purpose and then treated at St Thomas'?

A. Yes. At St George's there were, of course, truly excellent orthopaedic surgeons but they were excellent enough to recognise that operating on a haemophilia joint, particularly one that had undergone substantial damage through chronic haemophilic arthropathy over the years, where there were forms of contraction and

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1 synovial hypertrophy that orthopaedic surgeons in
 2 general practice would almost never see, and very
 3 difficult to operate on those joints to do a joint
 4 replacement, that there was, on the other hand,
 5 a consultant orthopaedic surgeon at St Thomas' with
 6 experience of many such operations and, therefore, the
 7 most likely cause for a patient to be under joint care
 8 of the centre was that I had referred them on to
 9 Geoff Savidge and his orthopaedic surgeon for joint
 10 replacement treatment. So that was the main thought.
 11 **Q.** Just going to look and a couple of annual returns for
 12 St George's with you, just to see what we can see from
 13 it in terms of numbers of patients treated in two
 14 particular years and products used. The first is for
 15 1976, the second for 1983, those are the two returns
 16 we have for that period. Soumik could we have
 17 HCDO0000024_004, please.
 18 That's just a covering letter from
 19 Professor Flute to Ms Spooner at Oxford, but if we can
 20 go to the next page please, Soumik, we can see here
 21 this is the annual return for 1976, St George's
 22 Hospital, Professor Flute, number of haemophilic
 23 patients treated during the year 25, total number of
 24 Christmas disease patients treated during the year 5,
 25 and then we can see, in terms of the products being

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1 please -- thank you. We can see there now the amount
 2 of cryoprecipitate identified significantly less than
 3 1976, and it would appear used for hospital
 4 in-patients, and then we have, for NHS Factor VIII
 5 concentrate 62,770 units in hospital, 71,950 units for
 6 home treatment, and then we can see the use of Armour
 7 Factor VIII concentrate 270,755 and 309,680
 8 respectively for hospital and home treatment. A small
 9 amount of Koate being used, Cutter's Koate, and then
 10 we can see on the right-hand side cryoprecipitate
 11 being used for the treatment of von Willebrand's
 12 disease patients in hospital.
 13 Then, if we just go to the next page please,
 14 Soumik --
 15 **SIR BRIAN LANGSTAFF:** Just before you do, the
 16 cryoprecipitate, there's a note there in handwriting
 17 based on 50 units per pack. If we are to draw
 18 a comparison between this and the 1976 return, which
 19 is 0000024_004 -- let's just have a look at that --
 20 **MS RICHARDS:** HCDO0000024_004.
 21 **SIR BRIAN LANGSTAFF:** What I'm going to ask is: is there
 22 a like-for-like comparison? Let's have a look at the
 23 figure. There we only see the number of Factor VIII
 24 units, which is -- I think it's what we've come across
 25 before, roughly 70 units of activity per one bottle,

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1 used, cryoprecipitate and NHS Factor VIII concentrate
 2 in that year, and we have the figures there. So
 3 predominantly cryoprecipitate usage, it would seem.
 4 Then NHS Factor IX further down for the Christmas
 5 disease patients.
 6 **A.** Yes.
 7 **Q.** Then, if we go to the next page please, Soumik --
 8 **A.** That's the first time I've ever seen that one. That's
 9 very interesting. That was, of course, before I was
 10 a haematologist even.
 11 **Q.** Then, we'll go to the next page and we can see number
 12 of patients with von Willebrand's disease treated
 13 during the year 3, and the treatment there
 14 cryoprecipitate.
 15 **A.** Yes.
 16 **Q.** That's just to give us such information as we have
 17 from 1976. The next return we have, Dr Bevan, is 1983
 18 so we'll look at that next please HCDO0000143_003,
 19 please. If we go to the next page. We can see here,
 20 Dr Bevan, again this is the annual return for 1983,
 21 completed by Professor Flute. Total number of
 22 haemophilia A patients treated during the year 31,
 23 von Willebrand's disease patients treated during the
 24 year 4, and then if we look at the rest of the
 25 document please, Soumik, the whole of the page

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1 but are we comparing like with like looking at this
 2 and going back to the 1983 return?
 3 **A.** Probably. I mean, one of the uncertainties about
 4 cryoprecipitate is always exactly how many units are
 5 in a bag. A bag is -- a single bag of cryoprecipitate
 6 is the cryoprecipitate from a single unit of donor
 7 blood, and then a dose of cryoprecipitate would be
 8 assembled from, say, 10, sometimes a few more, bags
 9 for adults, perhaps up to 20 bags, and that would fit
 10 with 50 units per bag. 50 units per bag was probably
 11 the standard used by the National Blood Transfusion
 12 Service at that time. So they would expect their
 13 bags, you know, on testing to contain within plus or
 14 minus a couple of standard deviations of 50 units.
 15 So if a bag only contained 30 units they
 16 wouldn't issue it. So they had a standard. So we
 17 probably took that standard from them of 50 units per
 18 bag.
 19 **SIR BRIAN LANGSTAFF:** Thank you.
 20 **A.** I mean -- yes, sorry. So I think they are comparing
 21 like with like.
 22 **MS RICHARDS:** If we just go back then to the '83 return or
 23 forward to the '83 return.
 24 HCDO0000143_003, please, Soumik.
 25 We can see here perhaps the most significant

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- 1 change from 1976 is the use of significant quantities
2 of commercial concentrate.
- 3 A. Oh, vastly and, of course, this was the pattern all
4 across the haemophilia world. I mean, we may even --
5 St George's may have even been slightly slow to
6 replace cryoprecipitate with concentrate. But the
7 massive increase in concentrate -- and basically,
8 looking at that, haemophilia -- I mean,
9 cryoprecipitate essentially ceasing to be used,
10 because 200 units is a less than a single dose.
- 11 Q. Then if we just go to the next page of this document,
12 Soumik, please, just to complete the picture for '83,
13 as we have a full return for that year, this is
14 patients with antibodies, haemophilia A patients with
15 Factor VIII antibodies, one patient treated during the
16 year, and we can see that's with both Armour
17 Factor VIII and FEIBA.
- 18 Then if we go to the next page, please, Soumik,
19 we have the figures for the haemophilia B patients
20 treated during that year.
- 21 We can see there three patients with
22 haemophilia B treated during that year, and
23 exclusively NHS Factor IX concentrate both at hospital
24 and for home treatment?
- 25 A. That's how I remember it.

29

- 1 started. What can you recall about it?
- 2 A. Well, I think it had grown, and I think that was shown
3 by the 1983 returns, that in terms of the usage of
4 Factor VIII concentrate, that it was sort of fairly
5 evenly balanced between home treatment and on-demand
6 treatment in hospital. I mean, it was acknowledged
7 that home treatment was a far better model for
8 treating haemophilia because the doses -- the required
9 doses of factor were given earlier.
- 10 So there are two forms of prophylaxis. One
11 is -- sorry, there are two forms of home treatment.
12 It obviously is a model for prophylactic treatment but
13 at the time that I started, prophylactic treatment was
14 used in some patients, who were mostly in children or
15 young people, and was still a minority thing. So most
16 people on home therapy kept it in order to administer
17 themselves doses in the event of a bleed, they
18 perceived they were having a bleed. So that's called
19 on demand. So the majority of the home treatment was
20 on demand. To give home treatment you needed
21 a patient or a relative, in some cases it was their
22 parents that injected them, who was training in
23 venepuncture and intravenous administration. So some
24 people were never really interested in it because they
25 didn't feel able to do it, they weren't able to do

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- 1 Q. Now -- we can take the document down, thank you,
2 Soumik.
- 3 We're going to come on in a moment to ask you
4 in a little more detail about the approach to
5 treatment and the kind of decisions that were taken as
6 to which products to use. First of all, however, is
7 this right, that in the period up until the time you
8 took over as director in the summer of 1985, decisions
9 as to which treatments to use and which particular
10 products to use were the responsibility of
11 Professor Flute?
- 12 A. Yes, 100 per cent.
- 13 Q. Your statement would suggest that you had little
14 involvement in the process, in part because you were
15 in training and also because you were circulating,
16 rotating around a number of different hospitals?
- 17 A. That's correct. I'd only just seen my first bottle of
18 Factor VIII ever just before starting in 1976 at
19 St George's, and I had essentially no idea of the
20 commercial world of Factor VIII purchase. So, no, he
21 did all that.
- 22 Q. Now, in that period of time, late 70s and the first
23 half of the 80s, what was the home treatment, home
24 therapy programme at St George's? I think you have
25 referred to it as having been piecemeal when you

30

- 1 that, or their veins did not allow it.
- 2 So that was the sense it was piecemeal. It
3 wasn't for -- not everybody wanted it and we could
4 certainly only afford a certain amount of it. The
5 moment you start giving home treatment, your treatment
6 requirements go up. The reason being that, of course,
7 a patient will -- patients don't like going to
8 hospital having intravenous injections, and they would
9 surely delay going until it was absolutely imperative,
10 which means the bleed has already reached a certain
11 point, which has probably done damage to the joint,
12 which will become permanent, whereas with home
13 treatment the patient -- there aren't the barriers of
14 travelling and waiting in hospital, the patient can
15 administer the product as soon as they get sometimes
16 quite early feelings that come with an incipient bleed
17 in the joint. So an experienced patient will
18 recognise the very earliest features of an oncoming
19 bleed in a joint and be able to treat when perhaps the
20 volume of blood in the joint is still very low. So
21 that's why home treatment is absolutely a better form
22 of treatment.
- 23 Q. Now, you told us in your statement your understanding
24 of Professor Flute's approach to treatment, and I'm
25 going to go through different categories of patient.

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1 You say in your statement you were aware of
 2 Professor Flute's decisions only insofar as he
 3 explained them to junior staff. To what extent did he
 4 explain his thinking to staff? You obviously got
 5 a broad idea of what products he generally used for
 6 different types of patients but to what extent did you
 7 know why?

8 A. He would occasionally share parts of his
 9 decision-making. Professor Flute was an extremely
 10 genial and pleasant man but he'd come from
 11 a tradition, almost like semi-military tradition, in
 12 fact, I believe he was still a colonel in the
 13 Territorial Army, responsible for blood transfusion
 14 within the Territorial Army, and there was something
 15 of the senior officer about him, in that we would --
 16 we were let -- on a need-to-know basis in terms of our
 17 training of the running of the department he would let
 18 us know. But we were not privy to many of the reasons
 19 for his decisions.

20 He did, however, as I've said, promote the idea
 21 that, in his opinion, it was not a good idea to have
 22 a multitude of providers, which I think you can see
 23 from the returns, that once he settled on a supplier
 24 he would stick with that supplier, in that case
 25 Armour. So I have read other evidence which suggests

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1 Q. Now, severe haemophiliacs, you've said in your
 2 statement that, as far as you can recall,
 3 Professor Flute's preference was to treat children and
 4 younger adults who had severe haemophilia A with the
 5 NHS Elstree product, if it was available, because he
 6 considered it less likely to transmit non-A, non-B
 7 hepatitis; is that correct?

8 A. That was my understanding at the time, yes.

9 I mean, he was perfectly aware of the
 10 occurrence of what I think he probably still called
 11 serum hepatitis until late 70s, and made that
 12 decision, yes.

13 Q. Can you recall any discussions with Professor Flute
 14 about why he considered the Elstree concentrate less
 15 likely to transmit non-A, non-B hepatitis? Were there
 16 discussions about relative pool sizes or donor
 17 attributes, for example?

18 A. I'm afraid I do not recall any specific mention of
 19 that issue.

20 Q. Your statement says that unfortunately there was never
 21 enough Elstree product so older adults were usually
 22 given commercial concentrate, the Armour Factor VIII
 23 as we see reflected in the returns, and that in fact
 24 younger patients would also end up receiving Armour
 25 Factor VIII because it was a regular event that there

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1 that people felt that they shouldn't put all their
 2 eggs in one basket, that you might run out. He didn't
 3 work according to that principle. His principle was
 4 that he wanted very much all his eggs in one basket
 5 because -- I don't know. I can't say what his reasons
 6 for this were. They could have just been convenience,
 7 i.e. you only have to deal with one set of commercial
 8 operatives from a company. But anyway, that was very
 9 much his view. He told us about that and it's
 10 expressed in the annual returns.

11 Q. Now, haemophilia B patients were, as I understand your
 12 statement, and from your recollection, consistently
 13 treated with NHS Factor IX concentrate, which you
 14 recall being the Oxford concentrate prepared at
 15 Dr Bidwell's laboratory?

16 A. Yes. Dr Bidwell -- amazing. I mean, completely
 17 self-sufficient production of Factor IX. Of course,
 18 you don't need as many units of Factor IX nationally
 19 but that was -- and what's more, she managed to keep
 20 up the supply for what was required.

21 So, yes, I'm glad to see that we were
 22 restricted to that. And then when the concentrate
 23 came in to the NHS -- sorry, to the -- BPL Factor IX,
 24 that also we didn't need much in the way of commercial
 25 Factor IX.

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1 was insufficient Elstree product; is that right?

2 A. Yes, that's true.

3 Q. Did children also end up receiving Armour because
 4 there wasn't enough BPL product available?

5 A. I'm afraid I can't say with any certainty, but I would
 6 have thought it was inevitable.

7 Q. Can you recall anything -- again, I'm talking really
 8 about the period in the late 70s and the first half of
 9 the 80s here, before you took over as director, but
 10 can you recall anything about what the arrangements
 11 were for obtaining the Elstree product or the Armour
 12 product? Was it all done via the Blood Transfusion
 13 Centre in Tooting or was it done directly with BPL or
 14 the pharmaceutical company?

15 A. The commercial Factor VIII was purchased from the
 16 pharmaceutical companies with direct contracts.
 17 The BPL product was accessed through the National
 18 Blood Transfusion Service. Now here my knowledge is
 19 not complete but my understanding was that during the
 20 early years it was managed through BPL. It was
 21 essentially free product, although nothing from BPL is
 22 truly free, but the fact is that it was -- the
 23 region -- right, so the South West Thames NBTS Centre
 24 was also at Tooting, on the St George's site, and the
 25 amount of BPL product it received to pass to the

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1 haemophilia centres in the region was linked to the
2 amount of plasma the NBTS Tooting contributed to the
3 national plasma -- the BPL product pools.

4 Whether that or actual total product production
5 by BPL was the limiting factor on supplies -- I think
6 probably their overall production was more a limiting
7 factor than any particular shortfall of the
8 NBTS centre. But, yes, that was -- if you like, there
9 was a double constraint on the amount of BPL product
10 that was available to us in that regard.

11 Q. Dr Winter told us about his experience of particular
12 difficulties obtaining sufficient quantities of
13 NHS product from Tooting, and he identified
14 a particular problem being that the Tooting Regional
15 Transfusion Centre covered two very large regional
16 health authority areas: the South East Thames and the
17 South West Thames, and his evidence described
18 a service under pressure, unable to meet demand.

19 Is that something you have any recollection of
20 yourself?

21 A. As far as I recall, that was true, yes. That was
22 true. Yes, very much so.

23 In addition, of course, they had within their
24 catchment area the Royal Marsden Hospital, which was
25 a very large consumer of blood products such as

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1 A. In strict terms, no. However, Professor Flute did
2 communicate to us that he told everyone that was going
3 to receive concentrate that they would be likely to
4 get a brief period where their liver function was
5 affected, that there was a form of hepatitis was
6 almost inevitable -- as it was -- very soon after
7 first exposure to commercial pooled product. He would
8 tell them about this, but he would tell them about it,
9 and us, in a reassuring way: everybody goes through
10 this, it doesn't seem to cause any problem, people
11 don't get very sick with it, sometimes you don't even
12 have jaundice sort of thing.

13 So they were informed, but I would say that
14 neither Professor Flute nor the patients were what we
15 now call fully informed about that, validly informed.

16 Q. I'll come on to ask you in a little while about
17 hepatitis in a little more detail.

18 In terms of patients with mild haemophilia,
19 what can you recall being the approach to their
20 treatment? Again, I'm talking in the period under
21 Professor Flute's directorship up until 1985.

22 A. Well, by mild haemophilia you mean -- you know, the
23 technical definition is anyone with greater than
24 5 per cent, if you like, of residual Factor VIII, but
25 it also goes up to people who are on the edge of

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1 platelet transfusions. So yes, I think they were
2 never -- they were always short. They were never
3 replete.

4 Q. Now, going back to the treatment policies towards
5 severe haemophiliacs, those with haemophilia A, you
6 describe in your statement there having been when you
7 arrived a small number of individuals on
8 cryoprecipitate, and you say that Professor Flute
9 had -- I'm paraphrasing your statement here -- been
10 content for that to be the case because it was cheaper
11 to treat with cryoprecipitate than it was with
12 concentrate.

13 A. Well, essentially cryoprecipitate was free at point of
14 use. I mean, obviously in the NHS structure as
15 a whole it wasn't free but to the end user it was
16 free, whereas from the very start the commercial
17 concentrate was regarded, certainly by other aspects
18 of the hospital, as one of the most expensive
19 therapeutic products on the entire field. So, yes, it
20 was much more a hit on one's budgets to buy the
21 commercial Factor VIII.

22 Q. Do you know what, if anything, patients were told by
23 Professor Flute about the comparative risks of
24 concentrate versus cryoprecipitate or NHS concentrate
25 versus commercial concentrate?

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1 normal, in fact may probably be normal, just a few
2 points off. I think his position was they didn't need
3 treatment at all.

4 When desmopressin came in, which was about
5 1982/3 I think, then he commenced to use it with some
6 enthusiasm, because he saw it as a way -- firstly, in
7 terms of treating individuals with von Willebrand's
8 disease, it covered a lot of the conditions that you
9 would need to treat them for, and this was certainly
10 true of mild haemophilia as well. So we were
11 definitely using desmopressin when I was a senior
12 registrar. In fact, my colleague and I reported
13 a case of an elderly gentleman who actually died after
14 receiving desmopressin from a myocardial infarction,
15 and this was published in -- and got us a bit of
16 criticism from Mannucci for exaggerating it.

17 But, I mean, that was highly unusual. And,
18 after that, we learnt to be cautious with certain
19 types of individual, giving them desmopressin.

20 Q. We've heard from other clinicians in some centres that
21 they were able to use desmopressin from the late 70s.
22 Your recollection is that it was a little later for
23 St George's?

24 A. During my period as a senior registrar it was in full
25 use at St George's. So when he started it I'm afraid

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1 I can't say.

2 **Q.** If, for whatever reason, desmopressin was not

3 available or not suitable for a patient with mild

4 haemophilia, and leaving aside the requirements

5 potentially for major surgery, what was the next

6 product of choice for a mild haemophiliac? Was it

7 cryoprecipitate or was it concentrate?

8 **A.** Well, by definition, if you were going to treat mild

9 haemophilia, it would usually be for a surgical

10 operation. A surgical operation -- it obviously

11 depends on the nature of the operation but if it's

12 major surgery you need to maintain Factor VIII around

13 100 per cent maybe for a week to allow the initial

14 wound healing to happen. It's very difficult to

15 achieve that with desmopressin because after -- after

16 a second -- desmopressin raises the von Willebrand

17 factor in Factor VIII for about 24 hours. If you need

18 it longer than that, a second dose of desmopressin is

19 often less effective than the first and, after

20 a second dose, you begin to run into the other problem

21 with desmopressin, which is that it is an analogue of

22 a pituitary hormone which conserves sodium -- sorry,

23 which conserves water, and therefore people can get

24 very dilute plasma and low sodium, which can be fatal.

25 So you can't maintain someone at 100 per cent of

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1 attempt to use BPL in those patients. But I can't --

2 knowing the shortage of BPL, I'm pretty sure that

3 there might have been exposure to commercial

4 concentrate in that period.

5 **Q.** You describe in your statement drawbacks of

6 cryoprecipitate, and you've put it this way in your

7 statement:

8 "The majority of patients receiving

9 cryoprecipitate would, after cumulative exposures,

10 experience severe febrile transfusion reactions."

11 Now, Dr Bevan, we've heard other clinicians

12 describe reactions to cryoprecipitate, but I don't

13 think we've heard it put quite as strongly as that,

14 that the majority of patients would respond in that

15 way. Bearing in mind there were, I think, only five

16 of six patients receiving cryoprecipitate when you

17 arrived, and that number diminished down to -- I think

18 you describe one or two and then none in your

19 statement, what is the factual basis for your

20 understanding that the majority of patients would

21 experience such reactions?

22 **A.** Right. We only had eight patients, so a majority

23 would just be three or four of them, I think. So as

24 far as I remember it was widespread, but my memory is

25 such that, obviously, such reactions were very

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1 Factor VIII for a week with desmopressin. So you have

2 to use some other form.

3 I think it would be very rare but that in the

4 event of major surgery someone with mild haemophilia

5 would usually receive BPL factor. I would think that

6 would be done. He would classify them as a rare user

7 and therefore do everything he could do give them

8 entirely BPL product.

9 **Q.** Now, what about patients with moderate haemophilia A?

10 What was the approach to treating them?

11 **A.** Well, people with moderate haemophilia A are very

12 heterogenous, so to have just 1.5 per cent, if you

13 like, no essential difference to severe haemophilia,

14 certainly in terms of bleeding around surgery. You

15 may get less spontaneous bleeding and not need

16 prophylaxis and not need home therapy, but if you have

17 a surgery you would be in exactly the same position as

18 someone with severe haemophilia.

19 I think internationally it's been shown, where

20 surveys have been done, that in general, over

21 a lifetime, people with moderate haemophilia end up

22 having the same ballpark of treatments with factor.

23 So I think it was more likely that if -- in the case

24 of the surgery they would receive a Factor VIII

25 concentrate and, again, I imagine that he would

42

1 striking and much more likely to stick in my memory

2 than, say, the person who didn't have them. Then --

3 again, this is probably quite a widespread

4 perception -- with a small number of patients, the

5 people who needed cryoprecipitate on a regular basis,

6 who were severe haemophiliacs who had no other

7 product, would receive -- decided to have no other

8 product. They were the frequent attenders. So it may

9 be the majority of attendances I remember that this

10 was an issue. Maybe not everyone got the most severe

11 form. Maybe most -- maybe on many occasions you could

12 suppress the symptoms of the reaction with

13 hydrocortisone and Piriton but the ones that stuck in

14 my memory, and therefore after so many years come to

15 dominate my entire picture are two individuals,

16 fully-grown adults, one of them almost middle-aged,

17 and sitting suffering in the bed with the bed shaking

18 and rattling, because it was an old-fashioned,

19 steel-framed bed, with the power of this rigors they

20 were getting, and that was despite going up to the

21 limit of safe treatment with Piriton and

22 hydrocortisone.

23 So it was -- you know, it was a very prominent

24 thing in my memory.

25 **Q.** The reactions that you describe, and describe as

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1 being, in the ones that certainly stick in your
 2 memory, unpleasant reactions, were they nonetheless
 3 temporary reactions?

4 **A.** They were temporary, although when the body has
 5 a reaction like that, there is a kind of cytokine --
 6 a brief cytokine storm, so there is an after-effect
 7 that may last for several hours. For a start, the
 8 amount of Piriton they get will almost certainly have
 9 sedated them and made it impossible for them to drive
 10 home, for example, so they would need to rest up for
 11 a couple of hours after this, you know, a cup of tea.
 12 So, yes, they would recover but I think that for one
 13 of those patients, definitely, he developed an almost
 14 phobic response in that he would delay coming until
 15 the bleed was really quite advanced.

16 So, yes, that's how I remember cryoprecipitate.

17 **Q.** Now, cryoprecipitate wasn't, I think from your
 18 statement, used for home therapy at all at
 19 St George's.

20 **A.** No.

21 **Q.** Were you aware at the time that it was used for home
 22 therapy, or had been used for home therapy, with
 23 apparent success in some centres, Royal Free and
 24 Birmingham are two that the Inquiry is aware of.

25 **A.** Well, as a haemophilia director, I perhaps wasn't

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1 We know that -- so I'm -- I'm interested that some
 2 centres found that practicable.

3 I remember reading about Katharine Dormandy's
 4 approach that she used to transport the cryo, even if
 5 the patients did not have home freezers, they used to
 6 keep it with solid carbon dioxide cardice. I mean,
 7 a hazardous substance likely to administer serious
 8 cold burns if you mishandle it. So complex and with
 9 many pitfalls but, nonetheless, I can see they did it.
 10 I didn't know at the time they were doing it.

11 **Q.** Is this correct -- please say if it's not -- that, in
 12 terms of the treatment of children at St George's,
 13 during -- again, I'm talking about the period up until
 14 1985, cryoprecipitate was not, as far as you can
 15 recall, used for children at all?

16 **A.** No, because all those problems about volume and
 17 reactions, if you like, more prominent, more
 18 prohibitory in children and, I think, also with
 19 children, quite rightly, you have huge input from the
 20 parents and if the parents -- parents, given the
 21 option of a concentrate versus cryo, would always go
 22 for -- because they reduced volume of injection down
 23 to about 30mls with the early concentrates, it was
 24 an enormous step, because now an injection could be
 25 given through -- I mean, establishing intravenous

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1 aware of the practice in the UK. I was aware that in
 2 America, where many homes had domestic freezers, that
 3 cryoprecipitate could be used. I still think that it
 4 would pose considerable practical difficulties for the
 5 patient to administer cryoprecipitate. First of all,
 6 there's the business of subsampling bags, this is in
 7 the British system. So I think part of the American
 8 facility of using cryoprecipitate in home therapy was
 9 that their formulation of cryoprecipitate was somewhat
 10 different. They had, for example, freeze-dried
 11 cryoprecipitate, they had liquid cryoprecipitate, they
 12 had various forms which were, if you like, more
 13 convenient to use.

The British form, where you needed to subsample
 to get a dose from -- so, for example, you've seen
 that the broad number of units in a single bag of
 cryoprecipitate was 50. Therefore, a dose for
 an adult, it has to be maybe 2,000 units. So you have
 to give 20 or more bags, and subsampling these into
 a single bag is fine when you can infuse it through
 a drip in hospital, but setting up drips on yourself
 is not a straightforward thing. So the home user
 would have to draw it up into a very large-barrelled
 syringe, 50 ml syringe, and give it in several
 doses -- I mean, very, very inconvenient and complex.

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1 access in a child is difficult, can be difficult and
 2 is -- you know, you want to use it and get out of
 3 there as soon as possible. You don't want to trust to
 4 an intravenous cannula being able sit in position for
 5 perhaps 20 minutes or half-an-hour, while you slowly
 6 administer viscous cryo.

So there were all sorts of reasons why the
 children got concentrate.

Q. You have said in your statement parents wouldn't have
 allowed children to have cryoprecipitate, and one can
 quite understand the convenience of concentrate over
 cryoprecipitate for a parent, but would you accept
 that a parent's choice in those circumstances might
 depend upon what they were told about relative risks,
 and we'll come on to talk about the risks of AIDS
 a little later, Dr Bevan, but a parent might well wish
 to opt for a safe but inconvenient product over
 a riskier but more convenient one.

A. Yes, I can't say what parents were told about that
 either by Professor Flute or by their paediatric
 consultant. Yes, I mean, I think here, at that time
 the only risk we knew about was non-A, non-B
 hepatitis. We thought that the Hep B situation was
 covered by testing. Accordingly, cryoprecipitate was
 not free from risk of transmitting non-A, non-B

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hepatitis. In fact, you may see later when it comes to the Hep C look-back at St George's, my main two patients, where one was one that received NHS cryoprecipitate entirely during treatment for a condition called TTP. Another was a patient who received platelet transfusions from the BTS.

So cryoprecipitate could not be considered free from non-A, non-B. Yes, because of the pool size it was less but, again, you have to consider that if for a dose of cryo you have to subsample donations of cryoprecipitate from ten bags, that's ten donors. It builds up, and over a year someone entirely on cryoprecipitate would experience exposure to the plasma of perhaps 100 donors. So non-A, non-B was in the British population, in the donor population, and being transmitted by these products -- much lower risk but the risk was not zero.

Q. In relation to those patients, the handful of patients who'd remained on cryoprecipitate, you have said in your statement they negotiated a change to concentrate within a year or two, or Professor Flute had negotiated a change to concentrate within a year or two of your arrival. Do you know what those patients were told about relative risks of cryoprecipitate versus concentrate?

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Q. I wanted to ask you next about your knowledge of hepatitis risks, in particular non-A, non-B hepatitis.

You have said in your statement that as a trainee you knew that blood and blood products could be infective, and you have said also this in your statement:

"Like any British doctor trained during the 1970s, I was well aware of the hepatitis B outbreak that killed patients, nurses at renal units in Scotland."

What can you recall learning, whether as part of your general medical training or your junior medical work, about hepatitis and risks from blood and blood products?

A. Well, of course one learnt about hepatitis during courses on liver disease and in general medicine, and one met patients with chronic hepatitis, cirrhosis, and other, and one was aware of phenomena of autoimmune hepatitis. And, among this, one was also aware of serum hepatitis, which had been recognised for a very long time, exposure to blood products.

Hepatitis B was obviously the most clear-cut and dramatic of those situations, and partly this was because it could be an acutely devastating disease, so that the outbreak at Glasgow, and also I know now that

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A. No. No, I don't know.

MS RICHARDS: Sir, I note the time and I am going to move to a slightly different topic, so perhaps this might be a convenient moment for a break.

SIR BRIAN LANGSTAFF: Yes, we will take a break. We normally have a half-hour break in the morning to allow people at home watching, and you giving evidence, to have a cup of coffee or whatever and that's what we do. What you mustn't do, you may have heard me say this on other occasions to other witnesses, I don't know, you mustn't discuss your evidence, either the evidence you have given or that which you are likely to give, you think, with anyone, whoever they are, that includes your daughter if she was interested, but you can talk about anything else you like. I look forward to seeing you back at, shall we say, quarter to 12.

A. Quarter to 12, thank you very much. No, I won't talk to anybody.

(11.18 am)

(A short break)

(11.44 am)

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: Dr Bevan --

A. Sorry -- yes, I'm here.

50

there was one at Guy's, was, you know, very dramatic, a lot of very sick people, some people died of acute hepatic necrosis and then, in addition, you had the remarkable serendipitous discovery of so-called Australia antigen, which could actually just as well be called haemophilia antibody because the antigen was identified by its reaction with sera from haemophilia patients, and therefore, that one could actually screen blood for this.

So by the time I took up haematology I was aware that one of the major risks of blood-transmitted infection had been modified to the point of excluded by good serological testing of donor blood but that obviously there were other causes of transfusion-transmitted hepatitis which were not Australia antigen positive and therefore could not be screened for and then, as I said, it very quickly became clear to me as a registrar that patients with haemophilia were being probably given this by the product they received. So, sorry, where did you -- have I answered your question?

Q. You have. Just dealing with -- you have referred to the outbreak in Scotland with the devastating consequences it had. Had you been aware in the 70s of the outbreak at Guy's Hospital? I know we've supplied

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1 you with an article that refers to it but is that
 2 something you can recall being aware about at the
 3 time?
 4 **A.** I think I was. The one at Glasgow was very prominent,
 5 and for the most superficial of reasons: that serving
 6 doctor was one of the first of many to write a novel
 7 about it, called *The Houseman's Tale*, which was
 8 published while I was a house officer in Darlington,
 9 which was an extremely -- how can I put -- almost
 10 crazy in terms of the workload, and so I was desperate
 11 for some kind of relaxation, so I -- because there was
 12 this book called *The Houseman's Tale* and I read it.
 13 I think it is quite a scurrilous view of the Glasgow
 14 outbreak because it invoked sexual transmission as the
 15 main -- which is almost certainly not true. So -- but
 16 nonetheless, that's the way in which things achieve
 17 prominence in your mind. So I then took care to
 18 actually familiarise myself with the true nature of
 19 the Glasgow outbreak.
 20 But the Guy's outbreak I probably did know
 21 about, but it was, like, in second place, although it
 22 was a much bigger outbreak in fact.
 23 **Q.** Do you recall reading about or learning about at the
 24 time the outbreak at Bournemouth that was reported by
 25 Dr Craske in 1975 in *The Lancet*?

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1 I mean, the inevitable bit was probably correct in
 2 terms of commercial blood product exposure or even any
 3 pooled donor product exposure on a regular basis.
 4 But classically it happened during the very
 5 first few exposures of a child, for example, or
 6 a young person to any kind of commercial concentrate.
 7 And that was the way I think it was explained
 8 to them: that this is inevitable, it's just
 9 a disturbance in liver transaminases, so-called
 10 transaminitis. There's no jaundice, so it can't be --
 11 I mean, completely unacceptable -- what's the right
 12 word -- assumptions, as it turned out, and probably
 13 even in principle, to assume that something is
 14 harmless.
 15 **Q.** You have said in your statement that you've got
 16 a recollection in 1979 of attending a UKHCDO meeting
 17 and hearing a talk from Dr Craske which effectively
 18 led to your understanding that non-A, non-B hepatitis
 19 was something to be taken seriously?
 20 **A.** Absolutely right. I mean, I'll have to apologise
 21 again for memory, which as we saw in the case of
 22 cryoprecipitate, is not a quantitative thing, it's not
 23 going to -- images stand out, and Dr Craske was quite
 24 a recognisable speaker at the podium. He had a huge
 25 shock of white hair and he was -- you know, you knew

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1 **A.** No, I wasn't aware of that one.
 2 **Q.** Now, you said in your statement that you knew
 3 before 1979 that most severe haemophiliacs were being
 4 infected with serum hepatitis, and do I correctly
 5 understand your statement as reflecting your
 6 understanding that by this time serum hepatitis was
 7 essentially the same as non-A, non-B hepatitis,
 8 because testing for hepatitis B was now available?
 9 **A.** Yes, and hepatitis A had its own clear-cut clinical
 10 features. So I don't think I can say with any
 11 confidence which year the designation "non-A, non-B"
 12 very first appeared or became common currency, but
 13 I guess it was the late 1970s, yes.
 14 **Q.** So there came a point in your practice and in the
 15 dealings and interactions you had with others where
 16 the term "serum hepatitis" effectively became replaced
 17 by "non-A, non-B hepatitis"?
 18 **A.** Yes.
 19 **Q.** You have said also in your statement that up
 20 until 1979 this infection was presented to trainees by
 21 their mentors as inevitable and harmless. Can you
 22 elaborate upon that.
 23 **A.** Well, once again, I think I've unaccountably
 24 generalised that statement. It was mentioned to me by
 25 my mentor as generally harmless and inevitable.

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1 when you were being talked to by Dr Craske. And so
 2 I just remember that and thinking, yes, you know, this
 3 authority is taking it seriously and we all should.
 4 **Q.** Just so that we can give a probable date to that, I'm
 5 just going to put up on screen the minutes of the
 6 November '79 UKHCDO meeting.
 7 Soumik, it's HCDO0000015_068.
 8 We can see from the top of the page:
 9 "Minutes of the tenth meeting of UK Haemophilia
 10 Centre Directors held in Oxford ... 20th and
 11 21st November, 1979."
 12 Then we can see among the list of attendees as
 13 being present both days, yours is the, I think, fourth
 14 name down: "Dr ... Bevan, St George's Hospital"?
 15 **A.** Yes.
 16 **Q.** I think this is right, Dr Bevan, you were effectively
 17 attending in Professor Flute's stead, and you had done
 18 so also the previous year in 1978?
 19 **A.** Yes. I think this was a mixture between his
 20 encouragement of my attending of events such as the
 21 haemostasis club and the actual deputation in that he
 22 couldn't go himself, so he wanted the Centre always
 23 represented there. So I was the point person to do
 24 that.
 25 **Q.** If we go on, please, Soumik, to page 18 I think -- no,

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(14) Pages 53 - 56

1 sorry, if we go back -- it's page 18 if you look at
2 the pagination at the top. So go back perhaps three
3 pages, Soumik. My apologies. That's it.
4 It doesn't necessarily give the flavour of
5 everything that was being said by Dr Craske but we can
6 see here that on day 1 of the two-day meeting there
7 was a report by Dr Craske of the Hepatitis Working
8 Party, and we can see that there's a discussion
9 halfway down that long paragraph saying:

10 "... it was important for the incidence of
11 chronic hepatitis in haemophilic patients to be
12 assessed. There was much discussion regarding the
13 incidence of chronic hepatitis in haemophilia
14 patients, the possible value of liver biopsies ..."

15 And then there's a discussion of liver biopsies
16 and a discussion of the possibilities of obtaining
17 samples post-mortem, discussion of attack rates.

18 "Dr Craske commented ..."

19 This is towards the bottom of the page,
20 Dr Bevan.

21 "... that most patients thought to have
22 developed chronic liver disease had not previously had
23 an overt attack of hepatitis. There were various
24 possible causes of hepatitis ..."

25 If we go over the page.

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1 liver biopsy was of the chronic persistent type of
2 hepatitis. So there was still some -- there wasn't
3 the absolutely clear-cut role of the hepatitis C
4 virus, which of course it eventually became, where we
5 understand that there is no innocent type of chronic
6 hepatitis associated with it.

7 Q. We can take the document down, Soumik.

8 Can you recall whether -- post your hearing
9 that talk from Dr Craske in November 1979, can you
10 recall whether you had any further discussions with
11 Professor Flute about how non-A, non-B hepatitis
12 should be regarded?

13 A. I do not recall any such discussions. I kind of
14 understood that when he was being deputed that he
15 would go through the minutes, and he would have been
16 aware of that. And then of course there was
17 Eric Preston's paper on biopsy which was very close to
18 that.

19 Q. That was, in fact, the next matter I was going to ask
20 you about. I'm not going to turn to it unless you
21 want to look at it in detail, Dr Bevan. We have
22 looked at it on a number of occasions in the Inquiry.
23 It is 1978, Professor Preston's publication, liver
24 biopsy results, including findings of chronic active
25 hepatitis. Did you read that at the time as far as

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1 "... and one should keep an open mind about it.
2 There were two types of non-A, non-B hepatitis."
3 And then a discussion about forms for reporting
4 cases of chronic hepatitis.

5 So is it fair to say this is probably the
6 occasion that you have a memory of?

7 A. Yes. Yes, it is almost certainly.

8 Q. So is this a fair way of putting it, that from at
9 least late 1979 onwards you, as a relatively junior
10 doctor still at that stage, understood that non-A,
11 non-B hepatitis could be serious or, put another way,
12 it wasn't something that was inconsequential or benign
13 and harmless?

14 A. It certainly wasn't inconsequential. I mean, one of
15 the difficulties was the distinction that was being
16 made at that time between what was called
17 chronic active and chronic persistent hepatitis.

18 So chronic hepatitis could be of the type which
19 was, at that time, classified as chronic persistent,
20 which was thought to be not progressive towards
21 cirrhosis, whereas chronic active was regarded as
22 potentially progressive towards cirrhosis.

23 So for a time that belief that non-A, non-B
24 hepatitis had a harmless element or in some cases it
25 was harmless was based on the fact that the finding on

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1 you can recall?

2 A. I wish I could claim that I read it in detail at the
3 time. I think the implications of it were clear from
4 its publication, not least because, of course, at
5 UKHCDO meetings a fair amount of stuff takes place on
6 the podium but other stuff takes place in conversation
7 with peers. So some of the younger -- some of the
8 people of my similar age and stage as I was, like --
9 there were members of the Sheffield team, Makris, for
10 example, who were involved, and it was clear from
11 conversations that this was highly significant
12 finding.

13 I mean, there was no way -- I mean,
14 Professor Flute was of the generation of haemophilia
15 doctors where I think wild horses would not have
16 driven him to do a liver biopsy on a patient because
17 he was part of the group that felt it was completely
18 impermissible.

19 But I think that that was a prominent finding
20 and that was well appreciated at the time and I think
21 by me as well.

22 Q. Do you recall whether you saw the December 1975 World
23 in Action documentary which talked about hepatitis
24 risks and blood donation practices in the States?

25 A. I don't think I saw that documentary.

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1 Q. Do you consider that, as a matter of principle,
2 patients should have been told about the risks of
3 non-A, non-B hepatitis and that they could potentially
4 have serious consequences, at least from 1979 onwards?
5 A. I think that's unarguable. I don't think anybody
6 would claim that they should not know that since we
7 knew it by then.
8 Q. But I think from your earlier answers that -- again,
9 please correct me if I'm wrong -- you don't know
10 whether Professor Flute's advice to patients changed
11 at all about non-A, non-B hepatitis?
12 A. I'm afraid I have no knowledge of that. I would hope
13 it did but I can't say yes or no.
14 Q. What was your practice from the point in time at which
15 you became the responsible consultant for the
16 haemophilia patients at St George's, so summer of
17 1985, in the sort of years that followed in the second
18 half of the 1980s, prior to the availability of the
19 hepatitis C test, what was your practice in terms of
20 the information you'd provide to patients about non-A,
21 non-B hepatitis?
22 A. As far as I can recall, and I would certainly hope, my
23 practice was to inform them of the risk of non-A,
24 non-B hepatitis and what was known about it at the
25 time. Yes.

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1 that, that you knew that:
2 "People with haemophilia were at risk of
3 blood-borne infection because of their exposure to
4 pooled plasma from many donors, so the association, as
5 I understand it between blood product usage and AIDS
6 seemed quite likely to me."
7 A. Yes, at that time, I think I remember CADIC describing
8 it as, you know, the person with haemophilia exposed
9 to multi-donor products being the canary in the coal
10 mine for any blood-borne infection, and this would be
11 not just information that led to me regarding them as
12 risk but also, you know, quite good information
13 suggesting that you were looking at a blood-borne
14 virus or a blood-borne infectious agent, I should say.
15 Q. Again, we know and you will have seen this in some of
16 the material supplied to you for the purposes of your
17 evidence, Dr Bevan, that there were also in
18 December 1982 reports of AIDS or AIDS-type symptoms in
19 patients who had been transfused with platelets,
20 there's the San Francisco baby case --
21 A. Yes.
22 Q. -- do you recall becoming aware of that as well?
23 A. Yes, I think those early publications on AIDS in the
24 New England Journal and others, that were top-line
25 reading, I think, for all of us.

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1 Q. Did --
2 A. I think in this I was informed also by -- I tried to
3 say, the HIV or the AIDS epidemic changed everything,
4 and one of the things it changed was I became used to
5 working with a counsellor and she was -- if you like,
6 she became interested, as well, in Hep C. So from
7 then on my practice moved towards complete disclosure
8 of risks, I think, at the outset. We still regarded
9 consent to treatment with concentrate as categorical,
10 that is not to be renewed on every exposure,
11 necessarily, but I did put people in the picture.
12 Q. Moving to the question of AIDS, again, you've said in
13 your statement that you recall reading -- I think
14 you've put it as late 1982 -- an MMWR report of AIDS
15 in haemophiliacs in the United States; is that right?
16 A. Yes, I think I do. I mean, the MMWR is not something
17 that British haematologists would normally consult,
18 but the fact is it was published as a supplement.
19 A kind of digest of MMWR findings were published in
20 the Journal of the American Medical Association, as
21 far as I remember, and this was a journal I did read,
22 it was one of my kind of chronic reading lists, so
23 I had read that and I was aware of it and I was
24 alarmed by it, as you'd expect.
25 Q. You put it this way in your statement, having read

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1 Q. I'll come on to such discussions as you had with
2 Professor Flute on the issue but, before we do that,
3 can you recall what, if any, discussions were had
4 around this time, late 1982, first few months of 1983,
5 with others, other doctors in the hospitals in which
6 you worked, for example, the Royal Marsden?
7 A. No. By then -- so where are we talking about now?
8 1982/3, I think my relationship with the Royal Marsden
9 had essentially ended. I had no more attachments
10 there. I think -- and the Royal Marsden is a rather
11 enclosed cancer world, and I'm not sure -- so no,
12 I don't recall having any discussions with them at
13 that time, even on the issue of Kaposi's sarcoma.
14 I don't recall discussing them, yes.
15 Q. Can you recall, for the first half of 1983 where were
16 you in the rotation that you were undertaking, the
17 senior registrar rotation? Were you at St James'
18 Hospital or were you predominantly at St George's at
19 that time?
20 A. I think I was at St James'. I was attached to
21 St James' Hospital but, unfortunately, my precise CV
22 seems to have got lost in my loss of electronic
23 documents post-retirement. So I can't say for sure
24 but I think it was St James', because I think that
25 would fit it with my recollection that the first few

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1 months of my consultant appointment were at St James',
2 that I kind of continued that relationship.

3 **Q.** Can you recall when you became aware for the first
4 time of the first haemophiliac patient in the UK
5 thought to have AIDS, the Cardiff AIDS patient?

6 **A.** I cannot remember that with any certainty. You are
7 undoubtedly going to ask me about the conversation at
8 the teaching session we had with Professor Flute.
9 I've got a feeling that we hadn't had a British case
10 then, and that was part of his response, but I can't
11 remember for sure, sorry.

12 **Q.** Can you describe for us that conversation that you
13 recall you and, I think, Dr Richard Lee, another
14 trainee at the time, having with Professor Flute?

15 **A.** Well, I can recall that we were assembled at the
16 St George's base and we were, in fact, sitting in the
17 haemostasis laboratory, and because Richard was there
18 as well -- he was a colleague of mine, Dr Richard Lee,
19 similarly a lecturer, and we were both preparing for
20 the MRCPPath, and I think we probably attended
21 a teaching session on haemostasis in the laboratory
22 and, therefore, we had a moment where Professor Flute
23 took us through what we'd learnt.

24 As part of that discussion, I can't remember --
25 I think it was more or less raised it jointly with

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1 a second part of the explanation, he explained that in
2 no way would he take any action in terms of changing
3 infusion practice in haemophilia, unless there was
4 official firm guidance from the UKHCDO so to do, and
5 at that, as was a bit typical of Colonel Flute, the
6 discussion was over.

7 **Q.** In terms of that second reason, and the way you've put
8 it in your statement is this, he explained that it was
9 essential in times of uncertainty, particularly for
10 smaller centres to stick closely to the current
11 guidance from UKHCDO, which at that time was not to
12 discontinue US concentrate or revert to
13 cryoprecipitate, and he gave additional weight to
14 UKHCDO being supported by The Haemophilia Society in
15 this opinion.

16 As far as you can recall, was your
17 understanding that that was a view personal to him or
18 did you understand it to be, in fact, the position of
19 UKHCDO, that smaller centres should fall in line with
20 UKHCDO's recommendations?

21 **A.** Definitely. I mean, I don't know whether there were
22 any real dissenting voices at UKHCDO. There may have
23 been warning voices but I don't think anybody actually
24 dissented from the general view. Of course, this was
25 informed by the structure of medical negligence

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1 him, had he read this, did he not think that this was
2 a transfusion-transmitted condition, from which all
3 our haemophiliacs would be at risk of, particularly
4 those who were receiving American concentrate, and
5 I just remember his response. I can actually, as
6 I said, in the narrative way remember these things.
7 I remember the fact it was a sunny day and he was
8 sitting by the window and he was, in his usual way,
9 kind of gruffly, jovially said he didn't regard this
10 as in any way a proven infection.

11 At that time, he was an editor for the British
12 Journal of Haematology and he said he'd seen recent
13 submissions of papers showing similar disorders among
14 T cell subsets in a bone marrow disorder known as
15 myelodysplasia, nothing to do with haemophilia and not
16 treated with similar blood products, but did get a lot
17 of red cell transfusions, sometimes platelet
18 transfusions, and he said that, as far as he was
19 concerned, the findings in the American group were
20 just typical of people who had received any kind of
21 transfusion therapy on a regular basis, that it was,
22 if you like, an immune system adjustment to being
23 exposed to other people's blood and their HLA antigens
24 and other foreign antigens in that material.

25 So he went into it in some detail and then, as

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1 thinking at the time, which was based on the Bolam
2 test. So, by and large, I don't have to tell you
3 about the Bolam test, but if you were following the
4 advice of an authoritative group of clinicians in
5 exactly the same field, if you're following their
6 advice to the letter, essentially, it was very
7 difficult to convict anyone of negligence. Whereas,
8 if you had gone off, away from their advice, you would
9 have become vulnerable to claims of negligence. So if
10 anything happened, if anything bad happened as
11 a result of switching people off their concentrate
12 then you would be in open view, sort of thing.

13 So I can understand why he was emphasising that
14 we didn't have the power as a small centre to go off
15 on our own track.

16 **Q.** In relation to the first of his reasons, and
17 acknowledging that you and Dr Lee were the junior
18 trainees at this point and that Professor Flute was,
19 as you described, the colonel in the Territorial Army,
20 did you and Dr Lee express a different view that you
21 can recall? Were you impressed by his reasoning?

22 **A.** I don't think we chose to quarrel with him.
23 Unfortunately, I cannot claim that we quarrelled with
24 this. You will have to ask Richard whether he felt we
25 were sufficiently -- or we just dropped it at that

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(17) Pages 65 - 68

1 point. I would draw a distinction here, of course,
 2 that this Dr Lee is not the same as Dr Christine Lee,
 3 who was also actually a trainee in the department
 4 under the part-time women's scheme.
 5 **Q.** Yes.
 6 **A.** This was Richard Lee.
 7 **Q.** Yes and we have a statement from Dr Richard Lee
 8 I think, in any event.
 9 Given that to your mind, at least in the
 10 first -- in early 1983, there was a likely association
 11 between the use of blood products and the development
 12 of AIDS or AIDS symptoms in haemophiliacs, would you
 13 agree as a matter of principle that patients should
 14 have been told of that possible or likely risk at the
 15 time?
 16 **A.** Well, I think they should have done but obviously if
 17 I was coming from the same position as
 18 Professor Flute, I would have thought that it was
 19 necessary to have a further degree of proof before you
 20 confronted the patients with it, yes.
 21 **Q.** Do you know what, if any, information or advice was
 22 given to patients as a matter of fact? It may seem
 23 from Professor Flute's words to you and Dr Lee that he
 24 may not have given patients warnings but do you have
 25 any knowledge yourself of that?

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1 heat-treated product.
 2 Soumik, could we have CBLA0002049, please.
 3 We can see this is a letter from
 4 Professor Flute, February 1985, to Dr Snape at BPL,
 5 and he is asking for a supply of heat-treated
 6 Factor VIII concentrates for patients named in an
 7 attached list. Two categories of patients. First
 8 category, those who had not received treatment in the
 9 past year, and few may do so in the year to come. And
 10 then category 2, patients who had all received
 11 treatment during 1984. Then it says this:
 12 "Their HTLV-III antibody status is under active
 13 investigation."
 14 Is this right, that you understand that
 15 reference to the "active investigation" to be to the
 16 fact that samples had been sent to Dr Tedder for
 17 testing by this time?
 18 **A.** Yes.
 19 **Q.** Do you know whether prior to this letter in
 20 February 1985 there had been a switch to commercial
 21 heat-treated concentrates at all or were patients
 22 still being treated with unheated concentrate in
 23 early '85?
 24 **A.** This is obviously quite a crucial thing, which
 25 unfortunately I cannot recall. I did visit

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1 **A.** I really have to say I don't recall any evidence that
 2 he raised this question with his patients. That would
 3 be slightly reinforced by my own conversations with
 4 them when I actually did -- when I shared the news of
 5 their seropositivity with them.
 6 **Q.** Is this correct, that as far as you know, there was no
 7 change of treatment policy at St George's in response
 8 to the risk of AIDS until the switch to heat-treated
 9 products in early '85?
 10 **A.** As far as I know, that's the case.
 11 **Q.** There were various communications from UKHCDO to
 12 centre directors in 1983. As well as the annual
 13 meeting there were some letters March and June of 1983
 14 on. I'm not going to take time going over them with
 15 you because, as I think from your earlier evidence,
 16 you were predominantly at St James' at that time, but
 17 was that material that you routinely saw? Did
 18 Professor Flute share with you and Dr Lee and other
 19 trainees information received from UKHCDO?
 20 **A.** I cannot recall having that information shared. Of
 21 course, you know, I followed the evolution of the
 22 subject through the medical literature, but from
 23 UKHCDO I cannot recall explicitly being shown their
 24 conclusions.
 25 **Q.** Now, we'll pick matters up now in 1985 and the move to

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1 St George's once or twice after hearing with the IBI
 2 to see if I knew any places where records of treatment
 3 documentation were kept. Because it was all noted
 4 down in kind of Dickensian ledgers exactly what -- and
 5 I was not able to access patient histories which would
 6 have letters and other clues in them about what
 7 exactly was being used during that time.
 8 My feeling is that during 1985, certainly by
 9 July 1985 I would hope that none of the factor we were
 10 giving was non-heat-treated but I cannot be certain of
 11 that. There may have been some residual non-heated
 12 material that was used at some time during 1985. So
 13 I apologise for not remembering that.
 14 **Q.** Your recollection in your statement from -- your
 15 approach from the middle of 1985, when you took over
 16 onwards, was that for the most part over the years
 17 that followed you were using BPL 8Y and BPL 9A, and
 18 you have said --
 19 **A.** Well, 9A is easy to say because I think we've
 20 always -- as you can see from past returns, the
 21 Christmas disease patients nearly all got BPL product
 22 of one form or another -- sorry, before that
 23 the Bidwell product and we never had to go to
 24 commercial 9.
 25 When it comes to Factor VIII, I cannot avoid

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1 a suspicion that there were some unheat-treated
 2 batches used up until the middle of 1985, but quite
 3 honestly, whether through wishful thinking or not,
 4 I do not think we gave, from my attendance, any
 5 non-heated product from July '85 onward.
 6 **Q.** You have said in your statement you don't have
 7 a memory of using commercial concentrates from when
 8 you took over in mid-1985 onwards but it could have
 9 happened due to shortages of heat-treated --
 10 **A.** Well, we definitely used commercial concentrate, but
 11 my feeling was it was heat-treated.
 12 **Q.** We can take the document down, Soumik.
 13 Now if we come to the question of the testing
 14 and informing patients of their test results, your
 15 understanding is that Professor Flute had sent samples
 16 in the early part of 1985 to Dr Tedder at the
 17 Middlesex Hospital. And is this right, that was not
 18 on stored samples because St George's didn't maintain
 19 a bank of stored samples? Is that right?
 20 **A.** I cannot say for certain that none of them were stored
 21 samples but I know that we had no bank of stored
 22 samples. So I guess it was -- when I said he would
 23 have started sending them to Richard Tedder's lab
 24 in -- when he wrote that letter to Dr Snape in
 25 December 1984, and that process of sending samples to

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1 informed.
 2 **Q.** As you have referred to, the task of telling patients
 3 the results of the HTLV-III testing fell to you in the
 4 summer of 1985, when you took over from
 5 Professor Flute. And I think your recollection in
 6 your statement was that the test results arrived
 7 shortly after you took over.
 8 **A.** That's my memory of it.
 9 **Q.** Do you know whether the likely infection of some of
 10 his patients with HIV was a factor in
 11 Professor Flute's departure?
 12 **A.** No, I can't say. I can't say.
 13 **Q.** You didn't have access to records for the purpose of
 14 making your statement but your recollection, as set
 15 out in your statement, was that there were between
 16 15 and 18 patients who were infected with HIV: one
 17 patient with moderate haemophilia A; one patient with
 18 haemophilia B; and the remainder, patients with severe
 19 haemophilia A, of whom three to four were children.
 20 **A.** That is the limit of my memory. That may not have
 21 been precisely right but I think that's as I remember
 22 it.
 23 **Q.** Could you explain to us how you went about the process
 24 of informing patients of their positive results.
 25 **A.** Well, as I said, because of my training at the

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1 the Middlesex may well have occupied several months
 2 of 1985 before all the samples he could get were
 3 there.

4 I believe that the agreement by
 5 Professor Tedder to test samples for British
 6 haemophiliacs put considerable load -- so he wasn't
 7 able to test them all at once. There was a kind of
 8 a queue and a backlog, which was eventually resolved.
 9 And as far as I remember -- again, one's memory is
 10 slightly suspect on this -- I received all the results
 11 simultaneously very soon after starting as director,
 12 which was -- to say it was a wake-up call was too
 13 trivial.

14 **Q.** Before we come to that, do you know whether the
 15 patients whose samples were sent off to Dr Tedder were
 16 informed that they were being tested for HTLV-III?
 17 **A.** No, unfortunately I -- I can certainly say that I have
 18 no idea. I do not know whether they were informed of
 19 the purpose of those samples. I think knowing --
 20 knowing the patients and Professor Flute, I think it's
 21 likely that most of them were but, on the other hand,
 22 I had certain evidence from when I eventually came to
 23 tell parents of children that that may not have been
 24 the case with children. So I cannot say either one
 25 way or the other whether they were informed or not

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1 Royal Marsden, which had a very formalised view of how
 2 to give patients bad news of all types, and in terms
 3 of a cancer hospital sometimes the worst conceivable
 4 news, I used the processes that I'd learnt there,
 5 which -- or the principles -- were that the patient
 6 was informed by the consultant in charge of their
 7 case. The patient was informed in confidence. But
 8 then, obviously, they could bring a close family
 9 member or other supporter with them, that if there
 10 were other people present this was cleared with the
 11 patient beforehand and their potential role was also
 12 introduced. That basically you told the truth. You
 13 didn't hedge, you didn't euphamise it, you told them
 14 the truth. And then you began, after a period, to
 15 talk about, in cancer terms, of course, the
 16 possibility of treatment, of what was going to happen,
 17 and the percentages.

18 Unfortunately, one could see, with the
 19 HIV situation, one could not say there was any
 20 treatment apart from we would treat any infections
 21 that arose as a result.

22 So I think I obeyed those principles. I think
 23 I did it confidentially, usually in clinic rooms.
 24 Later, when we were given by the health authority
 25 funding for a counsellor, who to my terrible shame

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1 I still can't remember the name, but she was a very
2 good supporter in further information and in
3 transmitting things like safe sex recommendations to
4 our patients and so forth. So sometimes she -- from
5 a later point she was present.
6 Obviously, I wasn't able to tell everybody
7 instantaneously. But that's as I recall it. I think
8 I told them the truth. But of course there was
9 a great deal of uncertainty then at that time. It
10 wasn't like giving a diagnosis of cancer where you
11 knew the epidemiology and the outcome chances.
12 Q. In terms of your general approach, I'm just going to
13 read if I may, Dr Bevan, the way you have put it in
14 your statement so that those who are listening who may
15 not have read your statement can understand. You said
16 in your statement:
17 "The Royal Marsden Hospital ethos is to be
18 utterly honest with patients with bad news, including
19 the worst news. Only complete honesty can be the
20 basis for valid patient consent to treatment including
21 palliative treatment. In addition to imbuing trainees
22 with this principle, the Royal Marsden Hospital also
23 gave us invaluable training in giving bad news. Part
24 of that training was that bad news had to be given
25 verbally, in person, in confidence, by the responsible

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1 children and children themselves in relation to the
2 three or four children who'd been infected?
3 A. I mean, obviously I won't have to say this was the
4 most difficult situation or the most painful
5 situation. I think I'm -- I'm pretty sure I pursued
6 the same thing in terms of telling the parent. Family
7 structure in haemophilia is often a single mother.
8 Tragically at that time, not so often now but in those
9 days, often the fathers somehow used to disappear from
10 the scene and the mother was left as sole carer for
11 the child, and so nearly all -- I seem to remember
12 that those discussions -- thankfully I didn't have
13 a huge number of affected children but those
14 conversations were held almost entirely with the
15 mothers. But I think I was honest with the mother.
16 Then whether one informed the child depended on
17 the age of the child. And I think here one generally
18 followed the kind of Gillick competent, Fraser
19 competent model, after the mother had had the chance
20 to think about it, because obviously I'd be very
21 guided very much by the mother in what I'd tell the
22 child, and we'd tell them together. I can remember
23 one child that we spoke to together in that way.
24 Then, in later years, obviously, as the
25 children grew up, they came into the knowledge one way

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1 consultant."
2 That, as far as you can recall, was your
3 approach to informing patients?
4 A. I hope and think that I did that.
5 Q. Can you recall what, if any, arrangements were made
6 for the testing of partners?
7 A. I think this was introduced subsequently and we did
8 offer to test partners in principle, and indeed
9 I think most partners got tested. I mean, not all
10 people with haemophilia have partners but I think we
11 did do that testing. We certainly offered it.
12 Q. Can you recall whether any partners tested positive
13 for HTLV-III?
14 A. I think one partner tested positive. And I think
15 there were other factors which might have led to that,
16 which I'm not sure I ... you know, both had other
17 practices which might have involved transmission.
18 No, mostly we found where people did have firm
19 partners, the partner was usually negative. And so,
20 through later months and years, we pursued a -- sperm
21 washing so that they could have -- they could try for
22 children. And I think at least one couple did have
23 children subsequently, safely, after interventions
24 like that.
25 Q. What was your approach to telling the parents of

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1 or the other.
2 Q. What was your practice, the centre's practice, in
3 relation to GPs being given this information?
4 A. I think that the approach I took was to get the
5 guidance from the patient on this: did they want their
6 GP to know? I certainly applied no blanket provision
7 that I would automatically -- you know, I would on
8 principle let all the GPs know. I would discuss that
9 with the patients first.
10 The same thing, even more so, went to
11 non-medical things, like schools. That was, again,
12 a difficult -- I'm not sure anyone ever solved that
13 issue, protecting a child from victimisation at
14 school. And I think sometimes people tried with the
15 best intentions and it didn't work -- you know, they
16 weren't safe from victimisation at school.
17 Later, when we had the counsellor, we used to
18 plan the possibility of a school visit where the
19 school nurse and headteacher team would be cautiously
20 informed. As far as I know none of my patients were
21 overtly victimised at school, but I can't say for
22 sure. It was a very, very difficult situation to
23 control.
24 Q. I'll just ask you more generally about the
25 decision-making structures that were in existence to

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look at risks of transfusion-transmitted infections in the late 70s and first half of the 80s. You've described in your statement the only St George's body that you were aware of was the Blood Transfusion Committee, but you said that as far as you understood it they were preoccupied with ensuring the prompt and plentiful supply of blood for surgery, and safety was seen as secondary to the maintenance of supply. Is that correct?

A. That's the way I see it. I mean, it may be a caricature of the way the blood transfusion -- but I think it's fair to say that the blood transfusion system -- the supply was like nine tenths of the law. The one fear they had was running out of blood for transfusion. So, as you'll see from future action, they were, for a while, very unwilling to -- or very, very conflicted about introducing, for example, hep CV testing, hepatitis C antibody testing on donor blood, because they thought it might actually dissuade donors and cut the donor number below critical point. And this has always been a huge issue for them. So that blood transfusion system was obsessed with the availability of blood, the non-wastage of blood.

So I can remember the director of the NBTS, when he appeared to talk to clinicians under his

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source of national recommendation or guidance to you?

A. I'm trying to map this against the early development of AIDS treatment units, like again at the Middlesex, whose process -- whose -- what's the right word? Anyway, their practice began to impact to a greater and greater degree on the rest of us. So at George's I was extraordinarily lucky to be on the site of one of the first AIDS treatment units that was developing under Professor Griffin and Dr Wansborough-Jones, and others whose clinical ward was adjacent to the haematology ward and so -- and we knew this -- them very well.

So they rapidly developed counselling and began to develop their own practices, and we tended to follow them. So I think I also had internal advice from the AIDS treatment unit, its clinicians and counsellors and nurses, which helped us along.

Q. Do you think, from your perspective, as first of all senior registrar and then as the consultant who took over, that it would have been advantageous to have national advice from Chief Medical Officer or Department of Health and Social Security?

A. I think that would have been helpful if it had been a programme, it might have come through UKHCDO. It would be likely to be expressed at a fairly high

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jurisdiction, the talk would always be about, "You're wasting blood, you're ordering too much blood", you know, "We'll run out". They were obsessed with it, quite frankly. And one can understand why. Since the Blood Transfusion Service was started, running out of blood has been the dominant -- so yes, the Blood Transfusion Committee was committed to supply of blood. And they may have discussed safety but I was never an active participant. Because it was a blood bank thing, Dr John Parker-Williams usually covered that committee, so I can't say -- but I don't think, either from the minutes or anything else, that HIV and non-A, non-B was ever discussed at the Blood Transfusion Committee.

Q. In terms of the South West Thames region more generally, you have said in your statement you think it probable that there were meetings held within the region by the Blood Transfusion Service or at Tooting to consider transfusion safety but it wasn't something you or your colleagues were party to or provided with information from?

A. To the extent of my memory, no.

Q. On a national basis, is this right, to the best of your recollection, that in terms of recommendations or guidance, it was really just UKHCDO and no other

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level, sort of, towards UKHCDO. I think that the role of the Chief Medical Officer -- I can't even recall who the Chief Medical Officer was, but I don't think there was an activist Chief Medical Officer in the same way as my colleague and friend Sally Davies became an activist to appear in public to promote certain things to warn other things. I think they were a much more bureaucratic person in those days, much less likely to go into the public domain in a big way. So, yes, presumably it would have added impetus to the actions of UKHCDO if direction was coming from the higher place but I'm not sure. I don't think it happened.

Q. Can I ask you to move forward a few years now to the early 1990s and the arrangements for testing patients for hepatitis C. What were the arrangements that you made at St George's for the testing of your bleeding disorder patients for hepatitis C, once the test became available?

A. As far as I recall, and this may not be 100 per cent reliable, we were able to do such testing internally with St George's virology department, rather than refer them outside. So that's my view. We were able to test them internally, more or less as the test became available. So I know that Professor Savidge

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1 felt that some of the commercial tests were more
 2 valid, more sensitive, more reliable than others and
 3 he -- so he went outside to people like
 4 Professor Tedder's laboratory. But I think we got
 5 ours internally. I don't think we had to refer them
 6 outside.

7 **Q.** Was there, for the hepatitis C testing, a process of
 8 pre-test counselling undertaken?

9 **A.** Yes, I think I can firmly say that, because then we
 10 had the counsellor and we'd learnt the lessons from
 11 the HIV setting about how to do this. So, again, the
 12 patients were told. I must admit that my
 13 recollections of those interviews were completely
 14 different with many of my more experienced patients
 15 saying, basically, I've got enough to worry about with
 16 HIV, without dealing with this situation. Since it
 17 doesn't seem to be affecting me it goes on the back
 18 burner, sort of thing. So their approach was, yes, it
 19 was distress at this too but also the fact that this
 20 seemed to be less of an immediate danger to them,
 21 which I think is true.

22 So I think we told everybody correctly. I hope
 23 we did. We should have done.

24 **Q.** Did you, as far as you can recall, follow the same
 25 process of talking to them in person, the news being

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1 **Q.** Can you recall what information you gave your patients
 2 on telling them of the hepatitis C result about the
 3 possible long-term consequences?

4 **A.** I told them -- I'm pretty sure that I told them about
 5 the findings of Sheffield that there was a risk of
 6 chronic hepatitis. I probably wasn't informed enough
 7 in those days. I hadn't worked with hepatologists
 8 enough to understand that once there was cirrhosis
 9 there was an in-built chance of hepatic cancer. To
 10 me, cirrhosis was, if you like, the worst case at that
 11 time. I think I was a bit naive.

12 The fact is also that none of my HCV
 13 seropositive patients had clinical liver disease at
 14 that time. So I don't think -- none of them had
 15 cirrhosis that we could diagnose without biopsy.
 16 I still largely did not press biopsy upon them and I'm
 17 pretty sure my patients wouldn't have accepted it. By
 18 that time I'd had an unacceptable experience with one
 19 person that we had tried to do a liver biopsy and, in
 20 fact, the operator had hit their spleen -- we managed
 21 to salvage the situation but it was very sticky for
 22 a while.

23 So I had no great desire to do -- their liver
 24 function tests seemed okay. They might have a mild
 25 transaminitis, they had no symptoms, they had no

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1 delivered by you?

2 **A.** Yes. By then, I would have my counsellor alongside
 3 me. Yes, I think we'd refined it by then.

4 **Q.** Again, I'm conscious you don't have access to records
 5 or data about the numbers of patients infected with
 6 hepatitis C. The estimate, I think your statement
 7 gives, was 70 per cent of patients, at least of those
 8 seen frequently, were infected. Is that consistent
 9 with your recollection?

10 **A.** Of the severe haemophilia group, I think that's
 11 probably roughly right. Unfortunately, I can't claim
 12 exactitude on that.

13 **Q.** Can you recall whether there was any particular
 14 features of the treatment, whether it was 30 per cent
 15 or a different percentage who were not infected, that
 16 would explain why their outcome was different?

17 **A.** Well, some of our patients by then had actually
 18 received only heat-treated product. So this would be
 19 true of the children up to about the age of 12, maybe,
 20 that they'd only required -- only received
 21 heat-treated product. So, while accepting that during
 22 the early phase of heat-treated product some of the
 23 heat treatments were not 100 per cent effective
 24 against HCV, they seemed to be -- in effect, those who
 25 had only received heat-treated product were negative.

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1 varices, they had no clinical signs of liver disease.
 2 I referred them, or I discussed referring them, to our
 3 hepatologist gastrointestinal specialists, and they
 4 would agree to be referred. The specialists were
 5 a little bit -- as I can say, "Do they have any
 6 symptoms? Do they have any signs of liver disease?
 7 If so, why am I seeing them?" Sort of thing. "I have
 8 clinics full of people with established cirrhosis."
 9 But eventually they did see them.

10 Again, as I pointed out, I think we had
 11 an ultrasound doctor at that time who reckoned he
 12 could diagnose cirrhosis on ultrasound, probably
 13 an illusion and so we put them through that and none
 14 of them appeared to have it. So, in the absence of
 15 any clinical evidence of actual liver disease, there
 16 was not much activity, and I think the majority of
 17 patients thought of it as a minor problem compared to
 18 their HIV seropositivity, if indeed they had it.

19 **Q.** In terms of the monitoring of the hepatitis C positive
 20 patients for the years that followed, in the 1990s and
 21 the early 2000s, what were the routine arrangements
 22 for monitoring and what was the point at which
 23 referral to a hepatologist or treatment with
 24 interferon and other early therapies became
 25 contemplated?

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1 A. Right, I think that yearly or six-monthly we tested
2 the transaminases and the other liver function tests,
3 I assume albumin or a gamma GT. So some of those
4 enzymes are very, very sensitive to hepatocellular
5 inflammation. Others like albumin content would only
6 fall during late liver disease. So you have got a bit
7 of a spread there between tests, which are either find
8 something that doesn't have any major implication or
9 too late to act on. But if the liver function test
10 became more disturbed, then I would refer them to --
11 then they would attend the hepatologist.

12 Sorry, when it came to interferon, right, I do
13 recall some patients of mine having treatment with
14 human cellular interferon, like the most crude version
15 of the drug, which comparatively had very severe side
16 effects, and both the patients who were put on that
17 drug couldn't tolerate it after about the second month
18 of treatment. So one doesn't really know if they ever
19 responded to it. That's at St George's Hospital.

20 So I'm still trying to think if anybody at
21 St George's progressed to varices or overt cirrhosis
22 during my tenure. I just can't remember it. I can't
23 remember it.

24 Q. Would decisions about interferon --

25 A. Sorry, I've misled you there. There was one patient

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1 aspect to it but I let the experts decide.

2 Q. I think, in relation to the treatment of patients with
3 in HIV, you said in your statement that there was no
4 need for you or your colleagues at the haemophilia
5 centre to become *ad hoc* HIV specialists, because you
6 had the on-site infectious diseases specialist unit
7 that you referred to?

8 A. Yes, I had opinion leaders and clinical scientists who
9 were advanced in the field to help me out at
10 St George's, just as later I did at Guy's and
11 St Thomas'.

12 Q. In the early years, the pre-treatment years for HIV,
13 you have described the care of patients in these terms
14 in your statement:

15 "This care became a desperate holding operation
16 as patients progressively succumbed to the onslaught
17 of multiple opportunistic infections. We lost four
18 patients quite quickly, including one who was 13 years
19 old. I had seen similar organisms cause disease in
20 immuno-suppressed leukaemia patients but never in
21 concert like this, rapidly invading multiple organs,
22 despite high dose antimicrobial therapy. The sense of
23 helplessness in the face of a new disease that was
24 outpacing the chasing clinicians was terrifying."

25 A. I think it was the most terrifying phase of my life,

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1 a very complicated patient who died and he was
2 co-infected with HIV and Hep C, and at the coroner's
3 inquest -- in any case, the coroner decided to
4 classify it as an HCV infected -- occasioned death.
5 So it would be wrong to say I had no problem when
6 I had a coroner's associated death. I think it was
7 more complicated than that and the coroner took family
8 views, but I should not go any further in that
9 respect.

10 So yes, I did have one patient with a degree of
11 cirrhosis and I think another patient with hepatic
12 varices. So, yes, by the time I left, some of the
13 longer-term patients had developed overt liver disease
14 and were under the care of hepatologists.

15 Q. Were decisions on prescribing interferon, whether it
16 was the early version you've described or pegylated
17 interferon, interferon and ribavirin, were those your
18 decisions or was that something which would be dealt
19 with by the hepatologist?

20 A. By then I'd come to the understanding that I, unlike
21 some of my colleagues like Mark Winter, was never
22 going to be a HIV or hepatitis doctor, and that I used
23 the true experts on site to manage those aspects. Of
24 course, they would discuss things with me if they
25 wanted a change in treatment or there was a clotting

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1 of my professional life, because of this feeling that
2 it was running out of your control. I mean, even
3 in -- you know, in cancer situations where people have
4 become profoundly immune suppressed, you felt
5 a certain degree of trust in the drug regimes, whether
6 they were antibiotic, anti-fungal, antiviral, that you
7 used, and by and large they worked to a useful degree.
8 But in the HIV it was -- it seemed to be running out
9 of control. The moment that you -- while you might
10 get the front line immune suppressed opportunistic
11 infections under some kind of control with pentamidine
12 inhalations, you name it, then along would come
13 bizarre versions of Hodgkins Disease or lymphoma in
14 the brain or elsewhere, that would -- eventually you
15 would not be able to treat.

16 Now, in retrospect, what happened was there was
17 an early cohort of patients who succumbed to this very
18 quickly and then there was another cohort that seemed
19 to have some residual resistance to this complex and
20 then, as I said, I had one patient who never even
21 developed a T cell abnormality, who presumably was
22 genetically in some way immune.

23 But that first cohort, it contained most of the
24 older patients. So anybody over 60 was at severe risk
25 of relatively early succumbing but we also had these

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very young patients who might have had some kind of pre-disposition to get severe disease. Very, very, very alarming.

To me, it brings great sympathy to the contemplating the intensive care doctors trying to deal with the first wave of Covid pneumonias, where clearly it was something different from what they'd ever seen before and they have learnt how to manage it and I think probably the HIV doctors did as well.

Q. I wanted to ask you next, Dr Bevan, about some of the reflections you have set out in your witness statement, paragraph 50. I don't know if you have a hard copy of your statement on hand or I can put it up on the screen?

A. I don't.

Q. It's WITN4106001, please, Soumik. If we go to page 22, please. If we look at the bottom paragraph of this page and the first two paragraphs of the next page first of all, you say this -- I will read it aloud because it will be easier for some of those following and watching to hear rather than read:

"To my current knowledge (from hearsay, largely informed by subsequent written sources such as Starr's revealing book 'Blood') during the 1970s and early 1980s plasma fractionation companies in the USA

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Just pausing there, and before I ask you about UKHCDO and the approach of doctors about which you may have more direct personal knowledge, do I correctly understand that what you have set out there is your view, now informed by the reading of material such as the Starr book that you have described? It's not based upon your own knowledge at the time or direct knowledge?

A. No, no, it's not based on anything I knew outside that history, as very persuasively demonstrated in the Starr book. Then, obviously, subsequently dealt with at some length, insofar as they are in the public domain, the legal arguments of various plaintiffs, particularly in America, American haemophilia groups against the companies involved. I must say that -- yes, sorry.

So, insofar as it can be backed up -- the thing about paramilitaries, I think, is in Starr alone. I've never seen any other reference to that. But the plasma market occupying the Canadian aspects -- the plasma brokers who traded large pools of plasma on that market, I think that's all been -- wherever I've seen it, it's been confirmed that it was taking place, but I have no personal knowledge at all.

SIR BRIAN LANGSTAFF: We do have some material which has

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bid for large pools of frozen plasma assembled from up to 40,000 donors, traded on the North American plasma 'spot' market (Toronto, Canada) by 'plasma brokers'. The companies and brokers who participated in this market maintained a state of wilful ignorance of the provenance of this plasma, which was widely known to have contained donations from US prison populations, so-called 'skid row' blood donation facilities buying blood for cash from street people (including substance abusers) and even donations forced from Central American villagers at gunpoint by paramilitaries. They performed screening for hepatitis B on the plasma pools but otherwise fractionated them into Factor VIII concentrate."

Then you say this:

"I therefore consider by far the dominant contribution to the scale of infection of patients with bleeding disorders in the USA and UK to have been made by the commercial fractionators who made and sold infected Factor VIII concentrate, because they knowingly abandoned any control over the safety of their raw material. Another significant contribution to the scale of infection was made by the acts of plasma market makers and brokers involved in the sale of plasma."

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been offered to the Inquiry which would tend to support the Central American reference which is set out here.

A. I mean, that's obviously absolutely horrible to contemplate.

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: You then continued in your statement by talking about the approach of UKHCDO and the generation of haematologists that dominated UKHCDO at the time. I want to ask you a little more about that, because obviously that's something about which you may have more direct knowledge and experience.

I'll just, again, read out the next few paragraphs, if I may, for the benefit of those listening:

"The AIDS epidemic was a turning point that utterly transformed medical practice in ways analogous to the effect of a World War. The decisions and policies of the generation of haematologists that dominated the UKHCDO and haemophilia treatment in the UK up to this point -- pre-AIDS -- were conditioned by the long period when haemophilia treatment was of limited availability and effectiveness.

"Their attitude and reactions were dominated by determination never to withhold treatment and never to

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run short -- let alone out -- of treatment. This unwillingness to countenance the loss of effective treatment was shared by the Haemophilia Society.

"The UKHCDO also took a position in many ways typical of British public health governance: Not to risk over-reaction, not to act prematurely, not to alarm the public, 'the evidence is not yet conclusive', 'we don't yet have proof' -- responses still evident during the early phase of the current Covid-19 pandemic."

Could we just continue down the page, Soumik.

You then refer in the next paragraph to Factor VIII companies pulling the wool over the eyes of doctors. I'll come back to that, if I may. I'll skip that for the moment. You then say this:

"However, taking all these things into account, the UKHCDO continued to hold the line, well into 1983, that the evidence of an infectious cause of AIDS was inconclusive, and that action would be premature, long after that position became obviously untenable. However, by then the scale of HIV infection in people with bleeding disorders in the UK was fully established."

And obviously that's a matter that the Inquiry will have to determine in due course.

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Obviously, whether that is correct or not is a matter for the chair but is that the sense of what you were trying to convey?

A. Yes, because they'd grown up during a period -- I mean, they had been trained, they'd had their early care when the majority -- in a time when, you know, the median survival of people with severe haemophilia had really stayed stuck very much in the Carol Birch area of mid-teens to early 20s, that young people with haemophilia essentially lost the use of their joints or many of their key joints, knee joints, ankles, elbows by the age of 20, and there were patients confined to wheelchairs by the scale of arthropathy that had been established.

Now, the introduction of cryoprecipitate in 1963 by Judith Pool changed the survivorship but, because of its complexities in giving prophylactic treatment, didn't really change the scale of joint damage. So it may have delayed it by five to ten years but the end result was still severe joint disease in haemophilia. So they saw all the downsides of not having prompt and convenient treatment, and they'd just been given, if you like, within the last ten years, this supply of treatment of concentrate that could -- they knew had the capacity to eradicate

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Just pausing there, I will come on to hepatitis C perhaps after the lunch break, first of all, are those observations you stand by?

A. I stand by those observations.

Q. The observations you set out there remain your view?

A. Every clinician is a creature of their generation. So I may well have attitudes that future generations will find equally -- not inexplicable, equally hidebound or non-responsive. So those doctors were in many ways admirable doctors, far more distinguished clinical scientists than I ever was. I would feel embarrassed confronting them with it but the fact is I think that they held the line to the point where it almost became like denial, a denial problem, into 1983.

I think to continue to propose that there was no conclusive evidence that AIDS was caused by an infectious agent was simply, in retrospect of course, untenable. So I still feel that way, yes.

Q. The sense that this part of your statement gives is an observation by you that the generation of haemophilia doctors, as you describe, those who dominated UKHCDO, were so focused on not withholding treatment and wanting to maintain treatment at all costs that it may have been that insufficient weight was given to counterbalancing concerns about safety.

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those problems of haemophilia. So their attitude was conditioned by their experience of the disease. It may still be the case that if one had withdrawn commercial factor or tried to substitute by widespread reintroduction of cryoprecipitate, we would still now be looking at patients in wheelchairs who wouldn't have been there otherwise.

So I can understand the attitude they took but I still see it as a kind of denial of the reality.

MS RICHARDS: Sir, I have a handful more questions on this topic and then a handful of other topics to cover, but I note the time and it may be a convenient point at which to break.

SIR BRIAN LANGSTAFF: We'll take a break. We'll come back at 2.05. Same rules apply. So 2.05.

(1.03 pm)

(Luncheon Adjournment)

(2.13 pm)

MS RICHARDS: Dr Bevan, can you see and hear me?

A. Yes, I'm not hearing you too good. The thing is not yet charged up properly.

SIR BRIAN LANGSTAFF: Do you want some more minutes or are you all right?

A. I can hear you clearly. I've got vision. Sorry, it lost all its power during the lunch break, like many

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1 of us.

2 **SIR BRIAN LANGSTAFF:** Well, I thought the idea of a lunch

3 break was to refuel but ...

4 Let's start up and see how we go. If we run

5 out, we'll just take a break.

6 **MS RICHARDS:** Dr Bevan, I was asking you about some

7 observations in your witness statement and I'm just

8 going to pick up on that again.

9 Soumik, could we have back on screen

10 WITN4106001, please, and go to page 23.

11 If we pick it up in the bottom half of the

12 page, you refer in the third paragraph of what's

13 on screen to some Factor VIII companies pulling the

14 wool over the eyes of medical opinion leaders:

15 "Armour ... [taking] visiting UK haemophilia

16 doctors around their plasma-collection facilities

17 where fresh-faced college students underwent

18 plasmapheresis to provide a relatively safe source of

19 product. However, Armour did not reveal to their

20 visitors the massive supplementation by pools bought

21 on the Canadian spot market. The eminent haemophilia

22 doctor Peter Jones published a brave *Mea Culpa*

23 admitting to having been deceived in this way."

24 Is that something of which you have personal

25 knowledge or discussed with colleagues or Dr Jones or

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1 unfortunately they were also supplementing it with

2 plasma, the safety of which they had absolutely no

3 control over.

4 **Q.** For the sake of completeness, Dr Bevan, what was the

5 year of your visit?

6 **A.** Oh, gosh, I can't remember. It was something like

7 '89, something like that.

8 **Q.** Then picking up with your observations in relation to

9 hepatitis C, so the bottom two paragraphs, you said

10 this:

11 "In the case of HCV, by comparison with AIDS,

12 there was ample warning. Every haemophilia treater in

13 the US, the UK, and elsewhere knew that their patients

14 were acquiring an infection from [Factor] VIII

15 concentrate, and that this infection was marked by

16 a significant rise in liver transaminase enzymes,

17 i.e. it was a hepatitis, likely to be a viral

18 hepatitis.

19 "For circumstantial reasons, including a lack

20 of symptoms during the acute phase, the absence of

21 jaundice and cases of acute liver necrosis, the lack

22 of a known pathogen and a blood test to demonstrate

23 antibodies to it, the disease was widely considered to

24 be non-serious. The progressive development of

25 chronic hepatitis and cirrhosis remained silent

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1 is that based upon what you'd read?

2 **A.** That's based upon his article, which came out at the

3 time. I myself have visited the Armour -- later, the

4 CSL bearing Revlon -- I forget which phase of their

5 ownership it was -- their Knoxville University

6 apheresis centre, which is indeed reassuring, but

7 I was additionally reassured by the fact it was taking

8 part after heat treatment had been introduced, and

9 they went into great detail about the complex donor

10 surveillance, donor selection criteria they were now

11 applying. So even though I saw the fresh-faced

12 college students giving plasma, they were actually

13 also getting proper antiviral testing before giving

14 plasma. In fact, they had really what I would see as

15 a rock-solid process whereby their plasma is held and

16 not used until they've passed several sequential

17 safety tests.

18 So I may have had the wool pulled over my eyes.

19 It was still a company trip but by then it had been

20 rendered safe, and in fact, as you know, subsequent to

21 that no infections have been transmitted through

22 plasma-derived products, although we avoid them upon

23 principle now. So I know that that was the policy of

24 the companies. I know they have relatively safe

25 plasmapheresis collection facilities, but

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1 because of the historic 'rule' that liver biopsy in

2 haemophilia was hazardous and absolutely

3 contraindicated. In the absence of evidence from

4 liver biopsies, the assumption was made that this

5 viral hepatitis was an inconvenience, but essentially

6 harmless."

7 Go over the page, please, Soumik, to the top of

8 the next page.

9 You say this:

10 "Such an assumption is the kind that doctors

11 should not make. The overt, potentially fatal, acute

12 severity of Hepatitis B was regarded as a

13 distinguishing between the two viral illnesses ..."

14 **SIR BRIAN LANGSTAFF:** Just a question there, did you

15 mean -- the way it's come out on the typing is

16 "a distinguishing"; did you mean "a distinction"?

17 **A.** Yes, "a distinction", or "distinguishing" without the

18 "a".

19 **MS RICHARDS:** "... between the two viral illnesses, when

20 attention should have been given to the likelihood

21 that they were similar. I feel guilt on account of

22 accepting this myth of harmlessness when it was first

23 expounded to me, even though I was just a junior

24 trainee with zero clout.

25 "Accordingly, I think that those who formulated

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the advice promulgated by UKHCDO were late to recognise the reality of transfusion-transmitted HIV infection, and so may have made a minor contribution to the scale of HIV infection in patients with bleeding disorders.

"The community of haemophilia specialists made a somewhat larger historical contribution (again much smaller than that of the companies) to the scale of the HCV infection -- a much older disorder -- by assuming that it was relatively harmless condition for much of the 1970s. However, it should be pointed out that throughout that time there were opponents of this view, and that it was members of the same community (including Dr Craske, Professor Eric Preston, Dr Mike Makris, and Professor Christine Lee) and the same organisation (UKHCDO) who thoroughly corrected this assumption during the 1980s."

Dr Bevan, just going back to the paragraph at the top of that page, I'm paraphrasing but is this the right way to understand what you are saying there, that in a sense the wrong question was asked or considered in relation to hepatitis B and non-A, non-B hepatitis? The distinction between the two in the acute phase was somehow regarded as the key criterion rather than consideration of whether in the longer

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or not defined. So, as I later discuss, the approach to vCJD for example, from the outset, has been based on the precautionary principle that, no matter what inconvenience/problems it may cause in everyday life, you have to proceed on the assumption that certain people are going to be transmitters of the disease.

But that concept of precautionary principle was certainly -- it may have been published by philosophers but it had not yet appeared in medical practice. Like many other subsequent developments, like the concept of clinical governance, et cetera.

That's all.

Q. We can take the statement down.

Dr Bevan, amongst the materials that have been provided to you in advance of your evidence was a letter from Dr Spence Galbraith, who was a public health doctor, epidemiologist, who in May of 1983 was advising the DHSS precisely along precautionary lines, suggesting that there should be a suspension of the importation of US concentrates. We can look at the document if you want but it has been provided to you. I hope you had the opportunity to look at it?

A. I recall it, yes.

Q. Was that something which ever came to your attention at the time?

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term the two illnesses or viruses might lead to similar consequences?

A. Yes, I think probably that might have been clarified if after "similar" I'd added "in the long-term", because as we know hepatitis B can also cause chronic hepatitis cirrhosis. So I meant in the long-term that they'd be similar.

Q. Is there anything else by way of addition or explanation that you have to add to the observations that you've set out there?

A. No, except -- again, hindsight bias is not something any of us can avoid. It's like an inherent part of the human brain. But I'm still rather amazed by the fact that that assumption, that they were looking at a harmless phenomenon, was sustained. It just doesn't seem to make any sense to me. Doctors are usually accused of over-exaggerating dangers rather than the reverse. I think that's probably our role.

So, again, one must avoid anachronism here in that concepts like that of -- what's the term I used, I used it later -- the precautionary principle did not to my knowledge exist then, certainly not in medical practice or common parlance. The idea that you would actually take action in respect to perceived dangers, even if those perceived dangers were relatively remote

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A. No, not in 1983.

Q. I'm going to move on now to deal with various other topics touched on by your statement, Dr Bevan. The first is in relation to the national tendering process that you describe in your statement as being implemented from 2005 onwards, which, as you put it in your statement, eliminated directors from the direct purchasing of blood products.

What were the advantages and any disadvantages of that system from your perspective?

A. From my perspective there were no disadvantages of the introduction of centralised purchasing. It was all good. I mean, first of all, it achieved, in world terms, a quite unique reduction in costs, reduction of price per unit. Secondly, it lifted what I would call an ethical weight, moral weight from the shoulders of haemophilia directors, who were no longer as -- obviously, the sole determinants of which products they used. I mean, I was particularly glad that by the time I took over the directorship at Guy's and St Thomas', when the product budget was of the order of GBP 25 million a year, that I no longer, if you like, had such very large amounts of money in my gift. I'm sure I would have been, you know, the subject of a lot more attention if it had been.

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So I was -- it seemed to me that the mechanism for the national contract involved quite sufficient elements of a degree of choice over which product you had, and that you were able to communicate your preferred product. By then I think most of us felt that the recombinant products that were introduced were completely identical in functional terms, whether they were -- you know, as you know, some of the recombinant products for the B domain of Factor VIII deleted and some people thought that that was a risk of inhibitor generation, it doesn't seem to be the case, so basically a certain degree -- where it was required, a certain degree of user choice was incorporated within the national contract structure.

So I think it was an overall great benefit.

Q. Do you know of any reason why such a system which would have meant individual directors were no longer having to take decisions that varied enormously from centre to centre and across the country, why such a system couldn't have been introduced earlier?

A. I mean, it was -- the organisation of the purchases with relation to haemophilia services, the funding of Factor VIII, had previously been dispersed and chaotic between various health authorities. There was -- haemophilia was not on the specialist commissioning --

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A. I mean, that was perhaps slightly unusual in that -- I can't remember. I mean, I explained that I can't remember that correspondence at all. It was at a time when, you know, I had quite wide responsibilities to a large number of patient groups and disease categories, and it was at the periphery of my knowledge. I used to generally discount communications from drug reps.

Now that's, with all due respect, because I've known some very, you know, correct drug reps, who know a lot about their subject, but I would normally consign such messages fairly rapidly to kind of the round file, as it's come to be ... So I do not recall that interaction at all. In fact, what she appears to be offering me is to do with the technique of heat treatment of the product.

So, if you like, because there was some -- at that time it was still uncertain, I think, which was the best heat treatment protocol for non-A, non-B hepatitis, Hep C, whereas it was quite clear that all the heat treatment techniques got rid of the HIV virus. There was a point to it but unfortunately I didn't recognise it at the time and I didn't recall it.

In terms of approaches, if you like, from the

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again, "commissioning" as such. Haemophilia needed to be under the aegis of a specialised commissioning function before proper attention could be paid to the funding of the subject.

There was no -- until the commissioning side of the subject was properly formulated, I don't see that they could have run a centralised purchasing -- so it required other developments before it could be put effectively into use.

Q. Those other developments reflecting reorganisation of the way in which NHS bodies dealt with one another?

A. Well, specifically the way in which they dealt with commissioning in haemophilia care, which became a separate item on specialised commissioning field.

Q. Moving from that into prior to 2005, when decisions were still either for individual directors or for regional consortia, we've provided you with a couple of examples of letters that were sent to you by Cutter, I think you described them in your statement sales pitches, letters talking about the particular Koate treatment and discussion of price and the like.

How common was it for you to receive approaches from pharmaceutical companies once you took over as director and what form did those approaches customarily take?

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competitors to the people who were supplying us, I would expect them at least once every six months from each company, usually, as I said, not based on something specific like this, which is the degree of heat treatment.

I think that's all I can say on that since my memory has failed me on that one.

Q. Some witnesses have described pharmaceutical companies providing some form of funding to centres, whether it be for training or education or facilities and products. Was the centre at St George's, to your knowledge, ever in receipt of funding along those lines from pharmaceutical companies, or donations from pharmaceutical companies?

A. No, direct donations to departments, as far as I'm concerned, never happened at St George's or, indeed, at Guy's and St Thomas', because that would be a very crude and overt way of doing it. The companies, of course, provided sponsorship for the attendance of medical staff, including the director, and often several members of the medical staff if you had them, to major international conferences, the sort of conference to which haemophilia directors really should be going, World Federation of Haemophilia, International Society of Thrombosis and Haemostasis,

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1 sometimes American Society of Haematology meetings,
2 where there would be substantial sessions on
3 haemophilia, on blood-transmitted infections --
4 I mean, where you are likely to see state of the art
5 research discussed and also to be able to discuss with
6 peers in other countries various approaches.

7 So I think it's -- doctors needed to go to
8 those affairs. They were extremely expensive to
9 attend and register for. So simply getting
10 a registration fee to ASH or World Federation of
11 Haemophilia would cost of the order of £600, £700 and
12 then you would have to -- usually, they were held in
13 major centres where there was vast amounts of hotel
14 accommodation, because these conferences were often 30
15 or 40,000 delegates from around the world, and that
16 was expensive and the travel was expensive, because
17 a lot of the conferences were in the US.

18 No way could any NHS clinician fund that out of
19 any NHS funds. They simply weren't available for such
20 things and very few had private means sufficient to do
21 that. So, in a way, we all took advantage of that
22 system.

23 Now, it may be that the companies could have
24 put people up at motels, and so on. Normally, they
25 chose 4 star or even more star hotels. As for having

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1 So drug companies have often funded the setup of such
2 organisations which involve patients and doctors, if
3 you like pressure groups for improved services.

4 So those are -- and the third thing is that
5 companies at one stage, knowing that you needed to
6 train patients and their carers to self-inject and
7 knowing that some places didn't have haemophilia
8 nurses to do this, offered nurse specialists that they
9 would entirely fund to teach your patients how to
10 administer the product. That was proposed to me once
11 at George's and it was regarded as internally
12 impossible or unwanted, by what then -- subsequently
13 has become the trust, then was just the hospital.

14 So they did offer that. They would provide
15 refrigerators for people to keep their product in at
16 home. They would provide carrier bags and cold store
17 equipment for patients who needed to keep it at home.
18 They would provide booklets and educational facilities
19 for patients, if you like, a range of activities which
20 would seem to be completely blameless or to have no
21 ulterior motive really.

22 Q. The motive of the pharmaceutical company and, for
23 example, funding the hotel and the meals and the
24 transport, and so on, was presumably at the very
25 least, in large measure, to influence the clinician to

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1 said that, I did stay at a motel once in Seattle,
2 because there simply weren't enough major hotel beds
3 in the centre and I was some way down the list.

4 Basically, yes, the companies provided that and
5 during attendance at such a conference the companies
6 would often take you out for a meal and, usually,
7 these were quite expensive restaurants. So, yes, to
8 one's shame, one participated.

9 Companies would sometimes provide -- with the
10 World Federation of Haemophilia, companies also
11 provided support to patients and family members and
12 members of organisations like Haemophilia Society to
13 attend those, because the World Federation of
14 Haemophilia is an open meeting for patients and their
15 representatives, as well as medics and nurses,
16 counsellors, the whole gamut of the multidisciplinary
17 team and they supported those as well.

18 When it came to the patient organisations, I'm
19 sure the companies supported The Haemophilia Society.
20 They tried to set up an organisation, which I don't
21 think was ever particularly -- I say this with due
22 respect -- took off, called The Haemophilia Alliance
23 which was on the basis of things like the renal --
24 I think there's a Renal Alliance, which is partly
25 funded by dialysis machine constructors, and so on.

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1 choose the products of that pharmaceutical company.

2 A. I've been thinking about this. Yes, it would but, at
3 the same time, it was mostly after the fact. So, by
4 and large, patients -- patients -- directors and other
5 staff were taken, were supported by companies they
6 already had a relationship with. So it may well have
7 been a *quid pro quo* but it was after the event, in
8 most cases. I know of no-one who's -- if you like,
9 there was a bidding war -- no, I mean, the company's
10 motive is always profit, always.

11 Q. What, if any, systems or processes were in place,
12 whether within St George's or in the NHS more widely,
13 to your knowledge, that might have protected against
14 at least unconscious bias, subconscious bias, as
15 a result of those kind of interactions and dealings?

16 A. Yes, of course, and that's why it's much less --
17 what's the right word -- much less indulgent nowadays.
18 I mean, various regulations have been put in place,
19 sequential regulations by the ABPI and other
20 international pharmacy governance agencies to steadily
21 reduce the monetary value of any such support.

22 However, I believe the basic elements which are
23 registration fees, hotel costs and travel costs are
24 still being supported.

25 Q. Let me move to ask you briefly about vCJD. You have

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touched upon the difference of approach as a matter of principle and the application of a more precautionary approach, and I just wanted to ask you about one document you refer to in your statement. Soumik could we have on screen, please, WITN1194004, please. If we go to the next page.

You'll see, Dr Bevan, this is a letter from you and your paediatric colleague and haemophilia nurse specialist, September 2004, and it says this:

"You may have heard -- from The Haemophilia Society, in newspapers or on television -- that some batches of clotting factors (manufactured in the UK by BPL), were made from 'pools' that included plasma donated by individuals who later developed ... (vCJD). These newly identified batches are in addition to some that were similarly affected a while ago.

"So far, only a few batches of clotting factor, used between 1994 and 1997, are known to contain this material. However, new cases of vCJD, in people who were once plasma donors, might occur in the future, so all clotting factors made from 'UK pooled plasma' between 1980-2001 have now been reclassified as being 'at-risk' of transmitting vCJD.

"Because in the past you received some clotting factors made from pooled UK plasma donations you may

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something completely different from HCV or HIV, in that you're dealing with a huge area of uncertainty. So the uncertainty is expressed in the second paragraph, in that we can't say which batches -- that these are the only batches that have a risk of this type. Since vCJD has an incubation period of anything up to 40 years, I don't know what the current feeling is, then it was 20 to 30 years, now it is probably longer, basically any plasma product produced in the UK might contain such stuff and, of course, any plasma donated in the UK was subsequently excluded from any use in the manufacture of clotting factors.

So you're immediately transmitting a feeling of uncertainty to patients. Have you been exposed or have you not? We can't say at this point. We have to cover all bases.

Secondly, we have no idea of the actual degree of this risk of actually getting clinical vCJD. As it turns out, the risk seems to be vanishingly low because still no people with haemophilia in the UK have developed vCJD. I know there was one that had pathological prion extracted from their spleen but since the spleen is the organ in the body which tries to filter out junk from our circulation that might do us harm, that may mean that the body had in some way

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have an 'additional risk' of acquiring vCJD. The risk is called 'additional' because anyone who ate UK beef products during those years is assumed to be at a low degree of risk of developing vCJD, so any risk from UK plasma products is 'in addition'."

Then you refer to an information pack:

"After you have read the information you will need to decide whether you want to know if you received any batch of clotting factor known to contain plasma from individuals who later developed vCJD. The haemophilia centre staff will help in any way possible, before or after your decision. Our preferred way would be to see you in person for confidential discussion of the issues involved."

I'm not going to go through the details of all the kind of national notification processes but this was a process in which, as I understand your statement, Dr Bevan, you and your colleagues decided to afford your patients the right to say if they wanted to have this information or not. Is that correct and can you just explain your thinking please?

A. Yes, that's correct. I don't think we were unique in this at all.

Okay, let me just get my head round this.

The problem was that here we're dealing with

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neutralised it.

So, basically, what are you going to tell people? You have no test to test their blood. It's not like HIV or non-A, non-B. You can't test their blood and tell them whether they've been infected or not. There's no way of forestalling what might happen if they were infected, no known way still of treating prion disease, and so all you're doing is giving them a form of uncertainty, which is worse than the form of uncertainty -- that was my view. I knew that some patients felt this, that there was no point knowing this sort of information, that it could only possibly prove to be a source of long-term anxiety and blight in a way.

So we decided that, as well as explaining, as usual, you know, because we don't have a test but with the test you are supposed to explain the implications of having the test, with a view to them deciding not to have the test under certain circumstances, here we thought it was the information itself that the patient should decide they want to hear about or not.

In fact, after talking to our patients that this letter would have gone to, they divided, as far as I remember, fairly equally between people who had a very pronounced desire to know and people who had

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1 an equally pronounced desire not to think about it
 2 ever again. There was no public health implication of
 3 this, in that -- you know, so basically, for all those
 4 reasons, we decided to offer them the option. As
 5 I said, I don't think we were the only centre to do
 6 this.

7 **Q.** The way you put it in your statement, Dr Bevan, is
 8 that you and your colleagues concluded individuals
 9 should be given the right to know or not to know, the
 10 right not to be passive recipients of the information?

11 **A.** Yes.

12 **Q.** We can take the letter down. Thank you, Soumik.
 13 I next want to ask you about a letter you wrote
 14 to --

15 **A.** I mean, I would say I never had any feedback from
 16 patients suggesting they were offended by the letter
 17 or confused by it or otherwise wished they hadn't had
 18 it. Most people seemed to appreciate that we were
 19 giving them a degree of empowerment, however slight.

20 **Q.** I'm next going to ask you about a letter that you
 21 wrote to a newspaper. I think it was The Independent.
 22 You have discussed it in some detail in your statement
 23 but I just want to ask you about a couple of parts of
 24 it.

25 It's UHMB0000006_064, please, Soumik.

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1 medico-legal burden of providing the safest possible
 2 products for their patients will find themselves
 3 constrained by a ruthless requirement to cut costs.

4 "In case haemophilia treaters feel disinclined
 5 to favour these products on the open market,
 6 a scandalous linkage has been arranged between the
 7 proportion of BPL products bought and the price that
 8 the hospital concerned will be charged for totally
 9 different blood products such as red cells and
 10 platelets. This smart move in effect places patients
 11 with leukaemia and other serious blood disorders in
 12 the position of hostages in a sordid commercial battle
 13 for Factor VIII orders.

14 "Such destruction of the ethos of the gift
 15 relationship in blood and plasma donation, previously
 16 exemplified to the highest degree by the Blood
 17 Transfusion Service and its Blood Products Laboratory
 18 at Elstree, surely illustrates the dark side of these
 19 invidious 'reforms'."

20 Dr Bevan, I wanted to ask you two questions.
 21 One is specifically about the linkage you refer to in
 22 the penultimate paragraph. But before we get to that,
 23 what was it broadly that triggered your writing to the
 24 paper in these terms?

25 **A.** What a firebrand, eh? How nice it was to be young ...

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1 **A.** Oh dear.

2 **Q.** It's a letter written in April 1991, or published
 3 I think in April 1991, and you say this -- I'll just
 4 read it so that again those following can follow the
 5 evidence:

6 "The worst conceivable response to the HIV
 7 tragedy in British haemophiliacs is to throw this
 8 group of patients to the mercy of the markets, not
 9 only for provision of their health care, but also for
 10 the supply of Factor VIII on which their health and
 11 lives depend. That is what is happening, however, as
 12 part of the 'reform' of the National Health Service.

13 "Presumably, the Government feels that its
 14 obligations to the British haemophilia community have
 15 been paid off by the settlement of the recent legal
 16 action, but must be aware that a cost-cutting war
 17 among haemophilia treaters and Factor VIII
 18 manufacturers will reduce the safety of the blood
 19 supply, as illustrated by your article of 9 April.

20 "They should also be aware that the legalistic
 21 defences which saw them through will not work a second
 22 time, since they can never again claim to be surprised
 23 by the contamination of crude preparations of bulk
 24 plasma by unknown viruses or other infectious agents.
 25 The haemophilia treaters who will bear the ethical and

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1 I think the main lesson of this letter is
 2 probably to take care before writing to newspapers.
 3 And I must admit when I saw it published in
 4 The Independent my heart dropped through my boots.
 5 They had edited it substantially but I can't even
 6 remember what they edited out of it. I don't think
 7 they changed the sense of it.

8 So what may have provoked this was anything
 9 from a manager giving me a hard time at St George's
 10 about the amount I was spending on Factor VIII, and
 11 telling me I had to stop or I had to stop treating
 12 patients, but the thing -- the centre of it is,
 13 I mean, BPL was finding its way as a commercial
 14 organisation or a pseudo-commercial organisation in
 15 the face of the Government reforms, you know, the
 16 Government reforms of the NHS, which obviously from
 17 that you can tell I'm no supporter of, and the
 18 intensification of budget pressure on treaters.

19 Of course, as haemophilia treaters, we were
 20 always way outside in terms of product cost per
 21 patient and therefore an easy target, particularly
 22 since, you know, we were accused of spending as much
 23 on treating 20 patients as the hospital spent on the
 24 entire paediatric ward and things like that, which was
 25 actually the way it was -- not just at the Royal Free

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but also at George's I was getting similar stuff from the managers, newly empowered by the reforms.

One of those reforms meant that BPL had to try to find a commercial footing. So no longer were they allowed -- going to be allowed to provide free product based on plasma donations, as in the past, but they had to charge for it, and they were struggling with exactly how to do this while fulfilling their mission to supply patients with the blood products they needed.

One of their mechanisms that they proposed, and which I was directly attacking in this letter, was to say: well, we'll make the price of platelet transfusion, the platelet concentrates you need, to your hospital dependent on the amount of Factor VIII you order from us. So the more Factor VIII you order from us and buy from us under the new arrangements, the cheaper will be your platelets. And if you don't buy so much BPL from us, the cost of your platelets will go up.

I must admit, I found this linkage -- this is what I call the "scandalous linkage" -- it particularly hit me because I was responsible both for treating haemophiliacs with Factor VIII and for treating people with leukaemia and other conditions

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Q. Again, for the benefit of those listening who may not have read your statement, on that issue you talk about the adoption of high purity Factor VIII. You've said this in your statement:

"I strongly agreed with those UK clinicians who considered that the adoption of high purity Factor VIII was an important step in future briefing Factor VIII safety, since HIV showed that novel organisms with hitherto unpredicted effects could suddenly invade the blood supply. It was no good to simply protect against known pathogens; in future they might not be enveloped viruses susceptible to heat or viruses at all. The official contention was that the HIV epidemic was an unforeseeable event due to a completely novel virus that couldn't be seen coming. My doubt about that excuse was that it simply would not do next time around."

A. No. Yes, that's right.

I mean, whether the partial purification by affinity chromatography, which is what we were talking about, I mean, that was a variety of commercial -- new versions of commercial Factor VIII. They were treated with heat appropriately and they were safe but they were also purified so that things of unpredictable chemical nature would tend to be avoided.

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with platelets. So it sort of directly hit me that I was being sort of held to ransom over -- in fact, I think they dropped that idea pretty quickly. I do not claim any agency in that for this letter but I think I wasn't the only person to object to this linkage of blood product costs to how much BPL product you bought.

The fact I was actually keen to buy probably as much Factor VIII-wise possible for a long time didn't play any role in this. In fact, in the paragraph where I allude to, you know, they can't be surprised by the contamination of crude preparations of bulk plasma, I was at that time part of a group of haemophilia treaters who wanted to go to the so-called high purity Factor VIII, on the basis that if you construct a system which specifically extracts Factor VIII from plasma, you are likely to leave unwanted things behind, and I suppose you can say that my warning that there will be new agents with unpredicted characteristics which will invade the blood supply actually was manifested by the vCJD experience.

Even though I'm embarrassed by this in retrospect, I'm no longer -- I feel no actual huge difference from it now.

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Of course, a few years later, you know, one was able to do that simply by moving to recombinant products, achieve the same degree of theoretical safety. Whether the high purity products actually did eliminate any infections is moot. We never knew.

Q. The next topic, Dr Bevan, is to ask you about your involvement in the HCV look-back exercise, and I wanted to ask you first about the national look-back in the 90s. I think we sent you a couple of examples of Blood Transfusion Service-generated letters about individual patients from 1996.

I'm not asking you about the details of individual patients but what can you recall from your perspective, as consultant and Haemophilia Centre Director, of your involvement in the national blood transfusion-led hepatitis C look-back in the mid-90s?

A. In the mid-90s I think we complied with it as well as we could, given the information we had. And it was a result of our look-back that resulted in the identification of the two cases that I was then written to by the blood transfusion lead, would I be prepared to counsel them, which of course I was because they were my patients, with -- but they didn't have haemophilia. I mean, a slight irony. And of course, that's what the look-back was intended to do,

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not just pick up people with bleeding disorders but everybody who had been exposed.

So there it helped having a relatively small group of patients. The workload imposed on the department by the look-back in the mid-'90s I think was not -- we did it, I think. I don't think we fell short of it.

The later look-back -- anyway you may not be asking me questions about the later look-back.

Q. I will come to that in a moment but can you recall what the mechanics were or the process was that was asked of you at St George's in relation to the first look-back, the 1990s look-back?

A. It was just to record every example of a person given a blood product within that timescale in the hospital, which is obviously a large one and largely stems from the blood transfusion department as organised -- and anyone who'd every known my colleague Dr John Parker-Williams would know he was like the encyclopaedia about that. So, as far as I remember, I just, repeatedly -- I just, not for the first time, provided the list of my patients who had been exposed to see through the plasma for their haemophilia treatment, and the rest was done by John Parker-Williams and the blood bank, and I think

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referral centre, call it what you will, comprehensive care centre, now responsible for a large network, we were constantly -- we were referred patients for shared care, or many more so, and they would have been from other centres in the area, so Lewisham and others. There was uncertainty about whether -- you know, double reporting, patients deceased. In addition, of course, at St Thomas' I no longer had any contact with the -- direct involvement with the blood transfusion system at Guy's and St Thomas', so I didn't have any access to those but, thankfully, I did have a colleague, much regretted, Dr Thompson, who was able to devote a fair amount of his time to collecting it. So I think we did contribute data. It was much more difficult to be sure that one was complete of the data to the second look-back on having missed something.

Q. Can you recall roughly how many, if any, bleeding disorder patients, who may have been infected with hepatitis C were identified at St Thomas' as a result -- Guy's and St Thomas', as a result of this particular look-back exercise?

A. Who had never been recognised before?

Q. Mmm.

A. It must have been single figures but I'm afraid

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quite effectively.

Q. Then if we move to 2011 we look at HCDO0000510, please, Soumik, so these are the minutes of a meeting of the advisory committee and the annual general meeting of UKHCDO, October 2011, and you were in attendance, and if we just go to the bottom of page 3 please, Soumik, we can see the bottom of the page says:

"HCV Look-back exercise: the aim is to identify all patients affected with hepatitis C and to calculate the burden of disease for planning. There were 15,057 patients registered during the period of risk (mostly with mild bleeding disorders). 11,567 are still alive. The number of forms received is 3,266 [et cetera]."

Then it says in the next paragraph:

"It is generally that the burden being placed on Centres is too great."

Then there's a decision about what to do in relation to forms and collection of data.

What, if anything, can you recall about this look-back exercise in 2011?

A. I must admit, I found this look-back exercise somewhat amorphous because, as it says there, many patients had been treated -- because we were a reference centre,

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I can't remember this and I don't have access to any records of it.

Q. I want to ask you next on a different topic but looking also at a set of UKHCDO minutes from 1989, so could we have HCDO000015_035 please, Soumik. So this is a meeting of Haemophilia Centre Directors in October 1989 and, again, we can see that you're in attendance, and then if we go please to page 5, Soumik, halfway down the page under the heading "Litigation", there begins a fairly lengthy discussion about litigation. Sorry, I should have drawn your attention to the list of attendees. Dr Rejman from the Department of Health and a representative of the firm of solicitors, Cole & Cole, were also in attendance. We can see here there's a report from Dr Jones. In the second paragraph, it says:

"Dr Jones highlighted the damage being done to the doctor/patient relationship as the case dragged on ..."

Then we have a Mrs Simpson, partner in the firm of Cole & Cole, giving an outline of the progress of the defence to the patients' Statement of Claim. Then if we go over the page, we can see she provides various details about who's involved, about the progress of the litigation.

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1 If we can look at the bottom half of the page,
2 Soumik, a little closer, you'll see that long
3 paragraph there talks about a questionnaire being
4 produced and who the lawyers were involved, and then
5 that long paragraph ends with this:

6 "Haemophilia Centre Directors were not
7 defendants and the lawyers would like the Directors to
8 co-operate fully and give as much help as possible."

9 Then in the next paragraph there's a question
10 about individual directors and the solicitor
11 emphasised that the Health Authorities were the
12 defendants and not the directors. Then if we go over
13 the page please, and we zoom in on the first half of
14 that long paragraph in the middle of the page please,
15 Soumik, we can see Dr Chisholm asks about the cost to
16 patients and if directors could do anything to help
17 patients. Mrs Simpson talks about the defence lawyers
18 looking to strike out the claim, and then there's
19 a long paragraph where Dr Rejman, representing the
20 Department of Health, gives the Government's
21 perspective:

22 "... no case for an out of court settlement ...
23 compensation must be sought through the courts",
24 et cetera, et cetera.

25 Now, it would appear from this discussion that

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1 a somewhat unwarranted assumption. I don't know quite
2 how I can reply to that. I don't remember any strong
3 feeling myself about things, just that this was the
4 way things happened. One was pretty aware, I think,
5 that cases of medical negligence were unlikely to be
6 straightforward against doctors involved, unless
7 people could be shown, for example -- as long as
8 people were following the guidelines set down by the
9 UKHCDO, for the aforesaid Bolam situation. I think --
10 obviously, I'm aware that Bolam is now defunct and
11 different standards are applied, but I think when it
12 comes to legal action about treatment, it would be
13 unusual if the doctors who'd prescribed that treatment
14 did not feel somehow in the focus of the litigation,
15 and the assurance that, so far, no doctors were
16 actually being individually sued would be regarded as
17 not necessarily applying to the future.

18 That's all I can say on that. I did not feel
19 particularly threatened by anything but I remember
20 feeling somewhat out of sympathy with Dr Rejman's
21 approach.

22 **SIR BRIAN LANGSTAFF:** Just one question about that, really
23 addressed through you, Ms Richards. If we go back to
24 the previous page -- thank you -- I think it's the
25 previous page, again.

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1 directors were, to some extent at least, being asked
2 to assist in the defence of the litigation. They were
3 certainly being given a fairly detailed account of the
4 defendants', including the Government's, response.
5 Can you recall whether at the time that struck you as
6 odd or concerning that directors were being drawn into
7 the litigation for the defendants in this way?

8 **A.** Okay. I kind of remember it because of Dr Rejman.
9 It's somewhat -- I could say he presented the
10 Government's position in a kind of hardline way that
11 struck me as unsuitable, inappropriate. That's about
12 the only thing I can remember of that.

13 Now, your question -- sorry, can I ask you to
14 clarify? You're asking was I surprised that doctors
15 were, what, talking about helping the plaintiffs or --

16 **Q.** No, the defendants, being -- as the doctors were not
17 themselves individually being sued, did anything
18 strike you at the time or does it strike you now as
19 concerning about the fact that directors were, as it
20 were, almost being assumed to be somehow on the
21 defendants' side or there to assist the defendants in
22 their defence of the litigation?

23 **A.** I mean, apart from the fact that, of course, the
24 defendants are all paid employees of the National
25 Health Service, I would have thought, yes, that was

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1 **MS RICHARDS:** The page before that, Soumik.

2 **SIR BRIAN LANGSTAFF:** 0005, thank you. What Mrs Barbara
3 Simpson was saying. The underlying picture,
4 apparently being painted, was that the assembled
5 doctors were assumed to have some interest which
6 coincided with those of the defendants in the
7 litigation, and she appears to be asking the doctors
8 present to assist, insofar as they could. I've always
9 understood it as a general principle, when asking
10 people who are not themselves at least currently being
11 sued for what is expert opinion, that if it's offered
12 it should be available -- if the doctor or other
13 person is invited to give a comment, as opposed to
14 make a report -- should be available to both parties,
15 so that both parties can see what the individual has
16 to say and the impartiality is not compromised.

17 Do you know whether any enquiry has been made
18 of Barbara Simpson as to the basis of the request she
19 was making?

20 **MS RICHARDS:** I don't off the top of my head, sir. We can
21 certainly find out.

22 **SIR BRIAN LANGSTAFF:** Because it might be a matter of
23 importance. One has to take into account that it's at
24 a time, perhaps before Mr Justice Cresswell set out in
25 The Ikarian Reefer the general principles of how

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1 experts should behave, et cetera, but it was well
 2 known that if individuals were suing doctors who had
 3 been involved in their treatment that they ought to be
 4 freely available to go to other doctors who would be
 5 under no sort of pressure one way or the other to say
 6 anything to the would-be plaintiff other than what
 7 they really thought, and the defendant similarly.

8 **MS RICHARDS:** Yes.

9 **SIR BRIAN LANGSTAFF:** That's a comment by me, really,
 10 doctor. It's just arising out of this particular
 11 document, which we have seen before and I haven't
 12 asked that question before. I felt prompted to ask it
 13 at the moment.

14 **A.** Okay.

15 **MS RICHARDS:** Before we leave that, Dr Bevan, was there
 16 any further comment you had?

17 **A.** Sorry, is it fair to say then that I -- apart from
 18 a general air of concern, I didn't get any feeling
 19 that we were being directed not to provide evidence
 20 for the plaintiffs.

21 **SIR BRIAN LANGSTAFF:** That's helpful to know at any rate.
 22 Thank you very much. That's some reassurance --

23 **A.** I mean, I subsequently became much more acquainted
 24 with clinical negligence through my work as an expert
 25 witness in various cases, so even through the later

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1 **MS RICHARDS:** Dr Bevan, just a handful of questions for
 2 you that I have been asked to ask.

3 The first is in relation to dissemination of
 4 minutes by UKHCDO. You referred in your evidence this
 5 morning, when we were discussing the meetings you'd
 6 attended in '78/'79 on Professor Flute's behalf, your
 7 understanding was Professor Flute would go through the
 8 minutes of the meeting in due course when he received
 9 them.

10 Can I just check with you your understanding of
 11 what minutes were circulated by UKHCDO. Our
 12 understanding based on evidence so far has been that
 13 minutes of Reference Centre Director meetings were not
 14 generally circulated beyond the Reference Centre
 15 Directors. Is that your understanding?

16 **A.** That's my understanding, including the Reference
 17 Centre Director meetings I attended after taking up
 18 post at Guy's and St Thomas'.

19 **Q.** The minutes of the AGMs that were attended by or to
 20 which all Haemophilia Centre Directors were invited
 21 which took place annually, are those the minutes there
 22 you were referring to which you understood were
 23 circulated to all directors?

24 **A.** Yes.

25 **Q.** Thank you.

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1 knowledge I have, I wouldn't have seen any direction
 2 there that one was not to provide information to the
 3 plaintiffs or their representatives. Sorry.

4 **MS RICHARDS:** No, no.

5 Sir, that concludes the questions I had for
 6 Dr Bevan, but I had a handful questions from CPs, Core
 7 Participants, over lunch and obviously we should
 8 afford them the opportunity to suggest any further
 9 questions arising out of Dr Bevan's evidence today.
 10 So I was wondering if we could take a break now for
 11 perhaps 30 minutes and that will give the legal
 12 representatives of Core Participants the opportunity
 13 to email to me and to Mr Boukraa any further questions
 14 they would like us to consider asking Dr Bevan.

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

16 You may have seen if you watched any of the
 17 previous proceedings, Dr Bevan, that at this stage we
 18 take a break so that Ms Richards can field any of the
 19 questions which others may wish you to be asked, and
 20 as appropriate we'll ask questions when we return.
 21 So we'll take a break now until quarter to 4.

22 **A.** Excellent.

23 (3.12 pm)

24 (A short break)

25 (3.44 pm)

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1 Secondly, I asked you about contributions or
 2 sponsorship from pharmaceutical companies. As
 3 a matter of process, were those sponsorships or
 4 contributions that you were discussing in your
 5 evidence this afternoon declared to NHS Employers at
 6 the time and, if so, were they ever questioned or were
 7 any concerns or objections ever expressed by your
 8 employer?

9 **A.** Definitely at Guy's and St Thomas' any such
 10 contributions were declared to the Trust and one had
 11 to clear them -- one's attendance at the conference
 12 and support with the line manager in the general
 13 management team.

14 At George's I think, once again, after line
 15 managers came in, one was supposed to clear it with
 16 them. But the formal requirement for it being
 17 declared was much more -- much less prominent, let's
 18 put it that way. So I think they were probably very
 19 likely declared before about -- before 1995 or so,
 20 possibly.

21 **Q.** So they were very likely or unlikely declared?

22 **A.** No, they were -- I think they were probably
 23 under-declared. I'm sorry, I'll modify that. Before
 24 1990. After the internal market came in, everything
 25 got a bit more corporate.

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1 Q. Did you ever have your line manager saying, "No, you
2 shouldn't accept this", or "You shouldn't go"?

3 A. No. And then I think the UKHCDO introduced
4 registration of such events and I think it was pretty
5 widely complied with. But of course that's not quite
6 the same thing.

7 Q. Thirdly, we talked about the precautionary principle,
8 and you said that the precautionary principle wasn't
9 something that was generally recognised or applied to
10 medical practice at the relevant time, and we were
11 talking about the late 70s/first half of the 80s. In
12 your view, should it have been? Should that have been
13 a key part of medical practice at the time?

14 A. That really refers to my whole feelings about a degree
15 on anachronism. There are many things that, if they
16 had been applied to the situation at that time, such
17 as the current principles of clinical governance, of
18 patient autonomy -- in a way, yes, they all would have
19 been better, but they weren't -- I mean, they didn't
20 exist. So it's a kind of strange question in a way.

21 Q. Okay.

22 A. I think there are many things that we -- as I've said
23 before, a lot of aspects of medical practice, not just
24 clinical practice but organisational practice, ethical
25 practice, changed as a result of the HIV epidemic.

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1 of her within a year of that.

2 Q. The final question I've been asked to raise with you
3 as about transfusion practice and your general
4 experience as a haematologist more widely. And
5 I think it might be most useful if I ask you to look
6 at a document and then ask you the question.

7 Soumik, could we have on screen, please,
8 NHBT0015055_001.

9 This is a medical report you prepared I think
10 for the purposes of a possible legal claim in
11 August 1991. I'm not going to ask you anything about
12 the individual patient or the individual circumstances
13 of the case but just about a general observation you
14 made at page 3.

15 So if we can go to page 3, and it's the bottom
16 half of the page, please, Soumik.

17 If we look at the penultimate paragraph there
18 is, Dr Bevan, you say this:

19 "The risk of acquiring any viral infection,
20 specifically viral hepatitis, from blood product
21 transfusion is proportional to the total number of
22 donor units to which the recipient is exposed. It is
23 therefore good clinical practice to restrict this
24 exposure as far as possible without jeopardising
25 a good outcome."

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1 And of course you could look at all those new
2 introductions and say, "Oh, they would have been much
3 better prior to the end, they would have achieved
4 a lot if they had been in place prior to the AIDS
5 epidemic", but the fact is they weren't. We needed
6 the stress and horror of the HIV epidemic to learn
7 those things.

8 Q. The next question is just in relation to the HIV
9 counselling. You referred to having a counsellor.
10 Can you recall how long it took, approximately, after
11 1985 for you to have the funding at St George's to
12 have the services of a counsellor, or was that
13 something that was attached to the infectious diseases
14 unit?

15 A. No, they had their own counsellors and we had ours,
16 and she was a great help and I find it to be appalling
17 that her name has just gone from my memory. And no
18 doubt the patients remember her.

19 I've tried to think of myself, my -- I think
20 time has become compressed in retrospect, and it may
21 well have been a year or so after getting those
22 initial HIV results before we got the counsellor. My
23 feeling is that within a year or two we had her,
24 because she was founded by the Wandsworth Health
25 Authority as a special grant. So I think we got hold

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1 That's a statement of principle that you made
2 about good clinical practice, and the question I've
3 been asked to ask you is about whether you were aware,
4 as part of your wider experience as a haematologist or
5 your knowledge of the Blood Transfusion Committee at
6 St George's, of whether there was any particular trend
7 or practice of over-transfusing patients?

8 A. Right, okay. So here, although I use the word "blood
9 product transfusion", I'm really talking about red
10 cell units, which obviously can only come from
11 a single donor, and therefore the larger the number of
12 red cell units transfused into someone, the more
13 donors they've been exposed to. Over-transfusion is
14 indeed a possible problem in hospital practice,
15 usually because in an emergency situation people, for
16 the best motives, assume the person has lost more
17 blood than they actually have.

18 I think in modern practice over-transfusion is
19 much less likely because of -- in critical operations
20 like cardiac bypass, there is real-time monitoring of
21 blood volume and other monitoring measures which would
22 mean that over-transfusion was far less likely now.
23 But I think, yes, over-transfusion could occur. Is
24 that -- does that answer your question?

25 Q. Yes, that's the question I've been asked to ask you,

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1 and I thought it might be useful to do so by reference
2 to the observation you've made in that report.

3 **A.** Yes, that's about a pulmonary bypass patient who was
4 transfused a large amount, and I'm just saying
5 that ... as you can see from the thing below, I'm not
6 saying that there was over-transfusion in this case --

7 **Q.** No, and I wasn't asking --

8 **A.** Given the complexity of the situation, the volume
9 seemed to be comparatively modest or appropriate.

10 **Q.** We can take that back down, thank you, Soumik.
11 Sir, those are the questions I have for
12 Dr Bevan, or those were the questions from CPs that
13 I'm proposing to ask. Before I ask Dr Bevan if he has
14 anything further to add, are there any questions you
15 have, sir?

16 **SIR BRIAN LANGSTAFF:** Do we have to ask -- is it,
17 Ms Shibilka?

18 **MS RICHARDS:** She has no questions.

19 **Questions by SIR BRIAN LANGSTAFF**

20 **SIR BRIAN LANGSTAFF:** Yes, I do.
21 Very early in your evidence this morning you
22 said -- something of an aside, but this. You said
23 "nothing from BPL is truly free". You'd just been
24 talking about how BPL product was free, and then you
25 added that. What did you mean?

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1 **SIR BRIAN LANGSTAFF:** I understand it. I wouldn't say
2 perfectly but I understand it I hope.

3 The next question really arises out of your
4 comment about the patients who were informed that they
5 had hepatitis C, and they're indicating to you they
6 thought it wasn't one of the most serious problems
7 they had because it was -- any particular risk was
8 long-term rather than immediate compared to the HIV
9 from which they might very well be suffering. That
10 was very much greater.

11 Just to put their view as to how serious it was
12 into some sort of context, did you ever know just how
13 many of your cohort that you were treating for
14 haemophilia actually took interferon when it was
15 available?

16 **A.** I would hope very much because later on in
17 South Thames, under the approval of the Pan-Thames
18 Haemophilia Consortium and its subsequent equivalents,
19 we formed a network of centres so that the link
20 between, say, the George's centre and St Thomas'
21 centre became more formalised, and most of the
22 patients with hepatitis C at St George's, including
23 one or two I remember very well, came to St Thomas' to
24 the liver clinic there. The reason being that the
25 liver clinic at St Thomas' had, you know, a typical

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1 **A.** Well, I meant the presumption that it -- the
2 manufacture or the production of such a product
3 involved costs, costs to the NHS. So somebody's
4 paying for it. I think it may not -- when it comes
5 over to the clinical side, in terms of the haemophilia
6 centre, we do not pay for it. It's, if you like, free
7 at the point of use.

8 **SIR BRIAN LANGSTAFF:** Yes.

9 **A.** But everybody must recognise that there is a cost.
10 The trouble is that the NHS has never been very good
11 at ascertaining, if you like, system-wide costs, as
12 opposed to the costs that appear on someone's budget
13 at the end usage.

14 This can sometimes be a problem, for example,
15 if you have a new drug that can radically simplify and
16 reduce the costs of, say, anti-coagulation in
17 thousands of people. That drug may not be used
18 because it's expensive at the point of use, whereas
19 the costs involved in using the old method are not
20 quantified properly, whereas the cost of a commercial
21 product that appears on an invoice on your budget is
22 real. The true cost of the thing has never been
23 collected and displayed in the same way. I've
24 probably overcomplicated my answer there.
25 I apologise.

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1 piece of Professor Savidge's financial acumen,
2 acquired a device that measured the elasticity of the
3 liver by sound waves. My ageing brain has temporarily
4 lost the name of the thing but basically it's a way of
5 accurately deciding whether someone has cirrhosis or
6 not without liver biopsies.

7 **SIR BRIAN LANGSTAFF:** So some form of fibro scanner.

8 **A.** Fibro scanner, that's the word I was looking for.
9 Thank you very much. So they had a FibroScan and
10 a FibroScan clinic run by one of the nurse specialists
11 there which gave a very good running account of
12 whether people had cirrhosis. So I'm pretty sure that
13 all the people who acquired HCV at St George's
14 eventually came to St Thomas' to attend that clinic.
15 So I think everyone there was then treated with not
16 just interferon but ribavirin and the newer drugs and
17 are currently on programmes where they've access to
18 single drug therapy and the modern forms of drug
19 therapy and EPSI, which have transformed the outlook
20 in the pre-cirrhotic population. So I've no doubt
21 they are being properly looked after.

22 **SIR BRIAN LANGSTAFF:** I suppose it might be said that
23 their view of how serious hepatitis C was, in the
24 light of what they've been told, wasn't perhaps quite
25 so sanguine if the knowledge which presumably they

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1 were given of the side effects of interferon and
 2 ribavirin meant that they were prepared to undergo it.
 3 That's a comment. Would you like to comment on it?
 4 **A.** I understand what you're saying. I think the fact is
 5 that their position was very much that right now, in
 6 the face of HIV, I haven't got time to worry about
 7 this and I'm finding the HIV treatment enough to be --
 8 without adding these other agents to it. In fact, my
 9 colleague Dr Mark Wansborough-Jones, who looked after
 10 my patients with both conditions, found it very
 11 difficult to persuade dually infected patients to add
 12 Hep C treatment of its early form of interferon or
 13 interferon and ribavirin, because the patients knew
 14 about the weight of side effects from those early
 15 regimes.

16 In fact, so that feeling of the comparison
 17 between the two was the reason why I think he found it
 18 difficult to persuade our patients to receive anti-HCV
 19 treatment.

20 **SIR BRIAN LANGSTAFF:** So it wasn't a case of being
 21 dismissive of the risk, it was a case of this is all
 22 just too much all at once.

23 **A.** I think so and that they would deal with that risk
 24 when the time came.

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

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1 hepatitis B was regarded as distinguishing between the
 2 two viral illnesses when attention should have been
 3 given to the likelihood that they were similar, and
 4 you added, having reflected on that in the course of
 5 your evidence, in the long-term.

6 **A.** Yes, they clearly weren't quite similar in the
 7 short-term.

8 **SIR BRIAN LANGSTAFF:** You told us earlier that serum
 9 hepatitis became known as hepatitis C, non-A, non-B
 10 first and then hepatitis C. Is it your understanding
 11 that before hepatitis B was identified, it too was
 12 seen as part of what was a composite whole known as
 13 serum hepatitis?

14 **A.** I think my practice in medicine and indeed my time as
 15 medical student didn't go back far enough to be aware
 16 of any such stage where all the hepatitides were
 17 lumped together -- sorry, apart from, I suppose,
 18 hepatitis A --

19 **SIR BRIAN LANGSTAFF:** Let me put the question a different
 20 way. The Inquiry has heard that ever since the War,
 21 if not earlier, it was known that blood could transmit
 22 hepatitis.

23 **A.** Yes.

24 **SIR BRIAN LANGSTAFF:** Was it -- again, I'm asking for your
 25 understanding, if you can't comment because of your

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1 **A.** I mean, by now, my haemophiliac patients, you know,
 2 they were -- how can I put it -- much more directly
 3 experienced in all this stuff than I was. I took my
 4 lessons from them by this stage. When I introduced
 5 the idea of vCJD to these somewhat battered guys,
 6 their response was perhaps even more dismissive. But,
 7 as you know, some haemophiliacs found the vCJD just
 8 like the absolute limit of what they could tolerate,
 9 a third experience. But, by now, the person -- I know
 10 that my patients understand the whole context in great
 11 depth, more depth than I could ever understand.

12 **SIR BRIAN LANGSTAFF:** The last question -- series of
 13 questions which I have to ask, really arises out of
 14 drawing the strands of two or three things that you
 15 said together and can I introduce it by taking you
 16 back to paragraph 50 of your witness statement.
 17 Soumik, that's 4106001 and it's paragraph 50. It's
 18 the third page of that, so it's page probably 0021 or
 19 021 would be the number, it is page 24 internally.
 20 Thank you. Let's move on. Page 24 internally,
 21 page 24.

22 Here you're talking about the approach, the
 23 dismissive approach that some doctors took to the risk
 24 of non-A, non-B hepatitis, and you comment that the
 25 overt, potentially fatal, acute severity of

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1 relative youth compared to some in the field, but was
 2 it your understanding that that, let us call it, serum
 3 hepatitis, that that was known to have long-term
 4 consequences in some cases?

5 **A.** I mean, hepatitis B was distinguished from other types
 6 of viral hepatitis before I became a medical student.
 7 So it would have been involved in a study of, if you
 8 like, history, medical history, which I was not able
 9 to do.

10 **SIR BRIAN LANGSTAFF:** The reason I asked you is because
 11 you have described non-A, non-B as not a new disease
 12 but rather an old one, well known.

13 **A.** I think serum hepatitis has been known of since serum
 14 was used as passive immunisation, you know, after
 15 Pasteur. So that goes back a long time. I know that
 16 some of the -- much of early serotherapy used horse
 17 therapy, horse serum and rabbit serum, but nonetheless
 18 I imagine that it came from those days, of the use of
 19 serum as a passive immunisation treatment. So indeed
 20 it was anciently recognised.

21 **SIR BRIAN LANGSTAFF:** If ancient --

22 **A.** To say that hepatitis B was once only serum hepatitis,
 23 if you like, it's not quite true because I think
 24 hepatitis B --

25 **SIR BRIAN LANGSTAFF:** That isn't what I'm asking. I think

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1 it's very helpful that you should say so.
 2 What I was really asking was -- serum hepatitis
 3 as it was identified after Pasteur, was it known to
 4 have, in some cases, serious long-term consequences?
 5 **A.** I'm unaware of that. I know of no reports of that in
 6 the medical literature.
 7 **SIR BRIAN LANGSTAFF:** I won't take that any further.
 8 That's all that I have to ask. Thank you very much.
 9 **MS RICHARDS:** Dr Bevan, is there anything further that you
 10 would like to add?
 11 **A.** Not really, except to say that the heroism,
 12 resilience, resourcefulness of my patients and their
 13 families and the ability, in haemophilia care, to know
 14 individuals from basically their infancy through to
 15 adulthood and beyond, has been an enormous privilege,
 16 and their responses to these concurrent epidemics
 17 should never be forgotten.
 18 I mean, the fact that I eventually managed to
 19 get into a position where I could do research meant
 20 I did research entirely on post human blood
 21 transfusion protocols, including recombinant factors
 22 with extended half lives, and indeed drugs which don't
 23 involve Factor VIII at all but which otherwise changed
 24 the haemostatic balance in the patient to achieve
 25 control of haemophilia, and some of those are coming

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1 hugely helpful.
 2 **A.** Thank you very much in turn. Thank you.
 3 **MS RICHARDS:** Sir, that's today's evidence and tomorrow we
 4 have a presentation on the Manchester Haemophilia
 5 Centre, that is to say the reference centre at
 6 Manchester Royal Infirmary.
 7 **SIR BRIAN LANGSTAFF:** So we start at ten o'clock.
 8 **MS RICHARDS:** We start at 10.00, tomorrow, sir.
 9 **SIR BRIAN LANGSTAFF:** So ten o'clock tomorrow. Thank you
 10 very much.
 11 **(4.12 pm)**
 12 **(Adjourned until 10.00 am the following day)**
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1 to fruition now and I'm very glad to see it. So
 2 hopefully we have moved on into a new world. But for
 3 the patients who were affected and their families it
 4 will always be there. My sympathies are with them
 5 entirely.

6 **MS RICHARDS:** Thank you, Dr Bevan.

7 Sir.

8 **SIR BRIAN LANGSTAFF:** I'd just like to thank you hugely
 9 for the evidence which you've given. It has been, in
 10 ways that you may not appreciate, though I hope you
 11 do, really very valuable indeed for us to hear
 12 evidence given with such honesty, practical, frank,
 13 straightforward and, in particular, you have been very
 14 careful not to say what you don't know and to avoid
 15 inventing it and told us what you do think in ways
 16 that listening, as I do, may well be seen to have at
 17 least the conviction of my knowing that you believe
 18 what you have had to say. I recognise that you have
 19 been shaken a little bit by some of the memories which
 20 come back. You have given us an insight into how
 21 memory truly works, by finding the colourful episodes
 22 in one's past which may colour the rest of our
 23 recollection but certainly give rise to a focal point
 24 from which true memory can expand and be given. So
 25 thank you for all that which, as I say, has been

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