Witness Name: Dr Joan Trowell
Statement No.: WITN3740003
Exhibits: Nil
Dated:

INFECTED BLOOD INQUIRY

THIRD WRITTEN STATEMENT OF DR JOAN TROWELL

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 19 February 2020.

I, Dr Joan Trowell, will say as follows: -

Section 1: Introduction

1. *Please set out your name, address, date of birth and professional qualifications.*

   1.1. My name is Dr Joan Trowell. My date of birth is GRO-C 1941. My address is known to the Inquiry. My professional qualifications are:

   - MB.BS. London (Royal Free) 1964
   - MRCP London 1967
   - FRCP London 1987
   - Member of the British Society of Gastroenterology (BSG) and the British Association for the Study of the Liver (BASL)

2. *Please set out your employment history including the various roles and responsibilities that you have held throughout your career, as well as the dates.*

   2.1. 1959-1964: I trained as a doctor at the Royal Free Hospital, London, with Professor Sheila Sherlock who set up and supervised the only specialist clinical liver unit in the UK at that that time.

   2.2. 1964 –1966: I worked in London (6 or 12 month appointments) at the Royal Free Hospital, Royal Northern Hospital, Brompton Hospital and the Hammersmith Hospital in a variety of medical specialties in junior medical posts.

2.3. 1968 -1969: I worked in Cambridge as a general medical registrar at Addenbrooke's Hospital.

2.4. 1969-1971: I returned as a Clinical Lecturer in Gastroenterology to the Royal Postgraduate Medical School at the Hammersmith Hospital.

2.4.1. In addition to general medical duties, I investigated abnormalities of liver function in patients and staff on a renal dialysis unit. At that time there were many fatalities from liver failure among patients and staff on dialysis units around the county. This proved to be due to a virus infection with what was later shown to be Hepatitis B, but there was no test for this at that time.

2.4.2. My work at the Hammersmith Hospital was in conjunction with the Virology department there and jointly we were able, using the electron microscope, to demonstrate the virus particles in the patients' serum at an early stage of the disease some of whom had no symptoms at the time that the blood sample was taken. This contributed subsequently to the development of more simple tests for the virus and also to the production of a vaccine against Hepatitis B which has been widely used throughout the world to protect at risk patients, professions and populations.

2.4.3. In order to extend the use of this test locally I was asked to set up a clinic to investigate patients with liver dysfunction. This led to a growing group of patients with liver disease who needed chronic care and so I established and supervised a specialist inpatient service which immediately before that time had not existed at the Hammersmith Hospital.

2.4.4. I moved to Oxford in 1971 for family reasons and from 1971 to 2006 I was employed by Oxford University in a variety of academic roles: research, teaching and clinical duties. From 1980, in view of my role with patient care, I also held an Honorary Consultant contract with the Oxford Hospitals.

2.4.5. Initially I worked at the Radcliffe Infirmary in the Nuffield Department of Medicine under Professor Paul Beeson (well known as an infectious disease specialist) and then Professor Sir David Weatherall.

2.4.6. I was also a clinical lecturer in the Department of the Regius Professor Sir Richard Doll where I was trained in epidemiological methods.

2.4.7. During this time I worked with Professor Alex Crampton Smith in the Nuffield Department of Anaesthetics investigating abnormalities of liver function and liver failure in patients who had repeated anaesthetics. This was subsequently shown by us, using prospective randomised controlled clinical trials, to be due to exposure to repeated use of the anaesthetic agent, Halothane, when its use was repeated after

only one to four weeks. This work changed anaesthetic practice during the 1970s and to the present, as anaesthetists are now trained not to repeat the use of Halothane in anaesthetics which are less than 6 months apart.

2.4.8. During these years, I was the only senior clinician in Oxford with training in the diagnosis and management of patients with liver disease, and so I established and supervised a clinic and inpatient practice at the Radcliffe Infirmary for patients with acute and chronic liver disease.

2.4.9. Initially I was a member of University Departments which were based at the Radcliffe Infirmary, Nuffield Department of Medicine (NDM) as a research fellow and as a Lecturer in Medicine in the Department of the Regius Professor of Medicine (RPM), but I moved to the John Radcliffe Hospital (JRH) when the second phase of the hospital opened to medical patients in the late 1970s. Latterly these departments were amalgamated under Professor Sir David Weatherall and later Professor Sir John Bell. After my work base moved to the JRH when this opened to medical patients, I looked after an increasingly busy clinical practice of patients with acute and chronic liver disease and other problems which were related to abnormalities of liver function.

2.4.10. Over my career my clinical and research interests and expertise related to the diagnosis and treatment of patients with liver disease and a variety of causes of liver damage including alcohol, viruses, sepsis, anaesthetic agents and other drugs.

2.4.11. I have no training or expertise in the care and management of patients with hereditary disorders of bleeding and clotting and never took any part in prescribing or administering blood products with clotting agents to the patients who were cared for by the staff of the Oxford Haemophilia Centre ('OHC'). When these men were inpatients at the JRH under my supervision the staff team from the OHC brought the necessary Factor VIII from the Churchill Hospital and administered it to the patient.

2.4.12. My clinical work involved two large out-patient clinics each week at the John Radcliffe Hospital and the supervision of the care of a variable number of inpatients there, ranging from about 10 to 20 at any time, many acutely and seriously ill, frequently with patients cared for in the Intensive Care Unit (ICU). I was asked to give an opinion and see many other patients who had abnormalities of liver function who were under the care of other consultants, and to advise on their care.

2.4.13. It was in this context that when a number of patients with hereditary bleeding disorders were found to have become jaundiced and have abnormalities of liver function, I was asked to attend a discussion at the Churchill Hospital about this

problem. I have no record of the date but would place it in mid 1970s. I think that initially these patients were boys at Lord Mayor Treloar College at Alton in Hampshire and after a discussion with a former director of the Haemophilia Centre in Oxford, I believe that several local patients had tests of their liver function and were found to also have abnormalities of liver function. I was not asked to see these patients and as I did not meet any of the patients at that time. I have no knowledge of any early discussions with them about their liver disease or its causes.

2.4.14. Subsequently news about liver problems in haemophiliacs spread rapidly among patients who were members of the Haemophilia Society and my understanding is that some patients then asked to be screened, but as the then staff of the Haemophilia Centre did not ask me for further involvement at that time, I cannot give the Inquiry any information about these patients or what patients were told at this time. I believe from earlier conversations with the former Director of the OHC that she held the view that the quality of life and the survival and life expectancy of patients with haemophilia had been transformed by the treatment they were given once the clotting Factor VIII was separated from whole blood donations. Previously they had frequent painful bleeds into joints and developed chronic arthritis with gross deformities. I do remember her telling me that before treatment with Factor VIII became available, few patients with Haemophilia lived beyond their teens.

2.4.15. I was never on the staff of the Oxford Haemophilia Centre (OHC) and during the years that I was involved I spent between one and two hours there at most, once per week. I was not involved in the production or procurement of Factor VIII concentrate or its finance and I did not decide what blood product was prescribed or given to any individual patient, except in a very general way in discussion during the planning of the research studies which I describe below.

2.4.16. I hold no records about any patient whose care I was involved with, as all my clinical records were filed in the patients' Oxford Hospital NHS paper notes files and I have had no access to these since my retirement in 2006. After each out- patient consultation, I wrote to the patient's General Practitioner and a copy of this letter was filed in the hospital records and also in the separate patient's records kept by the OHC. My research work was communicated to any colleagues and the patients concerned as our knowledge developed, publicised to the Haemophilia Centre Directors nationally and the Haemophilia Society, and published. I have no documents relating to it in my possession.

2.4.17. I have no record of the exact dates but sometime after my first conversations about liver problems in Haemophiliacs, the previous director of the Haemophilia

Centre retired and the new director, Dr Charles Rizza, asked me to come to the OHC for a discussion with various staff members including Dr Charles Rizza and Dr James Matthews. As a result of this I agreed to take clinical referrals from them of patients with clotting disorders who had received blood products and who had been found to have abnormalities of liver function. As many of these men and boys lived considerable distances from Oxford and were on home treatment with Factor VIII concentrates, I agreed to go to the Haemophilia Centre at the Churchill Hospital for a part of Tuesday mornings so I could see these patients on the same visit as when they came to Oxford and the Churchill Hospital for their routine annual or six monthly check-up.

2.4.18. At the time that they came to see me, these patients had already had blood tests to check their liver function which had been found to be abnormal, so I do not know what they were told before the blood was taken to test them for this. I remember being aware that viral hepatitis was a topic of general discussion among these patients and their families before I saw them, so I believe that most of them would probably have been made aware of the possibility that tests of liver function and for hepatitis viruses were a part of their routine follow up.

2.4.19. On several occasions I saw patients who were active in the Haemophilia Society and I remember meeting and speaking with members at meetings of the Society in Oxford, York, Glasgow and Dublin. I also attended meetings of the Haemophilia Centre directors on several occasions in order to discuss the current knowledge of Hepatitis viruses in blood products and to negotiate studies which could be undertaken with these patients in an attempt to reduce the occurrence of abnormal liver function after treatment with Factor VIII. We presented what was then known about the hepatitis viruses that can be transmitted by blood product transfusion and later discussed and helped to plan specific research projects which could be undertaken.

2.4.20. At that time, (probably from early/mid 1970s but I am not sure of exact dates) all blood donors in the UK were tested for Hepatitis B virus (HBV) so Factor VIII concentrate produced in the UK at the time I became involved with the OHC was no longer a source of HBV infection in haemophiliacs. I was told by staff at the OHC that locally produced Factor VIII concentrate, made from local blood donations was used for the newly diagnosed young patients referred to Oxford for their first and subsequent treatments. The blood products produced from UK blood donors were generally considered to carry less risk of contamination with hepatitis viruses as the donors were (and are) volunteers, in contrast to products from the USA and elsewhere, where donors were paid and many were believed to be drug

addicts and carriers of Hepatitis viruses – especially hepatitis B. The factor VIII concentrate produced locally required many blood donations to produce the Factor VIII dosage required. Before the hepatitis risk was defined, other older patients had already been treated with commercially produced concentrate made in the USA, so they would already have been exposed to any viruses that these products might contain.

2.4.21. As I never decided on exactly what treatment was given to any patient and I never gave any doses of Factor VIII concentrate to the patient, I do not know what conversations took place before treatment was given. All the Haemophiliac patients I saw in the early years had already had many doses of blood products before testing for liver function became routine. I do not know how many patients with bleeding disorders were treated at the OHC at the Churchill Hospital but it was a large number (I believe in the hundreds).

2.4.22. I have no record of how many patients with bleeding disorders I looked after over the next decade, but my memory is that I saw more than 50 patients who had received blood products for bleeding disorders and who had abnormalities of liver function. All patients referred who were seen by me had an extended discussion about what we knew about the blood borne Hepatitis viruses; this was a moving target as during these years our knowledge about the various Hepatitis viruses, and their occurrence in local blood donations, increased rapidly, not least because of the research studies that were undertaken through the Oxford Haemophilia Centre (OHC). The majority of patients referred to me had no symptoms that could be related to their liver disease. As they were seen at the centre only once or twice a year, I normally saw between one and three patients on any of my weekly visits to the OHC.

2.4.23. From time to time I was asked to attend the meeting of Haemophilia Centre Directors and its working group (from March 1978 – see document HCDO0000545) that was involved in advising on decisions about the production and use of Factor VIII concentrates. My involvement only related to determining the prevalence of liver disfunction after various treatments and then planning the research project described below which was an attempt to discover the true incidence of NANB hepatitis and reduce the frequency of abnormal liver function occurring in those who had received locally produced Factor VIII for the first time and reducing this. I was not involved with the purchase, prescription, production or administration of Factor VIII.

2.4.24. During the years I was going to the OHC there were reports of the early problems from New York of patients with HIV. Following this some haemophiliac patients

were described with symptoms characteristic of this new syndrome. Blood tests became available and I was made aware by staff at the OHC that some of the patients who saw me with abnormal LFTs had tested positive for HIV. I did not do these tests and do not know what patients were told before they were tested. Once the significance of HIV positive tests was realised, it became common practice that patients were told before blood was taken for HIV testing but as I did not do this test I am not aware in the early stages what was discussed with them. I was not personally involved with the work with HIV positive patients as they were seen and treated in the infectious diseases ward, John Warin Ward at the Churchill Hospital by the specialist team who were caring for all patients in Oxford diagnosed with HIV. These patients came under my care only if/when their liver failure became the most pressing clinical problem.

2.4.25. Later, after HIV infection became a problem in these haemophiliac patients, there were several who had clinical signs and symptoms of chronic liver disease with jaundice and ascites and gastrointestinal bleeds and encephalopathy. I was involved if they required hospital admission with liver failure; this was arranged to the JRH, to a single room with barrier nursing facilities on the ward where patients were admitted and cared for under my supervision. Even at this time all treatment for their Haemophilia was prescribed and administered by the staff from the OHC. Sadly, several of these patients died of liver failure.

2.4.26. It became apparent that patients who had what we then called "non A non B hepatitis" (NANB - now know to be HCV), which was normally chronic and asymptomatic but who tested positive for HIV, developed more rapidly progressive and symptomatic liver failure. I believe that the majority of haemophiliac patients who died under my care with rapidly progressive liver failure were HIV positive. For some years that side ward at the JRH was occupied by a succession of patients with haemophilia and HIV who were dying of liver failure. This was before there was any active treatment for HIV. Some of the older patients, who had received blood products for many years, developed a hepatoma: now recognised as a complication of longstanding chronic HBV and HCV infection.

2.4.27. Initially it was thought that blood borne hepatitis viruses were only transmitted by the Factor VIII concentrate made from overseas blood donations. But staff at the OHC became aware (I am unable to say when) that some young patients who had only had locally produced Factor VIII concentrate, and who were asymptomatic, had abnormalities of their liver function tests. I was asked to see them and could not find any other cause for these abnormalities and by exclusion it was probable that this "NonA NonB hepatitis" (NANB) was transmitted in locally produced blood

products.

2.4.28. After extended discussions we decided on a series of formal research projects with all previously untreated patients who were referred to the OHC. Initially several different production methods for Factor VIII concentrate were employed including heat treatment. As these products were considered to be safer than those in routine production, and in order to discover if there was any active hepatitis virus still present these products were prescribed to patients who were receiving their first dose of Factor VIII – and usually of any blood products. Initially we discovered abnormalities of liver function occurred in all patients after their first dose of Factor VIII concentrate produced locally in NHS fractionation laboratories. This was not HBV (for which by then we had a formal blood test) and which was already known to be a cause of abnormal liver function after blood product transfusions.

2.4.29. In an attempt to reduce the number of patients with abnormal liver function tests after first time treatments, the laboratory reduced the number of blood donations used to produce each batch of factor VIII. Before this, several thousand blood donations had been pooled to make the Factor VIII concentrate. Successive studies using progressively fewer blood donations did show a decline in the percentage of patients who after a first treatment had abnormalities of liver function. But even after treatment with a product made with as few as 200 pooled blood donations, abnormalities of liver function were observed in some of these patients. The treatment and immediate follow up of these patients, including blood tests to check their liver function was done by staff employed by the OHC. I was involved only in academic discussion in planning these studies and later in reviewing those patients clinically whose liver function had become abnormal.

2.4.30. I was not directly involved in the production of the factor VIII concentrate but I do remember discussions with staff from the OHC and the local fractionation laboratory which produced the factor. It was decided to try the effect of heating the product to discover if we could destroy the infectivity of the virus. After several different laboratory procedures, of which I cannot remember any details, this “heat- treated Factor VIII” was shown not to transmit what was then called “Non A Non B hepatitis”, now known as Hepatitis C (HCV). Since then blood tests for this virus have been developed, but these were not available to us at that time. Subsequent work has been directed to produce treatment for those infected with HCV and a vaccine against this virus, but this was all later work.

2.4.31. All of this research on patients who were receiving their first dose of Factor VIII concentrate was a formal research project approved by the local Central Oxford Research Ethics Committee (COREC) and the work was reviewed by this Ethics

Committee at regular intervals. We drafted an information sheet, approved by the Ethics Committee, and this was given to all the patients involved – or their parents as many were infant boys. I do not have a copy of the Information Sheet now but I remember that it did explain that we were aware that abnormalities of liver function could occur after Factor VIII treatment and we were working to discover more about this in an attempt to reduce the frequency of post transfusion hepatitis with the aim of abolishing this problem. The project did involve some extra blood tests of liver function but no "treatment" that would not have been given routinely to these patients for the bleeding problem that they already suffered from.

2.4.32. During these years we told the patients that had persisting evidence of chronic liver disfunction that this form of chronic liver disease was a chronic viral hepatitis probably related to the treatment with blood products. There was no proven anti- viral treatment and little knowledge of the natural history of the disease. The initial trials of early forms of treatment with interferon done at other centres were inconclusive and associated with distressing side effects. Patients who wished to be involved with these early trials of treatment were referred to centres where these trials were in progress but I am not aware that any had significant sustained resolution of their liver disfunction. I am aware that with the passage of several decades some have died of Hepatoma – now a documented consequence of chronic hepatitis C.

2.4.33. Apart from liver disfunction following Factor VIII concentrate, hepatitis viruses can be transmitted by single blood donations, or other products made from these, such as "cryoprecipitate". In the early days of blood donation, donors were asked if they had ever been jaundiced and excluded if they had. As blood tests for liver disfunction, and the diagnosis of live disease developed, it became apparent that some causes of jaundice such as gallstones did not carry any risk of virus transmission. Hepatitis B caused by HBV was the first virus hepatitis for which there was a blood test for the presence of the virus. Since then other viruses have been identified including HCV. The risk of a post transfusion jaundice is increased with an increase in the number of blood donations which are pooled during production of a batch of concentrate. We aimed to reduce this risk by reducing the number of donations that were pooled in the production of the Factor VIII concentrate. Our studies suggested that at least 1 in 200 blood donors in the Oxford region carried the HCV for which there was then no test. These individual donors had no history of jaundice and were well and remained asymptomatic for many years, but later it was suggested that these patients could develop chronic liver disease and hepatoma, as happened with haemophiliac patients.

2.4.34. As far as I can remember I had no part in any of the discussions about the payments made to any of the patients who developed any of the viral infections following treatment with blood products.

2.4.35. Throughout the time I was seeing patients at the OHC my main professional base was either at the Radcliffe Infirmary or the John Radcliffe Hospital. My main out patient clinics and inpatients were there and my visits to the OHC were fitted around responsibilities at these other hospitals. I attended meetings of the Working group set up by the Haemophilia Centre Directors and the main meetings of the Centre Directors when these did not prevent me carrying out my other professional responsibilities and would attend for that part of a meeting that related to the work that I was involved with and I would then excuse myself to drive across Oxford to an outpatient clinic at the John Radcliffe Hospital.

2.4.36. From early 1998 to the end of 2006 I was a member of the General Medical Council, initially appointed by the Universities of Oxford and Cambridge and later as an elected medical member of the smaller council. During this time, because I was frequently working in London and away from Oxford, I could no longer go regularly to the Haemophilia Centre in Oxford or supervise the care of seriously ill inpatients at the JRH. I handed on these responsibilities in stages and completely from about 2000. Others took on the out-patient clinic at the OHC and the acute inpatient practice at the John Radcliffe Hospital which included haemophiliacs who had developed complications of advanced liver disease.

2.5. During the 1980s I had increasing teaching and other professional responsibilities and from 1996 – 1999 I was Deputy Director of Clinical Studies in the medical school in Oxford.

2.6. I retired from my university appointment and all clinical medical practice in 2006. I have not been involved with any of this work for over 20 years.

2.7. In addition to this throughout my career I was actively involved with the training of medical students and junior hospital doctors. From 1996-9 I was Deputy Director of Clinical Studies in the Medical School in Oxford with responsibility for curriculum design, lecturing and organising examinations in addition to the academic and pastoral supervision of individual students.

2.8. From early 1998 to the end of 2006 I was a member of the General Medical Council, initially as an appointed member of Council representing the Universities of Oxford and Cambridge and latterly as an elected member of Council. During this time I sat on many committees of Council and from 2003 to 2006 I chaired the Council's Fitness to Practice Committee.

2.9. I retired from my university post and Honorary Consultant contract at the end

of September 2006 and from the General Medical Council (GMC) from the end of December 2006. Since then I have done no medical work.

3. *Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.*

3.1. I am not a member of any of the groups relevant to the Inquiry.

3.2. During the time I was involved with the care of patients of the OHC I spoke with many patients who were members of the Haemophilia Society and was asked by them to speak with local groups about the current knowledge of the hepatitis viruses and their transmission. I remember attending meetings with groups of patients in Oxford, Alton, Glasgow, Edinburgh and Dublin but have no record of the dates or precisely who organised the meetings.

3.3. I was asked to assist the Hepatitis Working Group set up by the Haemophilia Centre Directors and I remember attending a part of some of their meetings. The Working group was frequently organised to meet at the OHC in Oxford and sometimes on a Tuesday while I was there seeing patients. I would attend for those agenda items to which I could contribute but excuse myself after these had been discussed. The minutes show that much of the discussion was about the incidence of liver disease and other problems in other cities and following the use of doses of brands of commercial Factor VIII concentrate which was not used in Oxford, so I could not contribute to this discussion and it had no relevance to my responsibilities, and there were other pressures on my time.

3.4. One of my aims in attending meetings of both the Hepatitis Working Group and the Centre Directors was to discuss with them the current knowledge of post transfusion hepatitis and to cooperate with those responsible for prescribing the clotting products in designing prospective studies of liver function before and after patients had a dose of Factor VIII in order to evaluate the true extent of liver damage and discover the incidence of these problems with different forms of factor VIII concentrate. (My experience both in the Renal Dialysis unit at the Hammersmith Hospital and in investigating liver damage after repeated Halothane anaesthetics was that the true extent of the problem when studied by these methods was usually much greater than previously thought.) Especially with an infectious virus such a hepatitis virus, exposure could lead in time to chronic inflammation of the liver and liver failure.

3.5. My colleagues at the Oxford Haemophilia Centre did co-operate with these

suggestions and together we designed and set up a succession of prospective studies which did show an increased incidence of abnormalities of liver function during the weeks after the patients were treated with their first dose of Factor VIII concentrate. When we followed up patients who had received a first ever dose of Factor VIII, very nearly all of these patients showed significant abnormalities of liver function tests. We showed that this occurred after a first dose of Factor VIII concentrate with all of the products that were then available for use by the OHC, both commercially produced Factor VIII and also those products from NHS laboratories. As our prospective studies progressed and we had results to report I went with my Oxford colleagues to meetings of the Centre Directors in order to report our findings.

4. *Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations, criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements, reports or documents that you provided.*

4.1. I have not been involved with or given evidence to any other inquiries, investigations, criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products.

4.2. I have provided two witness statements in response to criticisms raised (WITN3740001 and WITN37400002). Copies have already been provided to the Inquiry.

Section 2: Decisions and actions of the Oxford Haemophilia Centre

5. *Please describe the roles, functions and responsibilities of the Oxford Haemophilia Centre ("the centre") during the time that you worked there. Please provide an account of the Centre's history, its establishment and its activities during this time.*

5.1. I had no managerial responsibilities at the OHC and never saw any documentation about its roles, functions or responsibilities. By the time I was involved the centre was already established at the Churchill Hospital and I know nothing about its history – other than that Factor VIII was first isolated in Oxford by Dr MacFarlane and so initially treatment with factor VIII was only available in Oxford, hence many families with haemophiliac sons moved to live in the area. Although by the time I was involved other centres been had established, Oxford remained with the largest number of patients and some of the smaller centres had had the care of under 10 patients, so they looked to

the staff at Oxford for support and advice.

6. *Please identify senior colleagues at the Centre and their roles and responsibilities during the time that you worked there.*

6.1. At the time I was involved Dr Charles Rizza was the Centre Director and Dr James Matthews was another doctor permanently on the staff. There was also a succession of junior doctors, each appointed for about 4 to 6 months and who looked after haemophiliacs and some other patients who were admitted to the Churchill Hospital. Several nurses and secretaries were involved in distributing the Factor VIII concentrate to the patients' homes and visiting patients' homes to provide support and counselling. I am also aware there was a fractionation laboratory on the site, but I never entered it (it was a sterile area) or knew anything about the details of the staff roles there. Any necessary communication with them was conducted through the medical staff at the OHC.

7. *Please describe:*

   a. *your role and responsibilities at the Centre and how, if applicable, this changed over time;*

   b. *your work at the John Radcliffe Hospital insofar as it involved the care of patients with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.*

7.1 My role at the centre was to see patients who were found to have liver disfunction who were referred to me for a clinical assessment and to discuss their liver problems with them. I reported back to their GPs and to Dr Rizza. From the start I was expected to consider and discuss any possible research that could assess the scale of the problem of hepatitis after Factor VIII treatment and if possible reduce the incidence of liver disfunction after Factor VIII treatment. I advised prospective studies following up patients before and after a dose of Factor VIII to gain a more reliable estimate of the number of patients affected. The Centre directors were already collecting data on Factor VIII use throughout the country and also any other illness in haemophiliac patients and the cause of death of haemophiliacs throughout the country.

7.2 During this time several different approaches during the fractionation of the blood to reducing hepatitis virus transmission were undertaken. As I was not involved technically in this work, I cannot remember or describe the technical details but I know that some batches were heat treated by a variety of methods in an attempt to destroy any hepatitis virus present. The centre progressively reduced the number of blood donations from local blood donors that were pooled to produce a batch of Factor VIII concentrate.

Ideally the patients included in the studies were patients receiving blood products for the first time, but this was not always possible. These studies were approved by the local clinical research ethics committee (COREC) and every patient, or their parents as many were young boys, was given an information sheet explaining the purpose of the study and that, while they would be given the same product whether or not they engaged with the study, if they agreed we would arrange extra blood tests to be taken after treatment to follow up the patient's liver function. I no longer have a copy of this patient information sheet.

7.3. With a team of junior doctors and specialist nurses and other staff, I looked after inpatients with liver disease and if they required hospital admission for the complications of their liver problems, the haemophiliac patients were admitted to a side ward on this ward at the John Radcliffe Hospital. Some of these patients also had HIV but they only came under my care if their liver disease was the main reason for their hospital admission. These patients were often very ill and sadly some died. This occurred more often if the patients had complications of both liver disease and HIV infection. Even in these patients I never prescribed the Factor VIII treatment as this was still managed by the staff team from the Haemophilia Centre at the Churchill Hospital.

8. *Approximately how many patients with bleeding disorders were under the care of the Centre when you began your clinics and over the years that followed? (If you are able to give exact rather than approximate figures, please do so).*

8.1. I do not know how many patients with bleeding disorders were under the care of the OHC. I believe there were many hundreds of patients seen there. I was only involved with those whose liver disease became a clinical problem. I have no documents about this and after this period of time I am not sure how many I saw – probably between about 50 and 100.

9. *To the best of your knowledge, what decisions and actions were taken, and what policies were formulated, by the Centre, regarding the importation, manufacture and use of blood products (in particular factor concentrates) during the time that you worked there? What if any involvement did you have in these decisions?*

9.1. I was not involved in any decisions or actions taken, or what policies were formulated, by the Centre, regarding the importation, manufacture and use of blood products. I became aware that locally produced factor VIII concentrates were largely kept for the new and younger patients who had not had imported products before. I believe that this was because the imported product was known to have more contamination with Hepatitis B virus, while local blood donors were tested for HBV. However, as I worked

with these patients it became apparent that this was not necessarily true of NonANonB Hepatitis virus as we showed that all batches made from large pools of local donors were shown to produce abnormalities of liver function when given to patients who were receiving their first treatment with Factor VIII.

10. *What responsibility did the Centre have for the selection and purchase of blood products, and what decisions were taken by the Centre as to which products to purchase and use? In addressing this issue, please answer the following questions:*

    a. *How, and on what basis, were decisions made about the selection and purchase of blood products?*

    I have no knowledge of what responsibility the Centre had for the selection and purchase of blood products, or what decisions were taken by the Centre as to which products to purchase and use.

    b. *What were the reasons or considerations that led to the choice of one product over another?*

    I do not know how, and on what basis, decisions were made about the selection and purchase of blood products. I believe that there were several factors as to why one product was preferred to another. I was not involved in these decisions and am unable to help the Inquiry further with this point.

    c. *What role did commercial and/or financial considerations play?*

    I do not know if or to what extent commercial or financial considerations were involved.

    d. *What if any involvement did you have?*

    I was not involved with such decisions other than in the fringes of discussions about setting up the research projects that were aimed to reduce the incidence of NANB hepatitis that were set up in Oxford during the years I was involved.

11. *What particular products were used for treating patients at the Centre, over what period of time and for which categories of patients?*

11.1. I know some patients, in particular those receiving Factor VIII treatment for the first time, received a product containing Factor VIII which was produced in the NHS fractionation laboratories. I do not know what other products were used for treating patients at the centre.

12. *What was the relationship between the Centre and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Centre's decisions and actions?*

12.1. I had no knowledge of the relationship between the OHC and the pharmaceutical companies manufacturing/supplying blood products, or what influence that relationship had on the Centre's decisions and actions.

13. *If the responsibility for the selection and purchase of blood products lay with an organisation other than the Centre, please specify which organisation and provide as much information as you can about its decision-making.*

13.1. I cannot assist the Inquiry with this as I was not involved in any way.

14. *How were decisions taken as to which products to use for individual patients? What involvement did you have in such decisions?*

14.1. I never knew how decisions were taken as to which products to use for individual patients. The only involvement I had around decisions as to which products to use for any particular group of patients was in discussions during the planning of research which aimed to reduce the incidence of hepatic disfunction after a first dose of Factor VIII. Even then I had no knowledge of which patients would be included in this research as patients were all treated by staff at the OHC. I was only involved and met the patients if they developed liver disfunction after they had been treated.

15. *What alternative treatments to factor concentrates were available for people with bleeding disorders?*

15.1. I do not know what alternative treatments to factor concentrates were available for people with bleeding disorders.

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

16.1. I did not, have do not, have expertise in this area and cannot assist the Inquiry with this.

17. *What was the Centre's policy and approach as regards the use of cryoprecipitate for the treatment of patients with bleeding disorders?*

    a. *Did that policy and approach change over time and if so how?*

       I cannot help the Inquiry with this as I did not have any part in any discussions regarding the use of cryoprecipitate.

    b. *How, if at all, was the policy and approach informed by discussions had with external parties? In answering this question, you may wish to have regard to the minutes of the meeting of UK Haemophilia Centre Directors on 17 October 1983 (enclosed [HCDO0000248_005]), at which you were present, where it*

was decided that there was no need for patients to be encouraged to "go over" to cryoprecipitate for home therapy despite the growing concern regarding the AIDS crisis. What is your recollection of this debate? What was your view of this conclusion? Looking back, would you maintain that this was the correct decision? If not, why not?

I note that my name is listed in the minutes among attendees for the meeting of the UK Haemophilia Centre Directors on 17 October 1983 [HCDO0000248_005]. I also note that this meeting was on a Monday, when I routinely had a multidisciplinary meeting at 1pm with the histo-pathologists when we reviewed all liver biopsy specimens from the previous week. In the afternoon I would then lead a weekly ward round of all inpatients who were being looked after by my team. I also note that many topics were on the agenda for which I could not have made any contribution as they were focused on matters relating to the administration of Haemophilia Centres. I would have been at the Haemophilia Centre Directors' meeting only for that part of the proceedings 11a. which included an early report from the Hepatitis working group of studies which were being undertaken in Oxford in attempt to reduce the incidence of hepatitis after Factor VIII treatment. The infectious diseases team were involved with the management of HIV and Aids and I would not have prioritised staying for this over my routine ward work at the John Radcliffe Hospital. (Incidentally, as I was not a Haemophilia Centre Director but only a member of one of the working groups, I would not have been sent a copy of these minutes but I suspect that items on the agenda were not taken in the order in which they have been recorded in the minutes.) I was not involved at all in decisions as to what clotting factors were given to which patients and have no expertise relevant to this.

18. *What was the Centre's policy and approach in relation to home treatment? Did the policy and approach change over time and if so how?*

18.1. I was not involved in decisions about home treatment and have no knowledge of how the policy and approach changed over time.

19. *What was the Centre's policy and approach in relation to prophylactic treatment? Did the policy and approach change over time and if so how?*

19.1. I was not involved in decisions about the Centre's policy and approach in relation to prophylactic treatment and do not know how the policy and approach changed over time.

20. *What was the Centre's policy and approach in relation to the use of factor concentrates for children? Did the policy and approach change over time and if so*

how?

20.1. I was not involved in decisions about the Centre's policy and approach in relation to the use of factor concentrates for children and do not know how the policy and approach change over time.

21. To what extent, and why, were people with mild or moderate bleeding disorders treated with factor concentrates?

21.1. I have no knowledge of to what extent or why the Centre treated people with mild or moderate bleeding disorders with factor concentrates.

22. What viruses or infections, other than HIV, HCV and HBV, were transmitted to patients at the Centre in consequence of the use of blood products?

22.1. I can remember only haemophiliac patients with HIV, HCV (which we knew at that time as NonA NonB) and HBV. As I would only have seen any haemophiliacs with liver disfunction, I cannot comment on the transmission of other viruses as a consequence of the use of blood products.

Section 3: Knowledge of, and response to, risk

General

23. When you began work as a consultant physician at the Centre, what did you know and understand about the risks of infection associated with blood and/or blood products? What were the sources of your knowledge? How did your knowledge and understanding develop over time?

23.1. I was never on the staff of the OHC and when I first started seeing patients referred by the OHC in the mid 1970s, I was not a consultant, but I was a clinical lecturer in the department of the Regius Professor of Medicine, Professor Sir Richard Doll. At that time I held a honorary senior registrar contract with the Oxford Hospitals and was based at the Radcliffe Infirmary. Later I held a Research Fellowship with tenure with Oxford University in the Nuffield Department of Medicine under Professor Sir David Weatherall and I was based at the John Radcliffe Hospital. Shortly after this I was granted an Honorary Consultant Contract with the Oxford Hospitals.

23.2. It is possibly worth reflecting that throughout the time I was working with the team at the OHC, our knowledge of what was called NonA NonB Hepatitis (now called Hepatitis C) was less than the current knowledge of Covid-19 as the background science has advanced considerably during the intervening 30+years – eg before it became a problem in Europe the Chinese had already identified the genome of covid-

19 as an RNA virus – during the years I was involved with the OHC we did not know as much as this about hepatitis C. We did not even know if NANB was due to only one or to more than one virus.

23.3. I was trained by Professor Sheila Sherlock at the Royal Free Hospital in London and at that time I was taught that there were two viruses which caused viral Hepatitis, that caused by HAV was known as Infectious Hepatitis, and was spread by faecal contamination (often occurring as epidemics especially at times of social disruption caused by wars and natural disasters such as earthquakes) and Hepatitis caused by HBV which was known as Serum Hepatitis as it was spread by blood and blood products and equipment contaminated with blood and blood products such as occurred by the reuse of needles and the use of dialysis machines by more than one patient.

23.4. From 1969 and 1971 I worked as a Clinical Lecturer in Gastroenterology at the Royal Postgraduate Medical School at the Hammersmith Hospital where I investigated abnormalities of liver function in patients and staff on the renal dialysis unit there. At that time there were many fatalities from liver failure among patients and staff on dialysis units around the county. This proved to be due to infection due to what was later shown to be Hepatitis B Virus (HBV) but there was no laboratory test for this at that time. We showed that the infection was spread by the use of a dialysis machine by several patients. During dialysis the patient's blood flows through the machine and inevitably microscopic traces are left even after vigorous cleaning. Once a dialysis machine was infected by the HBV subsequent patients using this machine were exposed to the risk of catching Hepatitis B. This work at the Hammersmith Hospital, which was in conjunction with the Virology department, contributed to our understanding of the behaviour of HBV and subsequently to the development of simpler blood tests for the virus allowing a study of the natural history of the disease it could cause and also to the production of a vaccine against Hepatitis B. It allowed for tests of blood donors as it became obvious that chronic carriers of the HBV could be asymptomatic. Since that time any equipment that can become contaminated with blood is used only for one patient. This includes needles and syringes as well as more complex machines such as those used for renal dialysis.

23.5. Later it was shown that Hepatitis A did not have a chronic carrier state but that the Hepatitis A virus (HAV) was present in blood for a few days towards the end of the incubation period before the individual became clinically jaundiced and in the early period after they became jaundiced. During these this period, especially the few days before the patient realised that they were unwell, HAV could be transmitted by blood and blood products. More frequently HAV occurs in epidemics at times when normal sanitary arrangements fail, such as during wars and after earthquakes. It can also be

transmitted by poor hygiene during food preparation by an individual who over a short period is acutely infected but not yet unwell.

23.6. Around the time that I was first in discussion with staff at the OHC (probably early/mid 1970s), it was reported that some individuals had become jaundiced after transfusion with blood and blood products and when tested this illness did not test positive for either HAV or HBV. This illness became known as NonA NonB Hepatitis. I do not remember the earliest point at which I was aware of this. It could have been in discussion with the Blood Transfusion team in Oxford as I was frequently in contact with them for blood and blood products for my patients with chronic liver disease at the John Radcliffe Hospital. It may have been in discussion at a meeting of BASL of which I was a member and I attended their scientific meetings several times a year.

23.7. During the time I was seeing patients who were referred by OHC (I was never a Consultant on the staff of the Centre) we learnt more about the behaviour of the NonA NonB Hepatitis virus. We learnt that the illness this caused was widespread among haemophiliacs, and was assumed that this was spread by transfusion of blood products, both those produced by the NHS and more commercial brands imported from America and elsewhere. Follow up of patients showed that some patients developed chronic abnormalities of liver function and once HIV became another problem, some patients with NANB hepatitis developed rapidly progressive disease that progressed to liver failure and death.

24. What advisory and decision-making structures were in place, or were put in place at the Centre, at the John Radcliffe and/or within the Oxfordshire region, to consider and assess the risks of infection associated with the use of blood and/or blood products?

24.1. I was not involved with the management of the transfusion service or production of blood products or in the management of the OHC to know what advisory and decision-making structures were in place, or were put in place at the Centre, at the John Radcliffe and/or within the Oxfordshire region, to consider and assess the risks of infection associated with the use of blood and/or blood products. I reported my observations regularly to the doctors at the fractionation laboratories and OHC who were closely involved with the production and prescription of blood products.

25. What was your understanding of the relative risks of infection from (i) the use of commercially supplied blood products, and (ii) the use of NHS blood products?

25.1. I was told by staff at the OHC that the commercially produced and supplied blood products were more likely to be contaminated with hepatitis viruses as it was made from blood from donors in countries where they were paid, many were drug addicts and were more likely to be carriers of HBV and other viruses. Blood products made by the NHS were from blood from local donors who volunteered and it was less likely to be

contaminated with Hepatitis viruses. During this time tests for HBV became available and were used to screen donors in the UK but during our studies it became apparent that local donors could be carriers of NonA NonB hepatitis virus and as many as one in approximately 200 were carriers of what is now known as HCV.

26. *What decisions and actions were taken by the Centre and/or by you to minimise or reduce exposure to infection?*

26.1. By the time I was asked to see any individual patient they already had evidence of liver disfunction, and I was not involved in prescribing or giving any dose of Factor VIII, so I was not in any position to prevent that patient from exposure to any hepatitis virus. During the time I was involved in liaising with the staff at the OHC, we jointly planned several prospective studies which aimed to look at liver function tests after a patient's first dose of Factor VIII. The products tested looked at Factor VIII products which had been prepared in different ways. I remember no precise technical details of the products as I was not involved in their preparation, but what I do remember was that for some studies the Factor VIII was prepared either by heating in a variety of ways, and/or that the number of blood donations which were pooled to make any batch of Factor VIII concentrate was progressively reduced. Again, I have no research documents and remember no precise details but what I can remember was that the number of donations pooled was progressively reduced from several thousand to about two hundred.

Hepatitis

27. *When you began work as a consultant physician at the Centre, what was your knowledge and understanding of the risks of the transmission of hepatitis (including hepatitis B and NANB hepatitis/hepatitis C) from blood and blood products? What were the sources of your knowledge? How did that knowledge and understanding develop over time?*

27.1. I was never "a consultant physician at the Centre" as my appointment when I was first contacted by the medical team at the OHC was as a clinical lecturer in the department of the Regius Professor of Medicine, Sir Richard Doll, and at that time I held a senior registrar contract with the Oxford Hospitals and was based at the Radcliffe Infirmary. Later I held a Research Fellowship with tenure with Oxford University in the Nuffield Department of Medicine under Professor Sir David Weatherall and I was based at the John Radcliffe Hospital. During this time I was awarded an Honorary Consultant Contract with the Oxford Hospitals and my main clinical and academic base was at the John Radcliffe Hospital.

27.2. As to my understanding for the risks of transmission of hepatitis, please see my response to question 23 above.

28. *In particular, please explain how, if at all, your knowledge of risk changed as a result of your involvement in the research project entitled Studies of the epidemiology and chronic sequelae of factor VIII and IX associated hepatitis in the United Kingdom (Project number J/S240/78/7, reports attached [HCDO0000270_066 and HCDO0000270_005]), together with Dr Craske and Dr Rizza.*

28.1. Although these are the second and third annual reports on projects J/S240/78/7 they do not name this project and I do not know what this project is. Although they do not name the author, I think that they were drafted by the chairman of the working group and were in fact his reports. Although they quote extensively from work largely done in Oxford, and I am listed as involved with this study, little of this was work with which I was directly involved as it dates from before I was working alongside the staff there. I have no memory of their being discussed at meetings of the Hepatitis working party. My role was to assess clinically patients referred by the OHC who had abnormalities of liver function. These reports do not describe the prospective studies which I helped design.

28.2. I was not involved in any way in many of the studies reported in both of these reports which were based in centres other than Oxford – see answer to 29.

29. *What, if any, further enquiries and/or investigations did you carry out or cause to be carried out in respect of the risks of the transmission of hepatitis? What information was obtained as a result?*

29.1. Please see document HCDO0000270_066. My involvement in the studies reported here was in assessing the patients from OHC found to have blood tests of liver function in which the Serum Transaminase levels (in particular those which are known as “AST” and/or “ALT”) was significantly and persistently raised. My clinical assessment was largely to discover if the patients had any symptoms or signs of acute or chronic liver disease and also to exclude other possible causes of liver disfunction. These patients all had a history of receiving Factor VIII treatment over several years and from a variety of fractionation laboratories. I do not have any records but I can remember only one patient who I saw who had become a chronic carrier of HBV and none in which the abnormalities were associated with HAV or other viruses such as “Glandular Fever” in which liver function can become abnormal. The majority were assumed to have “Non A Non B Hepatitis” NANB (now known as Hepatitis C) although there was no test for this at that time.

30. *What, if any, actions did you take to reduce the risk to patients of being infected with hepatitis (of any kind)?*

30.1. HCDO0000270_066 also mentions and HCDO0000270_005 outlines a possible clinical trial, a prospective multicentre study of infrequently treated Haemophiliacs following their bloods tests for abnormalities of liver function during the weeks after their treatment. As far as I remember such a study was undertaken but did not provide useful information as the majority of these patients had previously received Factor VIII treatment on many occasions so could have been already infected with hepatitis viruses and they were scattered with treatment centres all over the country so I never had any contact with these patients. However, blood tests on those patients who had never received blood products (and who were I think from the OHC) did show that all the patients subsequently had abnormal liver function tests. After this I helped design several prospective studies on previously untreated patients which were carried out at the OHC and I was involved both in helping to design these studies and in assessing some of the patients clinically afterwards. These studies used different methods of preparation of the Factor VIII using heat and then products from serum pooled from decreasing numbers of blood donors. I was not involved in the preparation of these products and can remember few details but I believe that even with Factor VIII produced from as few as 200 pooled donations several previously untreated patients who received certain batches of Factor VII concentrate developed abnormalities of liver function in the weeks after the treatment. However the incidence reduced overall.

31. What was your understanding of the nature and severity of the different forms of blood borne viral hepatitis and how did that understanding develop over time?

31.1. Hepatitis A, previously known as Infectious Hepatitis and not normally associated with Hepatitis following transfusion with blood or blood products, was not as far as I can remember transmitted to any of the patients receiving Factor VIII or Factor IX during the time I was referred patients by the OHC.

31.2. Hepatitis B, previously known as Serum Hepatitis and known to be transmitted by blood and blood products, did occur in Haemophiliac patients cared for by the team at the OHC. This was predominantly but not exclusively in patients who had received commercially produced blood products that had been produced from paid blood donors overseas and who had received treatment early in the years I was involved. A few of these patients did become chronic carriers of HBV and some developed chronic liver disease and its complications. These patients had a long-term risk of Hepatocellular cancer.

31.3. Non A Non B hepatitis - NANB (Hepatitis C) occurred in the majority of patients who had a first treatment with Factor VIII although this was reduced by using heat treatment during the production of the Factor VIII concentrate. In most of these patients the illness was mild with few if any symptoms, no detectable clinical jaundice but with elevated serum enzymes and with a risk of progression to chronic liver disease. This

illness was more rapidly progressive in some of the patients who also tested positive for HIV and some of these patients died of liver failure.

32. *According to your second written statement that you provided to the Inquiry on 24 September 2019, WITN3740002], you held a weekly clinic at the Centre seeing patients with bleeding disorders who had been found to have abnormal liver function tests.*

For some years I did go to the OHC for a few hours on Tuesday mornings, and saw patients referred by the staff at the OHC who had been found to have abnormalities of liver function.

a. *Please describe the kind of abnormalities in liver function that you observed.*

These patients had a variety of abnormal tests of liver function. Some had elevated AST and ALT which are normally taken as markers of active liver cell damage but some had changes usually associated with chronic liver damage such as low levels of serum albumen. Some did have elevated serum bilirubin levels but in few was this high enough for them to be clinically jaundiced.

b. *Approximately how many patients would you typically see at one of your weekly clinics?*

I usually saw between one and four patients on any Tuesday morning when I went to the OHC.

c. *What if any explanations or information would you provide to patients about their abnormal liver function tests?*

My normal practice when seeing any patient with abnormal liver function was to take a full medical and personal history and, as alcohol can cause liver disease, I would routinely ask a patient what alcohol they drank. I would take a full clinical history including questions about their lifestyle, their occupation, any medication, both prescribed and any bought by the patient, any contacts with other jaundiced patients and any travel recently or in the past which might have contributed to these abnormalities. All the patients referred by the OHC had received blood products, often from several centres and including products produced by the NHS and Factor VIII produced by various commercial companies and originating from blood donors in other countries. I did not document these in detail as there was a separate system supported by all the Haemophilia Centres directors which documented this in detail. Depending on the answers to these questions, I would explain the relevance of different possible causes of their liver disfunction. For the Haemophiliacs, I would discuss the knowledge of the hepatitis viruses that could be transmitted

by blood products that we had at that time. For the majority of the patients who I saw at the OHC, this was a "Non A non B" – NANB hepatitis (Hepatitis C). Initially we had limited knowledge of the prognosis or the long-term consequences of this infection but as time passed it became apparent that some patients had progressed to chronic liver disease and might have evidence of liver failure such as jaundice and ascites. We knew (from service men who had jaundice while serving in Burma during WW2) that Hepatitis B could be associated years later with primary liver call tumours, but it was only with the passage of time that we became aware that this was also true of Hepatitis C. I would answer any questions the patient asked as fully as I could, given our knowledge and understanding at that time. If they had a regular heavy alcohol intake I would explain that we normally suggested a modification of this as there was some evidence that alcohol could exacerbate any liver disease secondary to viral hepatitis.

HIV and AIDS

33. *What was your knowledge and understanding of HIV (HTLV-III) and AIDS and in particular of the risks of transmission from blood and blood products during your time working at the Centre? How did your knowledge and understanding develop over time?*

33.1. When I started seeing patients who were referred by the OHC at the Churchill Hospital, I do not think any of us had heard of HIV(HTLV-III). I cannot remember when I first heard of this infection, but it would have been initially as an infection which was spreading among homosexual men in New York. Later it became known that this illness could also follow transfusion with blood and blood products. As the blood tests for this were developed, it became routine for all patients who were on treatment with blood products at the OHC to be tested. I do not know how many of their patients tested positive for HTLV-III as I was not directly concerned in their care as they were referred to the Infectious diseases team working out of John Warin Ward at the Churchill Hospital. Of the patients with Aids, I saw only those who also had abnormalities of Liver Function.

33.2. In due course we came to realise that those patients who had become infected with both viruses, HTLV-III and Non A Non B Hepatitis, had more rapidly progressive liver disease. Several of these men, who had the double infection, progressed over relatively few years to chronic liver disease with ascites and oesophageal varicies and sadly several died with liver failure. I do not remember seeing this rapidly progressive liver

disease in any patients who did not have the double infection.

34. *How and when did you first become aware that there might be an association between AIDS and the use of blood products?*

34.1. I do not remember when I first became aware that there might be an association between AIDS and use of blood products.

35. *What, if any, enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of transmission of HIV or AIDS? What information was obtained as a result?*

35.1. I was not involved with the investigation of patients with AIDS and cannot help the Inquiry with any investigations, actions or inquiries that were carried out at the OHC in this respect.

36. *What, if any, actions did you and/or the Centre take to reduce the risk to your patients of being infected with HIV?*

36.1. I was not involved with the investigation of patients with AIDS and cannot help the Inquiry with any investigations, actions or inquiries that were carried out at the OHC in this respect.

37. *Did the Centre continue to use factor concentrates to treat patients, after becoming aware of the possible risks of infection of HIV? Why?*

37.1. I was not involved in selecting in what form Factor VIII treatment was given to any Haemophiliacs or in prescribing or administering Factor VIII concentrates.

Response to risk

38. *Did you or your colleagues at the Centre take steps to ensure that patients were informed and educated about the risks of hepatitis and HIV? If so, what steps?*

38.1. I encouraged staff at the OHC to refer patients who were found to have abnormal liver function and to discuss with them what was then known of the risks of transmitting Hepatitis with blood products. All the patients who I saw had this information from me and they had the opportunity to question me about our knowledge of this risk. I also discussed this with members of patients' families when these came with them. I spoke with groups of patients who were members of the Haemophilia Society. As I was not involved with HIV I did not discuss this in any detail with the patients who I saw but I was aware that the staff at the OHC did refer these patients to the team on John Warin Ward who were involved with HIV.

39. *When did the Centre begin to use heat treated factor products and for which*

categories of patients?

39.1. I do not remember when the OHC began to use heat treated products although I do know that this was in association with the prospective clinical trials which were conducted. Several methods of heat treatment were tried in the attempt to produce a product that still contained enough Factor VIII to be effective therapy but also succeeded in killing the virus.

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

40.1. I was not involved with the selection of what product was considered suitable for what patient or its production, but I do know that there was considerable effort by the fractionation laboratories directed towards producing a product that was both effective treatment and "safe". This was breaking new ground and no-one knew in advance if a heat treated product would be less likely to transmit NANB.

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

41.1. I was not involved with the selection of what product was considered suitable for what patient and was never involved in deciding what blood product to prescribe, so I do not know if the staff at the OHC reverted to using cryoprecipitate or, if they did, how they selected which patients would be offered `cryoprecipitate.

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

42.1. As far as I could judge the staff at the OHC took the risk of infection from blood products very seriously and called in expertise both with regard to the management of individuals with chronic liver disease and also with AIDS, although I was not involved with the latter. I was keen from the first discussion to discover the true extent of the risk of Non A Non B Hepatitis after blood products, and I encouraged the staff both to refer patients with abnormalities of liver function and once we had established a real risk of this infection, to discover the true incidence by studying patients receiving their first treatment with blood products. The fractionation laboratories produce heat treated products for these studies and from increasingly small donor pools. As we had no test for this virus we could not test donors and learnt about the natural history of the infection only by studying patients receiving their first dose of Factor VIII produced by various methods.

43. *Looking back now, what decisions or actions by you and/or by the Centre could and/or should have avoided, or brought to an end earlier, the use of infected blood products?*

43.1. The studies I have described were lengthy and time consuming and could not be rushed as we were dependent on recruiting patients with Haemophilia who had not had any previous treatment with blood products. Apart from the overall design of these studies, I was not involved in the decision as to which product to prescribe to any individual patient. I am not aware of any decisions or actions by myself or the Centre which could and/or should have avoided, or brought to an end earlier, the use of infected blood products. As far as I know at that time there were no other products available to treat these patients.

44. *What actions or decisions or policies of other clinicians or other organisations, within your knowledge, played a part in, or contributed to, the scale of infection in patients with bleeding disorders? What, if anything, do you consider could or should have been done differently by these others?*

44.1. The scale of the problem caused by blood products infected with HCV and HIV was in large part due to the relatively widespread use of blood products containing these viruses at a time when we did not know that these viruses existed, had no knowledge of these viruses or of the diseases which they caused. At that time there were no tests which could have excluded blood donors and donations which were contaminated with the viruses. We were also not aware of the molecular structure of the viruses or of Factor VIII so there was no source for this treatment other than from blood donors. Once blood had been fractionated to enable Factor VIII to be prepared as a pure concentrate and its efficacy in treating Haemophilia had been demonstrated, there was obviously pressure from parents to treat boys and young men with this life altering and life shortening disease. Although I was not involved, I was told that the concentrate allowed for the development of a scheme of home treatment whereby haemophiliacs could receive treatment in their own homes and so have an almost normal life. What had not been discovered or predicted was the range of viruses that were present in the blood of apparently healthy blood donors and which were selectively channelled into the fraction of the blood which contained Factor VIII. Given the state of scientific knowledge at that time I doubt that this could have been predicted.

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

45.1. When there were no tests for HCV or HIV and little was understood about their

biology, it is difficult to discover how to inactivate them, other than by the studies that involved using the blood products produced by various methods to treat previously untreated patients and in following these patients to discover if they developed any evidence of infection. I cannot remember when the fractionation laboratories first started to try methods to inactivate the viruses but certainly with the increasing awareness of HIV, the funding for such work became more available.

Section 4: Treatment of patients at the Centre and/or at the John Radcliffe Hospital

Provision of information to patients

46. What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients at the Centre with a bleeding disorder about the risks of infection in consequence of treatment with blood products (in particular, factor concentrates) prior to such treatment commencing? Please detail whether, and if so, how this changed over time.

46.1. I never saw patients with bleeding disorders at the OHC prior to treatment as I only saw those who were referred later with abnormalities of liver function following their treatment with blood products or concentrates. Because of this, I am unable to tell the Inquiry what information patients were given prior to any treatment with blood products except for those patients entering the trials described below.

46.2. I was involved with the design of a series of studies using various special blood products produced by heat treatment of the product and/or using successively smaller donor pools. These studies looked at previously untreated patients and the studies were conducted with the approved by the Clinical Research Ethics Committee in Oxford (COREC) and with their approval every patient and/or their parents when appropriate as many were young boys, were given a written information sheet which explained the reasons for and aims of the study. I no longer have a copy of this information sheet but I do remember that in explaining the reasons for the study it clearly outlined what we knew about the risks of transmission of the hepatitis viruses. All were given this document before they consented to enter the trial and were given an opportunity to ask questions about the information contained in the information sheet. As I did not prescribe or administer Factor VIII products I did not personally propose patients as suitable for the trial or conduct these discussions before consent was obtained to participate in the trial.

47. What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients about alternatives to treatment with

factor concentrates? Please detail whether, and if so, how this changed over time.

47.1. As I did not prescribe or administer Factor VIII products, or see patients before treatment, I do not know what information was provided by others to patients about alternatives to treatment with factor concentrates or how this changed over time.

48. What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients before they began home treatment/home therapy?

48.1. As I did not see patients at this stage and did not prescribe or administer Factor VIII products or recommend patients for home treatment/home therapy, I do not know what information was provided by others to patients before they began home treatment/home therapy.

HIV

49. When did you first discuss AIDS or HIV (HTLV-III) with any of your patients?

49.1. I cannot remember when I first discussed AIDS or HIV (HTLV-III) with any of my patients.

50. Please describe how and when you learned that patients under your care/the care of the Centre had been infected with HIV.

50.1. I cannot remember how and when I learned that patients under my care or the care of the Centre had been infected with HIV.

51. What if any arrangements were made at the Centre (or at the John Radcliffe) for pre-test counselling?

51.1. Patients from the OHC who were thought to be at risk of HIV were referred to the Infectious diseases team on John Warin Ward (JWW). I was not involved with patients at this stage of their care and I do not know what pre-test counselling was undertaken at the OHC or if they were referred directly to JWW for this discussion.

52. How and when and by whom were patients told that they had been, or might have been, infected with HIV? Were they told in person, by letter or by phone? Were they seen individually or in groups? What if any involvement did you have in this process?

52.1. I was not involved with patients from the OHC at this stage of their care and I do not know what or how patients at the OHC were told of a positive test for HIV. I was not involved in this process.

53. What information was given to them about the significance of a positive diagnosis? Were patients told to keep their infection a secret?

53.1. I was not involved with patients from the OHC at this stage of their care and do not know what information was given to them about the significance of a positive diagnosis or if patients were told to keep their infection a secret.

54. What was the Centre's/your policy in relation to testing partners/family members of people known or suspected to be infected with HIV? Under what circumstances were the tests carried out?

54.1. As I was not involved I do not know what was the Centre's policy in relation to testing partners or family members of people known or suspected to be infected with HIV, or under what circumstances the tests were carried out. If I saw patients in other contexts who were known to test positive to HIV, I did, on the very few occasions when this occurred, discuss with the patient the risk of sexual transmission of HIV and ask them to alert any sexual partners to this possibility and advised that they should discuss with then the possibility of making an appointment to be tested.

55. What, if any, information or advice was provided by you or colleagues at the Centre to partners or family members of people who were at risk of infection with HIV or were infected with HIV?

55.1. I was not involved with patients from the OHC or their partners or family members at this stage of their care and do not know what if any arrangements were made at the Centre for post-test counselling. Any patients from the OHC who tested positive for HIV had already been told of this before they were admitted to the John Radcliffe Hospital. This admission would be because of a complication of their liver disease and not any other complication directly related to their HIV status.

56. What if any arrangements were made at the Centre (or at the John Radcliffe) for post-test counselling?

56.1. I was not involved with patients from the OHC or their partners or family members at this stage of their care and do not know what if any arrangements were made at the Centre for post-test counselling. Any patients from the OHC who tested positive for HIV had already been told of this before they were admitted to the John Radcliffe Hospital. This admission would be because of a complication of their liver disease and not any other complication directly related to their HIV status.

57. How many patients at the Centre were infected with HIV? Of those infected,

a. How many had severe haemophilia A?

b. How many had moderate haemophilia A?

c. How many had mild haemophilia A?

d. How many had haemophilia B or von Willebrand's disease?

e. How many were children?

57.1. As I had no general, clinical or managerial responsibility for all the patients at the OHC and was not specifically involved with patients with HIV infection, I do not think I ever knew how many patients at the Oxford Haemophilia Centre were infected with HIV or the nature of their coagulation problem or their age profile.

58. Was work undertaken at the Centre to establish the time period during which patients seroconverted? If so, please describe what work was done and what if any conclusions were reached.

58.1. I was not involved and do not know if any work was undertaken at the Centre to establish the time period during which patients with HIV seroconverted or what, if any, conclusions were reached.

Hepatitis B

59. Were patients infected with hepatitis B informed of their infection and if so, how? What information was provided to patients infected with hepatitis B about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?

59.1. I am only able to describe what information about their infection was discussed with patients infected with hepatitis B who were referred to me. These patients were cared for by the OHC and when I first met them and discussed hepatitis B with them I formed the view that they were already well informed about this. I told them what was known about the HBV including the normal route of transmission of the infection through the transfusion of blood products, or needle stick injuries with needles or the use of equipment already contaminated with HBV, and by sexual contact; the clinical presentation both with and without jaundice; and the natural history of the disease as acute and chronic disease and the possible long-term risk of primary hepatocellular cancer. I explained that we could test patients and blood donors for HBV and as a result these individuals in Britain were prevented from being blood donors and consequently Factor VIII prepared from these donations was rarely if ever contaminated with HBV. At that time there was no proven treatment for infections with the HBV but some centres were running clinical trials treating patients who were chronic carriers of HBV with interferon and patients were offered the option of referral to these clinics if they wished. If they developed evidence of the complications of liver failure secondary to chronic liver damage and cirrhosis these could be treated by the team at the JRH. I saw these patients as out patients at the OHC and if they required admission to the JRH they

could be admitted to beds in isolation rooms on the ward where the team that I lead cared for patients with liver disease.

60. How many patients at the Centre were infected with hepatitis B?

60.1. I do not know how many patients attending the OHC were infected with HBV but I can only remember caring for one although there may have been more than this.

NANB Hepatitis/Hepatitis C

61. Were patients infected with NANB hepatitis informed of their infection and if so, how and by whom? What information was provided to patients infected with NANB hepatitis about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?

61.1. I am only able to describe what information of their infection was discussed with patients infected with NANB who were referred to me. These patients were cared for by the OHC and referred to me when they were found to abnormal liver function tests. When I first met them and discussed NANB with them I formed the view that they were already as well informed about this as we were at that time. The information about NANB provided to patients changed over the years as our understanding of NANB increased. The patients who were referred to me would have the opportunity to question me about the possible cause of their illness and I answered them explaining that we were learning more about this as we documented the problems of liver disfunction associated with the transfusion of blood products produced to correct their deficiency of Factor VIII. We became increasingly aware that these patients were developing an illness related to their treatment and that this could occur whatever the source of the product. This implied that healthy local blood donors who had no history of liver disease could transmit a NANB virus. I would explain to these patients that I was working with the staff of the OHC in an attempt to discover more about the virus and to produce products that did not transmit any NANB virus. At that time we did not know how many viruses were involved and there was no test which we could use to exclude any blood donors who carried any of these viruses. There was no documented treatment but later other centres did run trials treating NANB with interferon and I told patient this and if they asked to be referred I would arrange this. In time we observed that some patients developed chronic liver disease and its complications. Later we learnt that this illness appeared to progress to liver failure more frequently and more rapidly in some, but not all of the patients who tested positive for HIV.

62. When did the Centre/the John Radcliffe begin testing patients for hepatitis C? How,

when and by whom were patients informed of their diagnosis of hepatitis C? Were they told in person, by letter or by phone? What if any involvement did you have in this process?

62.1. I do not know when the Centre or the John Radcliffe begin testing patients for hepatitis C but I do not remember this being available during the time that I was involved in caring for these patients. I do not know when and by whom the patients were informed of their diagnosis of hepatitis C or if they were told in person, by letter or by phone as I was not involved in this process.

63. *What information was provided to patients infected with hepatitis C about their infection, its significance, prognosis, treatment options and management?*

63.1. I do not know what information about the significance of the test, prognosis, treatment options or management was provided to patients infected with hepatitis C about their infection once there was a specific test as I was not involved with these patients at the time that a test had become available.

64. *How many patients at the Centre were infected with hepatitis C?*

64.1. I do not know how many patients at the Centre were infected with hepatitis C.

Delay/public health/other information

65. *Were the results of testing for HIV and hepatitis (of all kinds) notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, explain why.*

65.1. I did not arrange testing for HIV and hepatitis of patients attending the OHC, as I was only involved in discussing the results of testing for HIV and hepatitis (of all kinds) with patients referred to me after these tests had been done, so do not know if they were informed promptly, or if there were delays in informing patients of their diagnosis.

66. *To what extent, if at all, did you/your colleagues take into account the public health implications of HIV, AIDS, hepatitis B, NANB hepatitis and hepatitis C, when taking decisions as to what information or advice to provide to patients or what treatment to offer patients?*

66.1. I was involved with patients from the OHC who tested positive for HIV only if they also had abnormalities of liver function. Patients testing positive for HIV who did not have abnormalities of liver function were referred for specialist care to the team working from John Warin Ward. The letter inviting a patient to my clinic always suggested that they could bring family members or friends to any clinic appointment that they had with me. This allowed for discussion about what was known about the risks of infection with

household members and sexual partners. If any of these patients developed complications of their liver disease that required in patient treatment they were admitted to a side room that had facilities for full barrier nursing on a ward at the John Radcliffe Hospital where the staff were experienced in caring for patients with the complications of liver disease and were able to discuss any issues relating to their illness that the patient or a family member or partner wished to discuss.

67. What information was provided to patients about the risks of other infections?

67.1. All patients referred to me we told that anyone who had chronic liver disease or liver failure was at increased risk of other infections and they should take these seriously and seek medical attention promptly. Many who were admitted under my care were admitted because they had an intercurrent infection which often lead to decompensation of their liver function and further complications.

68. What information was provided to patients about the risks of infecting others?

68.1. A part of taking a clinical history involved asking patients about their contacts with family and household members and also any sexual partners. I would discuss the routes of spread that we knew for HBV which did include needlestick injuries with contaminated needles and also sexual contact, especially but not exclusively among male homosexuals. At that time much less was known about the routes of spread of NANB but I would always discuss what we knew at that time. A study was conducted by the OHC among family members and sexual partners of Haemophiliacs looking for evidence of HIV, HBV and liver disfunction, but I was not directly involved in this.

69. What actions or decisions were taken by the Centre and/or the John Radcliffe to trace patients who may have been infected through the use of blood or blood products?

69.1. Although I was not directly involved in tracing patients who received blood products from the OHC I know that all patients who received treatment regularly from the centre we invited to attend every six months or annually for a general review. From the time that I was taking referrals of patients from the OHC, they included tests of liver function and for HBV among the blood tests that were routinely taken at this review. Later blood tests for HIV (HTLV3) were also included in this routine review.

Consent

70. How often were blood samples taken from patients attending the Centre and/or John Radcliffe Hospital and for what purposes? What information was given to patients about the purposes for which blood samples were taken? Did the patients give informed consent to the storage and use of the samples?

70.1. The frequency of blood tests depended on the clinical state of the patient. Out patients who were attending the OHC for routine review would be tested at that time. I was not involved in the care of all these patients so do not know all of the tests that were requested by the staff at the OHC. For those patients who saw me, blood would have been taken for tests of liver function and for those blood borne viruses for which we had tests at that time. I would explain this and later discuss the results of these tests with the patient. They were told that we were actively investigating the possibility of other blood borne viruses associated with Factor VIII treatment and that some serum would be stored for tests that might become available in the future. Inpatients at the John Radcliffe under my care were acutely unwell with conditions that fluctuated within hours. They would have had blood tests take more frequently, daily if they were acutely unwell. These tests would have screened for any anaemia, evidence of bacterial infection as well as tests of liver and renal function and electrolyte levels in the serum. Tests for blood borne viruses would not routinely have been done at this time as they had usually been done already by the OHC. Inpatients under my care were told about the blood tests that were being taken. One of the complications of liver failure is that patients can become very confused and can become unconscious with a metabolic coma. As these unconscious patients can recover with appropriate treatment, we could not always obtain informed consent at the time we took the test but would still briefly explain about the blood tests. We would proceed as obtaining result of these tests would guide the treatment given as a matter of urgency which could lead to the recovery of the patient's acute deterioration. Because of this it was considered to be in the best interests of the patient to proceed to take blood for those factors, such as the serum electrolytes the results of which would guide treatment.

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

71.1. I never prescribed or administered Factor VIII to any patient as this was always done by the team from the OHC. When Haemophiliac patients with liver disease were in the ward at the John Radcliffe Hospital and were in metabolic coma (see answer to 70) associated with haemorrhage from oesophageal varices into their gut, we did give blood transfusion when necessary without the patient being aware, as not to do so urgently when required would have shortened the patient's life.

72. *Were patients under your care (at the Centre and/or at John Radcliffe) tested for HIV or hepatitis or for any other purpose without their express consent? If so, how and why did this occur? What was your approach to obtaining consent for testing?*

72.1. I would not have tested patients at the OHC for HIV or Hepatitis viruses as this would have been done at their routine follow up visit before they were referred to me. Other routine blood tests were done on unconscious patients in liver coma (see answer to 70).

PUPS

73. Please detail all decisions and actions taken at the Centre by you or with your involvement with regard to a category of people referred to as 'previously untreated patients' (PUPS).

73.1. I never saw previously untreated patients (PUPS) before treatment. My only involvement with them was in suggesting the design of the studies which were carried out to discover the frequency and severity of liver disfunction after a first dose of Factor VIII. There were a series of these studies and I do not remember the precise details, but the OHC were interested to discover the frequency of liver disfunction after a first treatment with NHS produced Factor VIII concentrate, and then to adapt the methods used to produce these products in an attempt to reduce the transmission of hepatitis viruses. Initially this was using several methods to heat treat the product in an attempt to destroy any virus present. Later studies were designed to reduce the risk of transferring any virus by also reducing the number of blood donations which were pooled to produce a batch of the product that was transfused into the patient. This was also heat treated. These research studies were all submitted to and approved by the local research ethics committee (COREC). All patients (or their parents as many were young boys) were given a full verbal explanation and also a written sheet detailing the background and the purpose of the study and what would be involved for them.

Research

74. Please list all research studies that you were involved with during your time as a consultant at the Centre. In relation to those research studies that could be relevant to the Inquiry's Terms of Reference, please:

a. Describe the purpose of the research.

I was involved initially in assessing clinically any haemophiliacs found to have abnormalities of liver function. This was to excluded other possible reasons for these abnormalities and lead to the assumption that this was possibly due to a NANB virus transmitted in the blood products that they had received.

As described in the answer to 73, the main research I was involved with concerned the design of the prospective studies on PUPS.

The purpose of the research was to initially discover the "size of the problem" - the frequency of liver disfunction after a first dose of Factor VIII, and in later studies to reduce this by either destroying the virus by heat treatment of the Factor VIII concentrate during production, or by reducing the number of blood donations pooled to produce a batch of Factor VIII concentrate – or by a combination of both heat treatment during production and a reduction in the size of the pool of blood donations.

b. Explain the steps that were taken to obtain approval for the research.

The designs of all these studies were submitted to the local research ethics committee (COREC) and after discussion they were approved by them.

c. Explain what your involvement was.

My involvement in discussion with the doctors at the OHC was to suggest the design of the study and to help draft the information sheet and the papers that were submitted to the Research Ethics Committee. I do not have any records of these studies or their results.

d. Identify what other organisations or bodies were involved in the research.

I had suggested such studies to the hepatitis working party, but although they favoured a multicentre study this did not prove practical. The NHS fractionation laboratory produced the products that were involved in the research.

e. State how the research was funded and from whom the funds came.

I was not involved in applying for or administering the funding for these studies and do not know of any additional funds or from where they were procured.

f. State the number of patients involved.

I do not remember how many patients were involved.

g. Provide details of steps taken to inform patients of their involvement and to seek their informed consent.

These research studies were all submitted to and approved by the local research ethics committee (COREC). All patients (or their parents as many were young boys) were given a full verbal explanation and also a written sheet detailing the background and the purpose of the study and what would be involved for them. The patient received the same Factor VIII product that they would be prescribed whether they joined the study or not but, if they entered the study it would require additional blood tests in the weeks afterwards.

h. Provide details of any publications relating to the research.

I have no copies of any documents or publications but all results were reported to meetings of the Haemophilia Centre Directors.

75. The Inquiry understands, from information that has been provided to it, that the various research studies undertaken at the Centre included the following:

a. research into the development of Factor VIII, including pharmacodynamic studies in the early 1980s to determine the efficacy of the products;
b. a study of home treatment;
c. studies on small pool Factor VIII to try to determine whether or not it was safer than large pool material with regard to transmission of hepatitis;
d. a prospective study of post-transfusion hepatitis in previously untreated or infrequently treated patients;
e. monitoring safety of heated Factor VIII by careful follow-up of recipients;
f. research on the prevalence of HIV in the UK haemophiliac population;
g. a long-term study of immunity in haemophiliacs.

Please set out what you recall of these research studies and explain what involvement you had in them.

75.1 Of the studies described I was only involved in c. d. and e. I have described my involvement in these studies in my answer to 74. I helped design the studies and suggested what tests of liver function should be included and followed before and after treatment.

76. Please in particular explain your involvement in the research project entitled Studies of the epidemiology and chronic sequelae of factor VIII and IX associated hepatitis in the United Kingdom (Project number J/S240/78/7) in which you were involved together with Dr Craske and Dr Rizza.

76.1. The paper entitled *Studies of the epidemiology and chronic sequelae of factor VIII and IX associated hepatitis in the United Kingdom* (Project number J/S240/78/7)

(HCDO0000270_066) was not drafted by me and much of what it describes as originating from the OHC was not my work. My only involvement was to arrange to assess clinically those patients with abnormal liver function tests who were referred by the OHC to my clinic. Before I started seeing regular referrals from the OHC a research fellow reviewed all their patients with abnormalities of liver function but was not trained in the specialty so was not able to assess if there were any other possible causes of their liver disfunction. Later I was invited to review some of these patients who were unwell, but I did not see all the patients referred to in this report. There was also a secretarial team based at the OHC who collected and collated the data that was obtained from other haemophilia centres.

77. *What do you understand to be the ethical principles that should guide research? Did you apply those principles to the research studies referred to above and if so, how? If not, why?*

77.1. Research studies should be well planned and designed to answer a specific question(s) with no or minimal risk to the patient. Retrospective reports should not contain information that can be identified as coming from an individual without their consent. Any prospective research should be undertaken with the patient's full knowledge and consent. The studies reported in Project number J/S240/78/7 were retrospective studies and as far as I can see the text does not provide data such that any individual patient can be identified and it documents harm done by the routine treatment of patients and not by the study itself. It could be argued that this was audit rather than research as it was an attempt to assemble the data from many centres in order to discover the risk of liver damage after the use of various products containing Factor VIII. I was not involved in prescribing or giving any of the treatment with Factor VIII or in assembling the data reported in this study.

78. *Were patients involved in research studies without their express consent? If so, how and why did this occur?*

78.1. I was not involved in any studies at the OHC in which patients were involved without express consent from the patient or, where they were young boys, the consent of at least one their parents. I was not sufficiently involved in other studies to be able to comment on these.

79. *Was patient data (anonymised, de-identified or otherwise) used for the purpose of research or for any other purpose without their express consent? If so, what data was used and how and why did this occur?*

79.1. Data about Factor VIII use was reported centrally but I was not sufficiently involved in this or other studies to be able to comment on this.

80. *Was patient data (anonymised, de-identified or otherwise) shared with third parties*

(e.g. UKHCDO, Dr Craske) without their express consent? If so how, and why did this occur, and what information was provided to whom?

80.1. Anonymised retrospective data about the use of Factor VIII and some of the complications was shared with the Hepatitis Working Party (HWP) and the UKHCDs. I do not remember any instance when an individual patient was reported in a way in which he could be identified and again this was used as a form of audit to inform and improve the outcomes for patients treated with Factor VIII. Patients with whom I was involved did know that discussions took place between the directors from those centres all over the UK which used Factor VIII treatment. Meetings of the local members of the Haemophilia Society often took place in conjunction with meetings of the centre directors and presentations of the work that was being undertaken in Oxford were given to members of the Haemophilia Society in both Glasgow and Dublin when the centre directors met there.

81. Please provide details of any articles or studies that you have published insofar as relevant to the Inquiry's Terms of Reference.

81.1. I have kept no documentation or details of any publications of this work since my retirement.

Treatment of patients who had been infected with HIV and/or Hepatitis

82. How was the care and treatment of patients with HIV/AIDS managed at the Centre and at the John Radcliffe? In particular:

a. What steps were taken to arrange for, or refer patients for, specialist care?

The treatment of patients with HIV/Aids was managed between the staff at the OHC and those on John Warin Ward at the Churchill hospital who managed patients with HIV. I was involved only when the complications of chronic liver disease required more urgent intervention and treatment on the specialist ward at the John Radcliffe.

b. What treatment options were offered over the years to those infected with HIV?

I was not involved and cannot comment on the treatment options that were offered over the years to those infected with HIV.

c. What information was provided to patients about the risks and benefits of specific treatments and about side effects?

I was not involved and cannot comment on what information was provided to patients about the risks and benefits of specific treatments and about side effects.

83. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?*

83.1. I was not involved and cannot comment on what follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV.

84. *How was the care and treatment of patients with hepatitis B managed at the Centre and at the John Radcliffe? In particular:*

a. *What steps were taken to arrange for, or refer patients for, specialist care?*

b. *What treatment options were offered over the years?*

c. *What information was provided to patients about the risks and benefits of specific treatments and about side effects?*

84.1 The care and treatment of patients with hepatitis B managed at the Centre and at the John Radcliffe was as was available at that time. Initially there was no treatment that destroyed the HBV and care was directed at symptom control. As clinical trials with Interferon were started in various centres I would discuss this with patients and explain that there were side effects from this drug, but if they wished treatment I could transfer their care to a centre where a trial was taking place.

84.2. In response to (a): Patients with abnormal liver function were referred to me and seen in a clinic at the OHC. If patients required inpatient treatment for the complications of the liver disease they were admitted to the ward at the John Radcliffe which had specialist experience in the management of such problems.

84.3 In response to (b): During the early years that I was involved at the OHC, the only treatments that were available for HBV were either symptomatic treatment of the acute infection or management of the complications of chronic liver disease and liver failure. Later there were clinical trials in several centres of treatment with Interferon but as we saw very few patients with HBV in Oxford, I would discuss this with a patient and if they were interested I offered to refer them to a centre where such a study was in progress. I only remember one patient at the OHC who tested positive for HBV and I remember discussing this with him but that he was an asymptomatic carrier of HBV by the time I saw him and he declined treatment. His wife had also contracted HBV and was acutely ill but had cleared the virus within weeks and by the time she came to my clinic, so the question of Interferon did not arise.

84.4 In response to (c): Treatment with interferon was very much in the experimental stage at that time and I would explain this as there was no guarantee that a course of treatment

would remove the virus or alter its infectivity. Interferon treatment did cause acute and quite unpleasant side effects and I would describe these to the patient.

85. What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis B?

85.1. The one patient with HBV who I remember seeing at the OHC was on home treatment and so was reviewed six monthly or when treatment for joint bleeds required more active intervention than he could provide for himself.

86. What if any involvement did you and/or colleagues at the Centre or at the John Radcliffe have with any clinical trials in relation to treatments for HIV and Hepatitis C? Please provide details.

86.1. I was not involved in any of the clinical trials of treatment for HIV as these patients were cared for by the infectious diseases team on John Warin Ward. During the time I was involved with the care of patients from the OHC, we could not test routinely for HCV and we were at the stage of documenting the frequency and natural course of the disease. As the patients were largely asymptomatic and their liver dysfunction was low and fluctuated and any progress of the disease was slow except when the patient was also infected with HIV, clinical trials were not easy to devise and in general charted the level of active inflammation on repeated liver biopsies which we did not do on Haemophiliacs in Oxford. I remember discussing studies with the team from the liver unit at St Mary's in London but remember only early research studies they were doing of the virus markers in the blood but cannot recall any details.

87. How was the care and treatment of patients with NANB hepatitis managed at the Centre and at the John Radcliffe? In particular:

a. What steps were taken to arrange for, or refer patients for, specialist care?

b. What treatment options were offered over the years?

c. What information was provided to patients about the risks and benefits of specific treatments and about side effects?

87.1 Patients with abnormal liver function tests were referred to me and seen at the OHC on a Tuesday morning when they came to the centre for a routine follow up visit. I saw these patients personally and once blood tests and clinical examination had excluded other causes the patients were assumed to have NANB hepatitis, as we had no specific blood tests for this at that time.

87.2 For the majority of the time that I was involved at the OHC there was no specific treatment for the patients who had NANB. Later some centres were undertaking treatment with interferon or prednisolone for patients who had NANB

hepatitis, but as both these treatments have unpleasant and potentially serious side effects and as there was little evidence that the treatment altered the course of the illness, this treatment was not administered routinely in Oxford. The trials at other centres were discussed with the patients and if they wished they were referred there for further treatment. Patients who developed the complications of chronic NANB hepatitis were admitted if necessary to the John Radcliffe and their treatment was supervised on a specialist ward.

87.3 The outcomes of any studies and side effects that were reported were discussed. Steroids if given in the long term can produce central obesity with skin changes and metabolic effects including osteoporosis and electrolyte changes. The moon shaped face is the most immediately obvious side effect. Throughout this time there were no specific tests for the virus but the best outcome was a temporary improvement in liver function but this frequently reverted once the medication was stopped, suggesting that the effects of the virus were supressed but there was no long-term effect or removal of the virus.

88. *How was the care and treatment of patients with hepatitis C managed at the Centre and at the John Radcliffe? In particular:*

a. *What steps were taken to arrange for, or refer patients for, specialist care?*
b. *What treatment options were offered over the years?*
c. *What information was provided to patients about the risks and benefits of specific treatments and about side effects?*

88.1 During the time I was involved at the centre there was no specific test for HCV so the patients were diagnosed as having infection with NANB, and so the answers to these questions are identical to those provide in response to 87, a. b. and c.

89. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis C?*

89.1. As we had no test for HCV we referred at that time to patients with NANB hepatitis. The patients once referred to me were seen at regular intervals when they attended for the six-monthly review at the OHC. If they had evidence of liver failure or any other complications of chronic liver disease, I would review them more frequently or admit them to hospital as required by their clinical condition.

90. *What arrangements were made for the care and treatment of children infected with HIV or hepatitis? How did those arrangements differ (if at all) from the arrangements made for adults?*

90.1. I was involved with patients with HIV only if they also had evidence of a liver problem. I saw all out patients with Haemophilia at the OHC whatever their age and saw any children with their parents. I cannot recall any children with Haemophilia who required inpatient admission under my care.

91. What, if any, arrangements were made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support?

91.1. The OHC employed staff, doctors, nurses and others who counselled the patients and their families when they visited the hospital. Some of these staff members also visited the patients and their families at home to provide psychological and social support.

92. Did the Centre receive funding from the Department of Health and Social Security or form any other source to help with the counselling of patients infected with HIV?

92.1. I was not involved with any aspect of the funding of the OHC.

93. What (if any) difficulties did you/the Centre/the John Radcliffe encounter in obtaining sufficient funding for the treatment of people who had been infected with HIV and/or hepatitis C?

93.1. I did not have any managerial role either at the OHC or the John Radcliffe Hospital (JRH) so was not involved in obtaining funding and cannot comment on any difficulties there may have been.

94. What if any involvement did you or your patients have with clinical trials in relation to treatments for HIV and/or hepatitis? Please provide full details.

94.1. I was not involved with conducting any clinical trials in relation to treatments for HIV and/or hepatitis. I did discuss possible treatment with interferon with patients with Hepatitis and if they expressed an interest told them that I was willing to make a referral to a centre which was conducting these trials.

Records

95. What was (a) the Centre's and (b) the John Radcliffe's policy as regards to recording information on death certificates when a patient had been infected with HIV or hepatitis?

95.1. I cannot recall any JRH or OHC policy as regards the recording information on death

certificates when a patient had been infected with HIV or hepatitis?

96. *What were the retention policies of (a) the Centre and (b) the John Radcliffe in regards to medical records during the time you were practising there?*

96.1. All my clinical records were filed in the patient's paper NHS hospital notes folder. I did not write in any separate paper records kept by the OHC and did not know what retention policies were in place.

96.2. During the time I was practising at the JRH, the paper NHS hospital notes of all patients who were currently being treated were supervised by the hospital medical records department. During the time I was working the notes of some patients who had died or moved away were microfilmed by them. The policy on this did change while I was still working, but I was not aware of any precise details at the time and cannot provide any further information.

97. *Did you maintain separate files for some or all patients? If so, why; where were those files located; and where are those files now?*

97.1. I did not maintain any separate files for any patients. All my records for all patients who I saw were filed in the paper NHS hospital notes folder. Copies of the letters to the patient's GP which I sent after each consultation were also sent to the OHC. I do not know what happened to letters I sent to the OHC or what has happened to paper NHS hospital notes folders since I retired.

98. *Did you keep records or information (e.g. information being used for the purpose of research) about any of your patients at your home or anywhere other than the Centre or John Radcliffe? If so, why, what information and where is that information held now*

98.1. I did not keep any records or information, for clinical or research purposes, about any of my patients at my home or anywhere other than the OHC or John Radcliffe hospital.

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

99.1. I do not still hold records or information about any of my patients.

Section 5: UKHCDO

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

100.1. During the years that I looked after Haemophiliac patients I was involved with the

UKHCDO only as a member of a working group which discussed matters that related to hepatitis in Haemophiliacs. For several years I attended the meetings of this working group which met several times a year. As this was just a small part of my job and the working group dealt with matters that did not involve me, I attended only for those parts of the meetings that directly involved me. I was interested in discovering the true prevalence of NANB among the haemophiliacs and in trying to find a way to reduce this. As a member of the working group I was invited to some of the main meetings of the UKHCD. I remember attending meetings in Oxford, Glasgow and Dublin when the working group was involved in discussions to try to set up a multicentre trial of previously untreated patients.

101. *During the period that you were involved with UKHCDO, please outline:*

a. The purpose, functions and responsibilities of UKHCDO, as you understood them.

I was never a member of the UKHCDO and apart from those meetings when the Hepatitis working group was reporting, I did not attend or receive any of the papers. My understanding was that the meetings were open any doctors who ran centres in any UK hospital that treated Haemophiliac patients.

b. The structure, composition and role of its various committees or working groups.

Apart from the Hepatitis working group I knew nothing of any of its other committees or working groups.

c. The relationships between UKHCDO and pharmaceutical companies.

I knew nothing about the relationship between the UKHCDO and pharmaceutical companies.

d. How decisions were taken by UKHCDO.

I do not know how decisions were taken by the UKHCDO.

e. How information or advice was disseminated by UKHCDO and to whom.

I do not know if information or advice was disseminated by UKHCDO or to whom.

f. Any policies, guidance, actions or decisions of UKHCDO in which you were involved and which relate to:

- *the importation, purchase and selection of blood products;*
- *the manufacture of blood products;*
- *self-sufficiency;*
- *alternative treatments to factor products for patients with bleeding disorders;*

- *the risks of infection associated with the use of blood products;*
- *the sharing of information about such risks with patients and/or their families;*
- *obtaining consent from patients for the testing and storage of their blood, for treatment and for research;*
- *heat treatment;*
- *other measures to reduce risk;*
- *vCJD exposure; and*
- *treatments for HIV and hepatitis C.*

I was not a member of UKHCDO and I cannot remember being involved in any policies, guidance, actions or decisions of UKHCDO listed above.

If I influenced any practice or policy in any of these areas it would have been through discussions with Dr Charles Rizza who was the director of the OHC.

Section 6: Pharmaceutical companies/medical research/clinical trials

102. Have you ever provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products? If so, please list the names of the companies and give details of the advisory or consultancy services that you provided.

102.1. I have never provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products.

103. Have you ever received any pecuniary gain in return for performing an advisory/consultancy role for a pharmaceutical company involved in the manufacture or sale of blood products? If so, please provide details.

103.1. I have never received any pecuniary gain in return for performing an advisory/ consultancy role for a pharmaceutical company involved in the manufacture or sale of blood products.

104. Have you ever sat on any advisory panel, board, committee or similar body, of any pharmaceutical company involved in the manufacture or sale of blood products? If so, please provide details of your involvement and of any financial or other remuneration you received.

104.1. I have never sat on any advisory panel, board, committee or similar body, of any pharmaceutical company involved in the manufacture or sale of blood products.

105. Have you ever received any financial incentives from pharmaceutical companies to use certain blood products?

105.1. I have never received any financial incentives from pharmaceutical companies to use certain blood products.

106. Have you ever received any non-financial incentives from pharmaceutical companies to use certain blood products? If so, please provide details.

106.1. No

107. Have you ever received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company? If so, please provide details.

107.1. I have never received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company.

108. What regulations or requirements or guidelines were in place at the time concerning declaratory procedures for involvement with a pharmaceutical company? If you were so involved, did you follow these regulations, requirements and guidelines and what steps did you take?

108.1. I do not remember any regulations or requirements or guidelines that were in place at the time concerning declaratory procedures for involvement with a pharmaceutical company, and I was not involved with any pharmaceutical company.

109. Have you ever undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products? If so, please provide details.

109.1. I have never undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products. My memory is that all the blood products used in the succession of clinical trials at the OHC with which I was involved were produced at NHS Fractionation Laboratories.

110. Have you ever provided a pharmaceutical company with results from medical research studies that you have undertaken? If so, please provide details.

110.1. I have provided a pharmaceutical company with results from medical research studies that I have undertaken. These were results relating to the adverse effects on the liver of repeated anaesthetics using Halothane which, on the advice of Professor Sir Richard Doll, I supplied to ICI, who manufactured Halothane, the day before the paper reporting a randomised clinical trial showing this adverse effect, was published in the Lancet.

111. If you did receive funding from pharmaceutical companies for medical research, did you declare the fact that you were receiving funding and the source of the funding to your employing organisation?

111.1. When I received funding from a pharmaceutical company for medical research, this

funding was paid through Oxford University by whom I was employed.

Section 7: vCJD

112. When and in what circumstances did you become aware of the risks of transmission of vCJD associated with the use of blood and blood products?

112.1. I cannot remember when and in what circumstances I became aware of the risks of transmission of vCJD associated with the use of blood and blood products.

113. Did you have any involvement in decisions as to what information to provide to patients about vCJD? If so please answer the following questions:

a. What steps were taken put in place a process at the Centre and/or the John Radcliffe for informing patients about possible exposure to vCJD?

b. What steps were taken to tell patients of possible exposure to vCJD?

c. What steps were taken to provide information to patients about the risks of vCJD?

d. What steps were taken to arrange for counselling, support and/or advice to be offered to patients who were being informed that they might have been exposed to vCJD?

I did not have any involvement with patients with vCJD or in decisions as to what information to provide to patients about vCJD.

Section 8: The financial support schemes

114. What if any involvement did you have with the different trusts or funds (the Macfarlane Trust, the Eileen Trust, the Macfarlane and Eileen Trust, the Caxton Foundation, the Skipton Fund) which were set up to provide financial support to people who had been infected?

114.1. I did not have any involvement with the different trusts or funds (the Macfarlane Trust, the Eileen Trust, the Macfarlane and Eileen Trust, the Caxton Foundation, the Skipton Fund) which were set up to provide financial support to people who had been infected.

115. To what extent, during your time at the Centre and John Radcliffe, did staff (including you) inform patients about the different trusts or funds?

115.1. I think that the Macfarlane Fund was the only one of these funds which was functioning during the time I was caring for Haemophiliacs, and staff (including me) did

discuss this with patients and their families and the OHC provided them with information about this.

116. Did the Centre or the John Radcliffe have any policy or any guidance for staff members in relation to referring patients to the trusts and funds for support?

116.1. I do not remember any policy or any guidance from the OHC or JRH for staff members in relation to referring patients to the trusts and funds for support.

117. What kind of information did the Centre or John Radcliffe provide to the trusts and funds about, or on behalf of, patients who were seeking assistance from the trusts and funds?

117.1. I remember providing medical reports to patients or their families who I think were seeking assistance from the Macfarlane Fund.

118. Did the Centre, the John Radcliffe, or any of their staff, act as a gateway for determining whether a particular patient met the eligibility criteria for the receipt of assistance from any of the trusts and funds? If so, please explain who set the criteria, what they were and how they were applied.

118.1. I do not remember the OHC, the John Radcliffe Hospital, or any of their staff, act as a gateway for determining whether a particular patient met the eligibility criteria for the receipt of assistance from any of the trusts and funds.

119. Was the Centre, the John Radcliffe or any of its staff involved in determining applications made by patients for assistance from the trusts or funds? If so, please describe that involvement.

119.1. I do not remember the Centre, the John Radcliffe or any of its staff involved in determining applications made by patients for assistance from the trusts or funds.

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

120.1. I had no direct dealings with any of the trusts or funds but based on my memory of the experiences of my patients in relation to the trusts and funds, I do consider that the Macfarlane Trust was well run. It appeared to have achieved its purpose. One shortcoming in the way in which it initially causes problems for applicants for assistance was that at first only patients who were still alive could apply for assistance but I think this was overcome so that the dependents of Haemophiliacs who had already died when the fund was set up could receive assistance.

Section 9: Other Issues

121. Please provide details of any complaints made about you (insofar as relevant to the Inquiry's Terms of Reference) to your employer, to the General Medical Council, to the Health Service Ombudsman or to any other body or organisation which has a responsibility to investigate complaints.

121.1. I am not aware of any complaints made about me (insofar as relevant to the Inquiry's Terms of Reference) to my employer, to the General Medical Council, to the Health Service Ombudsman or to any other body or organisation which has a responsibility to investigate complaints.

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

122.1. At the present time my health is not good, with an extended hospital inpatient admission last year and a further operation planned for June 2020 - also many frequent outpatients attendances. I have provided all of the information I feel able to provide to the Inquiry, and do not believe that I am able to assist further.

Statement of Truth

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

Signed GRO-C

Dated 6th September 2020.

Table of exhibits:

Date	Notes/ Description	Exhibit number
	HCDO0000545	1
	HCDO0000248_005	2
	HCDO0000270_066	3