Witness Name: Dr Muriel Joan Seaman

Statement No.2: WITN3815002

Exhibits: NIL

Dated:
Oct, 8th 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR MURIEL JOAN SEAMAN

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 10 September 2020.

I, Dr Muriel Joan Seaman, will say as follows: -

Section 1: Introduction

1. My name is Muriel Joan Seaman. My address is known to the inquiry. My date of birth is GRO-C 1929. My qualifications are MB.BS (London), FRCPath.

2. Previous appointments:
   House Officer appointments (I am unable to recall the exact dates):
   1) St Charles Hospital, London
   2) Elizabeth Garrett Anderson Hospital, London
   3) Amersham General Hospital, Bucks
   Resident Pathologist – Elizabeth Garrett Anderson Hospital
   Senior House Officer – New End Hospital London
   Registrar – West London Hospital
   Registrar – Royal Free Hospital, Pathology, London
   Senior Registrar – Oxford Regional Board

Appointments at Cambridge:
Assistant Pathologist, University post at Addenbrookes Hospital, 1966
Senior Assistant Pathologist, University appointment, Addenbrookes, 1968
Consultant Haematologist, Addenbrookes Hospital, 1973 until retirement in 1990

Up until my appointment as a NHS consultant the posts were all supervised training posts.

Once I was a consultant I worked entirely within the Haemtology Department at Addenbrookes Hospital and was an assistant to the Head of Department, Dr DG Chalmers. My responsibilities included clinical interpretation of laboratory results and as a general supervisory role in the activities of the laboratory.

Dr Chalmers was the Haemophilia Centre director until his death in 1984. The laboratory had taken over the role of caring for patients with haemophilia in the area from Professor Hayhoe's department on our move to the new hospital in 1973.

I became the director of the Haemophilia Centre from 1984 to 1990 with assistance from junior medical staff (registrars and senior registrars). I was therefore responsible for the treatment and care of patients with haemophilia and Christmas disease.

I was responsible for arranging HIV tests and counselling as required. I endeavoured to provide as much information to patients or their carers/parents as was available to me at the time.

3. I was not a member of any other committee or groups. As the director of the Haemophilia Centre, I attended meetings wherever possible but I was not, to my knowledge, a member of any relevant group or committee. I do note, however, from the documents sent to me by the inquiry, that my name is entered with regards to the Regional Working Group on AIDS. I do not have any recollection of taking part in any meetings.

4. I have not provided any evidence or been involved in any other inquiry relating to HIV, Hepatitis B or vCJD.

5. I have no recollection of being involved in any litigation brought against Cambridge and East Anglia Health Authorities.

Section 2: Decisions and actions of the Haemophilia Centre, Addenbrooke's Hospital, Cambridge

6. (a) The Haemophilia Centre was responsible for the care and treatment of local patients with haemophilia. Initially patients were treated with cryoprecipitate until NHS Factor 8 became available. This NHS Factor 8 was obtained from the Blood Transfusion Service. When it was discovered that heat treatment deactivated the HIV virus, we were given permission by Addenbrookes Hospital Financial Department to acquire commercial heat treated Factor 8. This was largely from two firms, Cutter and Armour. If my recollection is correct, heat treated Factor 8 was given from December 1984.

   (b) I was the only senior member of the haematology staff until 1987. A second consultant was appointed (Dr Robert Marcus). He had responsibility for patients with leukaemia and did not have responsibility for patients with haemophilia.

   (c) On coming to Cambridge in 1966 I was working with Dr DG Chalmers in the Haematology Department. Dr Chalmers was the Director of the Haemophilia Centre from 1973 to 1984. I took over this role on his death in 1984. I therefore had overall responsibility for the treatment of patients under our care. Initially they were treated with cryoprecipitate until NHS Factor 8 became available which we obtained via the Blood Transfusion Centre housed in Addenbrookes Campus. In the 1980s when the HIV virus was discovered I was responsible for arranging the appropriate tests for the Cambridge centre patients, counselling when required and giving them as much information as was available at the time.

7. I do not recall how many patients with bleeding disorders were under the care of the centre. I have no access to documents that would provide this information.

8. (a – e) Products were used depending on what was available to us at the time. Supplies of Factor 8 were acquired from the Regional Transfusion Centre. Initially cryoprecipitate was used until Factor 8 concentrate became available, making hospital in-patient treatment no longer necessary. Home therapy was introduced where feasible. When it was discovered that heat treatment of the concentrate destroyed the virus and NHS supplies were not available we were able, with permission from Addenbrookes Financial Department, to acquire commercial heat treated Factor 8,

largely from Cutter and Armour. When it became available, NHS heat treated Factor 8 was given. I believe this was from December 1984.

9. As the supplies were from the Regional Blood Transfusion Centre in Cambridge no relationship existed between the centre and pharmaceutical companies.

10. We did not always have a choice as to what products were available. Patients generally accepted what was offered to them as we could not always give them a choice.

11. My knowledge of alternative treatment was limited. I took advice from Dr Darnborough (deceased) at the Regional Transfusion Centre. I cannot recollect any use of cryoprecipitate when I was the director.

12. (a – b) We gave home treatment wherever possible which was administered either by the patient or their parents/carer. This was largely to treat episodes but some prophylactic therapy was used in certain circumstances.

13. I cannot recall a special policy for the use of factor concentrates for children. I do not recall any small children needing therapy at the centre. We were largely concerned with treating older patients.

14. We only treated a particular episode but if needed Factor 8 concentrate would be used.

Section 3: Knowledge of, and response to, risk

15. I acquired any knowledge I had from colleagues and journals. I was not very conversant with the risk of hepatitis and blood transfusion but I knew it did occur.

16. (a – b) I was aware of the risk of infection with untreated concentrate and the risks of using unsuitable donor material.

17. I understood the nature and severity of blood borne virus infections from the literature at the time.

18. Knowledge of HIV and AIDS was gained from experience over time. This developed over time as more journal articles were published and more information became available.

19. I think I probably became aware of the possible association between AIDS and the use of blood products around 1982, but cannot be certain. This information would have been from journal articles.

20. We reduced risks by using heat treated material as described above. We also sought and followed advice from the Regional Transfusion Centre.

21. We only used heat treated material once this was available both commercially and on the NHS.

22. We began to use heat treated material as soon as it was available, probably in the mid-1980s.

23. I do not recall the conversation or the outcome of it. I do know that we did not restrict the use of heat treated Factor 8 to HIV negative only patients.

24. As I recall, all patients received heat treated Factor 8 whether they were HIV antibody positive or not.

25. No. I have no recollection of cryoprecipitate being used.

26. Yes. We did all we could at the time.

27. In retrospect I don't think we could have done anything differently.

28. (a) I have no recollection of attending this meeting (b) I gained knowledge from my colleagues and from journal articles at the time.

Section 4: Treatment of patients at the Centre

29. I cannot recall exactly but I think I would probably have informed the patients of any risk of infection. I do recall that I saw the patients and spoke to them personally.

30. I learnt that patients had become infected due to antibody testing by the Public Health Laboratory Service (PHLS) at Addenbrookes hospital. I think all of our patients were tested but I do not recall the details.

31. (a - b) I do not recall pre-test counselling but I did see all of the HIV positive patients and discussed the significance of this with them. It is likely that an explanation as to why the test was being done was given at the time the sample was taken. We tested all patients we had given treatment to.

32. I saw all the patients personally and individually. The fact that they may have been infected was always given face-to-face and never by telephone or letter. I discussed the significance of the infection with them. I do not recall telling any of the patients to keep this secret.

33. I don't recall that we had a specific policy in relation to testing partners/family members. We may have tested family members if they had asked to be tested.

34. I don't think that this was one of our centre's patients. I am not aware that an inaccurate result occurred in any other patients at our centre. I do not recall any repeat testing being necessary.

35. (a – e) I cannot recall the exact number but I do recall that there were no patients with (d) haemophilia B or (e) von Willebrand's disease who were HIV positive.

36. No work of this nature was undertaken at the centre.

37. Patients with hepatitis received care from the Regional Blood Transfusion Service.

38. Patients with hepatitis received care from the Regional Blood Transfusion Service.

39. Patients with hepatitis received care from the Regional Blood Transfusion Service.

40. Patients with hepatitis received care from the Regional Blood Transfusion Service.

41. I cannot recall how often blood samples were taken. It is very likely that the patient was aware that the test was for HIV and would have consented verbally to this. No consent

was formally recorded at the time as far as I can remember. Testing for hepatitis was undertaken by the Regional Blood Transfusion Service.

42. Patients agreed to the treatment they received. Consent would have been obtained verbally but not recorded in the notes, as far as I can recall.

43. Patients would have been told what the blood sample was for (HIV testing) and would have consented verbally to this at the time. I do not recall a written record being made of their consent. Patients being tested for hepatitis were under the care of the Regional Transfusion Centre.

44. I am not sure what this question refers to and therefore cannot provide a response.

45. I saw each patient and/or their relatives personally and as far as I can recall discussed the significance of HIV infection with them. At the centre, we gave them as much support as we could. The risks of transmission to others was discussed and information was also provided by the genito-urinary department. Patients who had been tested for hepatitis were cared for by the Regional Transfusion Centre.

46. We did not issue death certificates at the centre.

47. I do not recall what the retention policies were at the time. Patients with haemophilia had their own records at the Haemophilia Centre but I don't know what arrangements were made for these.

Section 5: Pharmaceutical companies/medical research/clinical trials

48. (a – h) I had no direct involvement with pharmaceutical companies/medical research or clinical trials. I did not make any financial gain.

Section 6: Other Issues

49. I had no interactions or dealings with Treloars. Any patients that had been at Treloars were undergraduates at Cambridge and we supervised their care. We had no immediate contact with Treloars. I arranged for a local GP to provide overall care.

50. I am aware that Mr Alan Burgess was critical of me and I have previously addressed this. Mr Burgess was not normally a patient at Addenbrookes. I understand that he was diagnosed and treated at Ipswich Hospital apart from a short in-patient stay at Addenbrookes after a football injury in 1982. I understand from the information I was provided with that Mr and Mrs Burgess came to see me in 1985. Mr Burgess was not, however, under my care. As this was approximately 35 years ago, I do not have any recollection of their visit or written evidence to support it. I was sorry to learn of the concerns that they raised. I had experience of talking to patients, particularly in relation to HIV infection, and this type of criticism was never made by another patient or their relatives. I am very sorry if I said anything that caused them upset. This was certainly not my intention. I had and still have enormous sympathy for the patients who became HIV positive after treatment which was meant to be entirely for their benefit.

51. I have no other matters to mention.

Statement of Truth

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

Signed GRO-C

Dated October 8th 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number