Witness Name: GRO-B

Statement No: WITN3466001

Exhibits: WITN3466002 – WITN3466009

Dated: 7 May 2021

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF GRO-B

I, GRO-B GRO-B will say as follows:

Section 1: Introduction

1. I make this Statement for the benefit and assistance of the Infected Blood Inquiry relating my to son GRO-B: S who was born on GRO-B 1967. S was approximately 9 months old when he was diagnosed with severe Haemophilia A.

2. My son tragically died from the effects of his HIV infection on GRO-B 1987. We were aware It should be noted that the consequences that caused his death were full blown AIDS.

Section 2: How Affected

3. We were not aware that S had haemophilia until an incident occurred where he hurt his knee whilst playing and we had to bring him to the hospital. It was only at that point were we made aware that S had sever Haemophilia A. S did not suffer any haemorrhages prior to this incident.

4. My wife and I had a daughter who was born two years prior to S so following on from his diagnosis, our daughter was then tested and it was found that she was in fact a carrier.

5. Whenever S suffered an injury or had to attend hospital, my wife would bring him, usually by ambulance. Whilst there, haemophiliacs were prescribed cryoprecipitate and that was the treatment he received when he was admitted.

6. Before S started school, he developed jaundice. In 1973 at the age of 6, he had suffered his second episode which resulted in being admitted to S Hospital. He was given vast quantities of Factor VIII whilst he was at hospital. Upon review of his medical records, it would seem that S Hospital believed that his diagnosis was a result of his haemophilia and serum hepatitis, WITN3466002.

7. Following a slip on ice in 1979, S was admitted to hospital as he was suffering from dizziness and pain. From review of his notes during this period, it says that blood products such as Factor VIII Concentrate can cause viral hepatitis, but the doctor didn't mention anything to us about this. This record also describes how S was treated 'with large doses of Factor VIII' during this period, WITN3466003.

8. It is now clear that S did, in fact, have Hepatitis B from a pathology report dated the 17th July 1974. Later medical records dated the 5th July 1978 again indicate that the Hepatitis B antibody was detected in S At no point were we as parents made aware of this. I attach copy records marked as WITN3466004.

9. On two occasions in 1982, further to S suffering multiple bleeds he was admitted to hospital firstly on an emergency basis and then place on the orthopaedic ward at Kettering and District General Hospital. On both admissions, S received large amounts of factor concentrates. WITN3466005.

10. When Factor VIII became available S would go to the hospital regularly to obtain his treatment and subsequently, S GP started to administer the treatment. During this time, we were never alerted to the risks associated with blood products.

11. Eventually, S took over and would administer the treatment himself; he was very good at taking his treatment and he took this very seriously.

12. In March of 1985, S was diagnosed with HIV. Despite the hospital delaying this diagnosis for a year, we were able to establish from his records that he was not told about his HIV diagnosis until the 2 April 1986 after he had indicated in February 1986 that he wanted to know the results of his HIV testing. Notes can be found at WITN3466006.

13. When S was diagnosed with HIV, he rarely complained as he did not want to worry us. However, he did disclose to us that the HIV campaigns caused him stress and anxiety. He told GRO-B and me that he did not want the family to know about his HIV diagnosis, so we kept it a secret and we still have told no one else to this day, including S sister.

14. I have attached a letters that S received from the Oxford Haemophilia Centre in 1986, listing numerous batch numbers of Factor VIII that were being recalled. One can only presume that it was a result of inadequately heated factor, WITN3466007.

Section 4: Consent

15. At no point throughout his childhood and early teens did anyone take the time speak with me or my wife to discuss the risks associated with the blood products.

16. From correspondence to a GP in 1979 (see WITN3466003) it is clear that GPs were informed that blood products could pass on Hepatitis. Why were GPs informed of this risk but not parents of young patients?

Section 5: Impact

17. Undoubtedly, for any parent to see their child suffer and pass away is the most painful of experiences. Also, the date of death would be at a time of significant hysteria, associated with an AIDS diagnosis. An issue that arises in the context of the secrecy that we as parents maintained, associated with S untimely demise from the consequence of AIDS, is that there was no support available from Government, or Government entities, where the only support of any nature, that was provided was from The Haemophilia Community and more particularly the local Haemophilia Society branch in GRO-B

18. Admittedly, Dr Matthews of The Oxford Centre, attended S funeral. Yet, the ability of both parents to cope with the consequences of the loss of their only son, in circumstances of no appropriate support being available, even as at the time of death, is an issue to be considered by the Inquiry and more particularly, the long-term consequences that occurred associated with that scenario from both a psychiatric and psychological perspective.

19. S passed away on the GRO-B 1987. The conclusion on S death certificate was that he died from a subarachnoid haemorrhage due to haemophilia. No inquest was conducted and S funeral was held on the same week he died.

20. It has been nearly 34 years since S was taken from us and despite the length of time that has passed, some days remain very tough. Watching your son live such a short life is heart breaking. A part of me died when my son passed away.

21. I am now a grandfather and two of my grandsons suffer with Haemophilia and accordingly I have a vested interest to ensure that ongoing treatments for Haemophilia care are both effective and safe.

Section 6: Treatment/Care/Support

22. We are almost certain that my son contracted Hepatitis Non-A Non-B from receipt of contaminated Factor VIII concentrates. Accordingly, the indication delivered to my family to the effect that he had not contracted Hepatitis C was, although technically correct as S had died prior to the introduction of Hepatitis C virus testing, in reality incorrect, he almost certainly had contracted Hepatitis Non-A Non-B, as one Factor VIII concentrate treatment would have been sufficient to cause that consequence' as a severe Haemophiliac, it is inevitable that he received multiple treatments prior to effective viral inactivation and death.

23. My wife nor I received any counselling or supports following our sons death. The only support we received was mainly from the local Haemophilia Society branch in GRO-B

Section 7: Financial Assistance

24. My son S died before compensation was given. However, we received a single person payment in the amount of £25,000 from the McFarlane Trust. The family did not receive any payments from the Skipton Fund however we did receive a payment of £20,000 from the EIBSS.

Section 8: Other Issues

Loss of opportunity

25. Whenever S suffered any injuries, he would have to stay at home and recover. Because of this, he missed a great deal of school which was disappointing as he did enjoy it.

26. As with the times we were living in [S] left school at the age of 16.

27. [S] was very inquisitive and looked into so many different careers that interested him. He considered many paths ranging from nursing, to training as a pilot to becoming a policeman. WITN3466008.

28 [S] volunteered in Kettering Hospital at one stage and the nursing tutor there wrote to Dr Matthews stating that he was very impressed with [S] but that nursing would be a very demanding career for him because of the long hours and having to lift patients regularly. [S] tutor said that he might be successful if he applied for some of the smaller centres which would not have been as demanding and which would have accepted lower grades. WITN3466009.

29 [S] got a job in 1984 as a packing inspector. Initially, his employers were hesitant to employ him due to his status [S] enjoyed going to work and he held this same position until he passed away.

30. There are so many unanswered questions that we as parent are left with. The Government continues to ignore the failings that occurred and never apologised. We would hope to find out why there was a delay in notifying [S] that he had contracted HIV, a year had passed from his diagnosis and informing him during which time he had a girlfriend who ought to have known.

31. There was a reliance on the Government to provide safe products to all patients and the Government failed in their duty.

Statement of Truth

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

Signed GRO-B

GRO-B

Dated 7/5/21