

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

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

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

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

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

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

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

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

4 Q. In the course of this period you took your MRCPATH  
5 exam?

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

11 Q. You have observed -- sorry?

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

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

17 A. Yes.

18 Q. -- you passed --

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

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

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

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

5 A. Yes.

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

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

10 Q. When Professor Flute took early retirement.

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

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

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

12 Q. That was in the summer of 1985?

13 A. July, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

11 A. Yes.

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

16 A. Not at all. I think the haemophilia directors of  
17 smaller centres -- we were a kind of medium-sized  
18 centre -- as Mark Winter's study showed in the south  
19 of England there were haemophilia centres with  
20 directors who attended regular meetings who had no  
21 actual patients or very few or mild patients only.  
22 But we did have a substantial number at St George's.  
23 Nonetheless, at UKHCDO, the roles on special working  
24 parties and their special committees were reserved for  
25 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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1 severely affected haemophilia patients were  
2 accompanied by a slightly greater number of moderately  
3 affected and very great number of mild. In fact, it's  
4 not like that at all with haemophilia.

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

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

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

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

25 Certainly, before we had a haemophilia nurse he

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

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

13 Q. Haemostasis club?

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

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

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

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

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

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

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

24

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

25

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,

27

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

26

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

28

- 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.

32

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

33

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

35

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.

34

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

39

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

40

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

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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.

14 The British form, where you needed to subsample  
15 to get a dose from -- so, for example, you've seen  
16 that the broad number of units in a single bag of  
17 cryoprecipitate was 50. Therefore, a dose for  
18 an adult, it has to be maybe 2,000 units. So you have  
19 to give 20 or more bags, and subsampling these into  
20 a single bag is fine when you can infuse it through  
21 a drip in hospital, but setting up drips on yourself  
22 is not a straightforward thing. So the home user  
23 would have to draw it up into a very large-barrelled  
24 syringe, 50 ml syringe, and give it in several  
25 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.

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

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

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

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

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

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

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

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

7 "Like any British doctor trained during the  
 8 1970s, I was well aware of the hepatitis B outbreak  
 9 that killed patients, nurses at renal units in  
 10 Scotland."

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

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

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

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

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

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

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

20 (11.18 am)

21 (A short break)

22 (11.44 am)

23 **SIR BRIAN LANGSTAFF:** Yes.

24 **MS RICHARDS:** Dr Bevan --

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

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

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

22 **Q.** You have. Just dealing with -- you have referred to  
 23 the outbreak in Scotland with the devastating  
 24 consequences it had. Had you been aware in the 70s of  
 25 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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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 deputised 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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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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1 look at risks of transfusion-transmitted infections in  
2 the late 70s and first half of the 80s. You've  
3 described in your statement the only St George's body  
4 that you were aware of was the Blood Transfusion  
5 Committee, but you said that as far as you understood  
6 it they were preoccupied with ensuring the prompt and  
7 plentiful supply of blood for surgery, and safety was  
8 seen as secondary to the maintenance of supply. Is  
9 that correct?

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

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

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1 source of national recommendation or guidance to you?  
2 **A.** I'm trying to map this against the early development  
3 of AIDS treatment units, like again at the Middlesex,  
4 whose process -- whose -- what's the right word?  
5 Anyway, their practice began to impact to a greater  
6 and greater degree on the rest of us. So at George's  
7 I was extraordinarily lucky to be on the site of one  
8 of the first AIDS treatment units that was developing  
9 under Professor Griffin and Dr Wansborough-Jones, and  
10 others whose clinical ward was adjacent to the  
11 haematology ward and so -- and we knew this -- them  
12 very well.

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

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

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

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

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

22 **A.** To the extent of my memory, no.

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

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

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

20 **A.** As far as I recall, and this may not be 100 per cent  
21 reliable, we were able to do such testing internally  
22 with St George's virology department, rather than  
23 refer them outside. So that's my view. We were able  
24 to test them internally, more or less as the test  
25 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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1 very young patients who might have had some kind of  
2 pre-disposition to get severe disease. Very, very,  
3 very alarming.

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

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

15 **A.** I don't.

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

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

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

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

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

25 **SIR BRIAN LANGSTAFF:** We do have some material which has

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

15 Then you say this:

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

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

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

6 **SIR BRIAN LANGSTAFF:** Yes.

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

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

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

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

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1 run short -- let alone out -- of treatment. This  
 2 unwillingness to countenance the loss of effective  
 3 treatment was shared by the Haemophilia Society.  
 4 "The UKHCDO also took a position in many ways  
 5 typical of British public health governance: Not to  
 6 risk over-reaction, not to act prematurely, not to  
 7 alarm the public, 'the evidence is not yet  
 8 conclusive', 'we don't yet have proof' -- responses  
 9 still evident during the early phase of the current  
 10 Covid-19 pandemic."  
 11 Could we just continue down the page, Soumik.  
 12 You then refer in the next paragraph to  
 13 Factor VIII companies pulling the wool over the eyes  
 14 of doctors. I'll come back to that, if I may. I'll  
 15 skip that for the moment. You then say this:  
 16 "However, taking all these things into account,  
 17 the UKHCDO continued to hold the line, well into 1983,  
 18 that the evidence of an infectious cause of AIDS was  
 19 inconclusive, and that action would be premature, long  
 20 after that position became obviously untenable.  
 21 However, by then the scale of HIV infection in people  
 22 with bleeding disorders in the UK was fully  
 23 established."  
 24 And obviously that's a matter that the Inquiry  
 25 will have to determine in due course.

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1 Obviously, whether that is correct or not is  
 2 a matter for the chair but is that the sense of what  
 3 you were trying to convey?  
 4 **A.** Yes, because they'd grown up during a period --  
 5 I mean, they had been trained, they'd had their early  
 6 care when the majority -- in a time when, you know,  
 7 the median survival of people with severe haemophilia  
 8 had really stayed stuck very much in the Carol Birch  
 9 area of mid-teens to early 20s, that young people with  
 10 haemophilia essentially lost the use of their joints  
 11 or many of their key joints, knee joints, ankles,  
 12 elbows by the age of 20, and there were patients  
 13 confined to wheelchairs by the scale of arthropathy  
 14 that had been established.  
 15 Now, the introduction of cryoprecipitate  
 16 in 1963 by Judith Pool changed the survivorship but,  
 17 because of its complexities in giving prophylactic  
 18 treatment, didn't really change the scale of joint  
 19 damage. So it may have delayed it by five to  
 20 ten years but the end result was still severe joint  
 21 disease in haemophilia. So they saw all the downsides  
 22 of not having prompt and convenient treatment, and  
 23 they'd just been given, if you like, within the last  
 24 ten years, this supply of treatment of concentrate  
 25 that could -- they knew had the capacity to eradicate

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1 Just pausing there, I will come on to  
 2 hepatitis C perhaps after the lunch break, first of  
 3 all, are those observations you stand by?  
 4 **A.** I stand by those observations.  
 5 **Q.** The observations you set out there remain your view?  
 6 **A.** Every clinician is a creature of their generation. So  
 7 I may well have attitudes that future generations will  
 8 find equally -- not inexplicable, equally hidebound or  
 9 non-responsive. So those doctors were in many ways  
 10 admirable doctors, far more distinguished clinical  
 11 scientists than I ever was. I would feel embarrassed  
 12 confronting them with it but the fact is I think that  
 13 they held the line to the point where it almost became  
 14 like denial, a denial problem, into 1983.  
 15 I think to continue to propose that there was  
 16 no conclusive evidence that AIDS was caused by an  
 17 infectious agent was simply, in retrospect of course,  
 18 untenable. So I still feel that way, yes.  
 19 **Q.** The sense that this part of your statement gives is an  
 20 observation by you that the generation of haemophilia  
 21 doctors, as you describe, those who dominated UKHCDO,  
 22 were so focused on not withholding treatment and  
 23 wanting to maintain treatment at all costs that it may  
 24 have been that insufficient weight was given to  
 25 counterbalancing concerns about safety.

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1 those problems of haemophilia. So their attitude was  
 2 conditioned by their experience of the disease. It  
 3 may still be the case that if one had withdrawn  
 4 commercial factor or tried to substitute by widespread  
 5 reintroduction of cryoprecipitate, we would still now  
 6 be looking at patients in wheelchairs who wouldn't  
 7 have been there otherwise.  
 8 So I can understand the attitude they took but  
 9 I still see it as a kind of denial of the reality.  
 10 **MS RICHARDS:** Sir, I have a handful more questions on this  
 11 topic and then a handful of other topics to cover, but  
 12 I note the time and it may be a convenient point at  
 13 which to break.  
 14 **SIR BRIAN LANGSTAFF:** We'll take a break. We'll come back  
 15 at 2.05. Same rules apply. So 2.05.  
 16 (1.03 pm)  
 17 (Luncheon Adjournment)  
 18 (2.13 pm)  
 19 **MS RICHARDS:** Dr Bevan, can you see and hear me?  
 20 **A.** Yes, I'm not hearing you too good. The thing is not  
 21 yet charged up properly.  
 22 **SIR BRIAN LANGSTAFF:** Do you want some more minutes or are  
 23 you all right?  
 24 **A.** I can hear you clearly. I've got vision. Sorry, it  
 25 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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1 the advice promulgated by UKHCDO were late to  
2 recognise the reality of transfusion-transmitted HIV  
3 infection, and so may have made a minor contribution  
4 to the scale of HIV infection in patients with  
5 bleeding disorders.

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

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

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

7 But that concept of precautionary principle was  
8 certainly -- it may have been published by  
9 philosophers but it had not yet appeared in medical  
10 practice. Like many other subsequent developments,  
11 like the concept of clinical governance, et cetera.  
12 That's all.

13 Q. We can take the statement down.

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

23 A. I recall it, yes.

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

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

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

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

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

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

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1 A. No, not in 1983.

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

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

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

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

15 So I think it was an overall great benefit.

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

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

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

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

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

25 In terms of approaches, if you like, from the

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

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

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

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

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

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

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

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

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

15 **A.** No, direct donations to departments, as far as I'm  
16 concerned, never happened at St George's or, indeed,  
17 at Guy's and St Thomas', because that would be a very  
18 crude and overt way of doing it. The companies, of  
19 course, provided sponsorship for the attendance of  
20 medical staff, including the director, and often  
21 several members of the medical staff if you had them,  
22 to major international conferences, the sort of  
23 conference to which haemophilia directors really  
24 should be going, World Federation of Haemophilia,  
25 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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1 touched upon the difference of approach as a matter of  
2 principle and the application of a more precautionary  
3 approach, and I just wanted to ask you about one  
4 document you refer to in your statement. Soumik could  
5 we have on screen, please, WITN1194004, please. If we  
6 go to the next page.

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

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

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

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

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

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

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

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

6 Then you refer to an information pack:

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

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

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

24 Okay, let me just get my head round this.

25 The problem was that here we're dealing with

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1 neutralised it.

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

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

22 In fact, after talking to our patients that  
23 this letter would have gone to, they divided, as far  
24 as I remember, fairly equally between people who had  
25 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 UHMB000006\_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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1 but also at George's I was getting similar stuff from  
 2 the managers, newly empowered by the reforms.  
 3 One of those reforms meant that BPL had to try  
 4 to find a commercial footing. So no longer were they  
 5 allowed -- going to be allowed to provide free product  
 6 based on plasma donations, as in the past, but they  
 7 had to charge for it, and they were struggling with  
 8 exactly how to do this while fulfilling their mission  
 9 to supply patients with the blood products they  
 10 needed.

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

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

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

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

18 **A.** No. Yes, that's right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **A.** Who had never been recognised before?

24 **Q.** Mmm.

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

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1 quite effectively.

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

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

16 Then it says in the next paragraph:

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

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

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

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

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

3 **Q.** I want to ask you next on a different topic but  
4 looking also at a set of UKHCDO minutes from 1989, so  
5 could we have HCDO0000015\_035 please, Soumik. So this  
6 is a meeting of Haemophilia Centre Directors in  
7 October 1989 and, again, we can see that you're in  
8 attendance, and then if we go please to page 5,  
9 Soumik, halfway down the page under the heading  
10 "Litigation", there begins a fairly lengthy discussion  
11 about litigation. Sorry, I should have drawn your  
12 attention to the list of attendees. Dr Rejman from  
13 the Department of Health and a representative of the  
14 firm of solicitors, Cole & Cole, were also in  
15 attendance. We can see here there's a report from  
16 Dr Jones. In the second paragraph, it says:

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

20 Then we have a Mrs Simpson, partner in the firm  
21 of Cole & Cole, giving an outline of the progress of  
22 the defence to the patients' Statement of Claim. Then  
23 if we go over the page, we can see she provides  
24 various details about who's involved, about the  
25 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

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.

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)

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.

- 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'  
24 to 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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