Witness Name: Dr John Keith Ramage
Statement No.: WITN4134014
Exhibits: WITN4134015- WITN41340016
Dated: 18 September 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF JOHN KEITH RAMAGE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 2 December 2019.

Section 1: Introduction

1. Name: John Keith Ramage, MB BS MD FRCP

DOB GRO-C 1955. Address: Department of Gastroenterology, Hampshire Hospitals Foundation Trust, Basingstoke, RG24 9NA

Current positions: Consultant Gastroenterologist and Hepatologist, Hampshire Hospitals Foundation Trust. I have held this position since 1996 and am the senior physician in the department of 11 consultants.

Honorary Consultant Physician, Institute of Liver Studies, Kings College Hospital, London, Honorary Senior Lecturer, Kings College, London, I have held this post since 1994 (part-time) and am the lead clinician for the neuroendocrine tumour service for Kings Health Partners (Kings College, Guys and St Thomas' trusts)

Visiting Professor University of Winchester. I have held this position since 2016 and am leading a collaboration between the University and Hampshire Hospitals.
I produce my full Curriculum Vitae as **WITN4134015**.

I have not been a member of the relevant committees related to the investigation.

Section 2: Response to criticisms made by Witness W0491 regarding Patient SG

Review of available records

2. This report is based on a series of results and letters between 29 May 2003 and 15 November 2007 that were saved in Hampshire Hospitals electronic record. I produce these collectively as WITN4134016. The paper notes relating to the period in question have not been made available to me by the Trust and it appears that they have been misfiled by a storage company. We are still trying to find the notes. This report is based solely on the electronic records. Should further records become available I reserve the right to revise this statement and/or submit supplementary observations.

3. The first record I have of SG, is a discharge summary from 23 March 2003. She had been admitted for an ERCP procedure, which is an endoscopic procedure designed to diagnose and treat disorders in the bile duct. SG had had quite severe right upper quadrant pain and an ultrasound had shown a dilated (wide) bile duct. She had slightly abnormal liver enzymes on her blood tests. It was thought possible that she had spasm of the sphincter of Oddi. She therefore had an ERCP (a type of endoscopy) and a sphincterotomy, which is a small cut in the lower bile duct in order to relieve pain. It was noted in this report that she needed a large amount of analgesia to relieve her pain. It was further noted she was already on Insulin, Warfarin, Movicol, Chlorpheniramine and Oxycontin (this is a Morphine-like agent for pain). Post procedure, the sphincterotomy did not help with her pain. At this stage her liver enzyme tests were mildly abnormal but there was no reason to suppose that she might be infected with hepatitis C at that time.

4. On 27 June 2003 she was seen my registrar Dr Callum Pearce (now professor of gastroenterology in Perth, Australia) at North Hampshire Hospital Trust. He noted that the pain had increased and that she had been admitted under the surgical team who thought that she may have chronic pancreatitis. It was noted at that time she was on Warfarin, Insulin, Creon and Pethidine. Her right upper quadrant pain continued. Dr Pearce discussed the case with me and I suggested that she be referred to Dr Pereira at University College Hospital in London, who specialised in sphincter of Oddi dysfunction.

5. There is a letter from 30 June 2003 from Dr Pearce referring SG to Dr Pereira. When SG went to University College Hospital they did a hepatitis screen as routine prior to any further intervention there. They found that she was hepatitis C antibody positive.

6. I then saw the patient on 7 November 2003. I noted that some of her symptoms were undoubtedly due to hepatitis C although I thought it was unlikely that all the symptoms were due to that. I wrote that it seemed likely that she had contracted hepatitis C from a transfusion in 1979 and we considered a liver biopsy, which we thought was risky. Therefore we decided she would have treatment for hepatitis C based on the genotype of the hepatitis C virus.

7. The next letter dated 19 December 2003, and from myself to Jeanne Prosser, who was our hepatitis specialist nurse at that time. I noted the results showed that SG was hepatitis C positive with a genotype 1 in her blood and that she would need to come in after Christmas for Interferon treatment for this.

8. I wrote a letter to the Clinical Commissioning Group to ask for funding for Interferon treatment as this was usual practice at that time. My letter of 19 December to Mark Satchell at Specialist Services Commissioning asked for funding for Interferon and Ribavirin.

9. The patient was next seen on the 22 January 2004 by Dr Corrine Brooks who had recently been appointed as a specialist in liver disease and hepatitis treatment. She wrote that she saw the patient with Jeanne Prosser the nurse specialist, and explained the nature of hepatitis C, the long-term prognosis and the expectations of anti-viral treatment. The toxicity of the treatment was discussed together with the possibility of withdrawal of treatment at 12 weeks if there was no sign of response by the virus. Dr Brooks specifically noted that the patient had a lot of symptoms namely pains, tiredness, abdominal pain and sweating. Dr Brooks explained that we were not sure how many of these symptoms could be attributed to hepatitis C. It was stated she accepted the explanations and she went away to think about treatment.

10. On 17 February 2004 it was noted by Dr Brooks that SG attended clinic to start her treatment for hepatitis C. She was instructed how to inject the Interferon and how to take the Ribavirin tablets. I would expect that she would have been monitored with weekly blood tests undertaken by the specialist nurse, in accordance with the national guidelines in operation at that time.

11. On 30 March 2004 Dr Brooks noted that she was tolerating the treatment well at week 7. The plan was to do a blood tests for viral load at 12 weeks.

12. In the discharge summary from the 10 May 2004, it was noted that SG had been admitted as an emergency with epigastric pain. The background of hepatitis C was noted. She had a normal amylase and there was no suggestion of pancreatitis. She had a slightly raised white cell count of 15,000 and a raised C Reactive Protein of 20, which is an indication of inflammation or infection and can be a side - effect of the treatment. The pain settled spontaneously overnight and she was discharged the next day.

13. On 1 June 2004 SG attended Dr Brooks. It was noted that at 12 weeks the viral load in the blood had only dropped by one log. The NICE regulations on funding for this treatment dictated that the treatment could not be continued beyond 12 weeks if this was the case. She would need at least a two log drop in the viral load to continue treatment. The lack of adequate response at 12 weeks indicated it was very unlikely that the hepatitis C would be eradicated. The treatment was therefore stopped, in accordance with the best available evidence and the regulations on funding for treatment at the time. None of these funding decisions were made by any of the consultants, or by the hospital, but were instead made on the basis of national guidelines and by the commissioning bodies.

14. On 15 July 2004, I wrote in response to some questions from her GP. The implication was that SG was not happy with stopping treatment at 12 weeks and that she had contacted her GP, Dr Jane Thompson, who had then written to me. I explained that between November 2003 and May 2004 SG had achieved a one log drop in viral load and that the NICE guidelines at that time clearly stated that treatment should be stopped unless there was a two-log drop. The NICE guidelines had been published recently by the Consensus Group and experts in hepatitis C. I was Secretary of the liver section at the British Society of Gastroenterology at the time, and so I was involved in the development and coordination of the guidelines. The letter noted that SG had been extremely anxious and keen to pursue a further three months of treatment even though it was very unlikely to be successful. I did however state in this letter that because SG was very anxious and was requesting a further three months of treatment, I had agreed to a further three months of therapy. I offered to refer her to another unit for a further opinion.

15. The next letter in the notes is dated 14 February 2005, from Dr Brooks, who stated that SG had been booked into her clinic in January or February 2005 but had not attended. We had received information suggesting that she was being seen by Dr Naoumov who was a hepatitis

specialist at University College. In view of this, a further appointment was not booked at Hampshire Hospitals.

16. On the 11 August 2006 I wrote to Jill Pellett who was a manager at North Hampshire Hospitals at that time. I do not have a copy of the original complaint from the patient but the response I gave is dated 11 August 2016. SG had complained that the local hospitals did not test for hepatitis C. This was incorrect since we were testing for hepatitis C at that time and for many years previously. I explained that her original complaint was pain with a dilated bile duct, and that this was an unusual presenting symptom of hepatitis C. When she was found to be hepatitis C positive, which was quite soon after her presentation to Hampshire Hospitals, she was counselled extensively about treatment with Interferon and Ribavirin by Dr Brooks. It was again explained that according to the NICE guidelines she needed to achieve a two-log drop in viral load in three months and unfortunately she did not do that. Both Dr Brooks and I had offered her an appointment to discuss further treatment but she did not attend. She did not need a referral for assessment of her suitability for a liver transplant at that time, as she had no symptoms or signs of liver failure when we were seeing her. I explained that her treatment was in accordance with national (NICE) protocol.

Response to specific criticisms raised by W0491

17. Paragraph 2.11 states that I *"used strange words to the effect of `we don't expect this sort of thing in Hampshire`"*

18. I do not recall saying anything like this, and the precise wording is not stated. I may have been referring to the fact that SG had no clear risk factors for hepatitis C and therefore this diagnosis would have been quite an unusual cause of mildly abnormal liver enzymes in her case. I am not sure that I was aware at that time that she had previously had a blood transfusion at Frimley Park Hospital. If we are correct that the patient contracted hepatitis C from a blood transfusion in 1979, and presented to this hospital in April 2003 when she was diagnosed with hepatitis C, then by October 2003 the delay of five months is likely to be irrelevant compared to the 24 years that the patient had hepatitis C infection prior to this.

19. The statement relating to bedside manner is hard to address at this stage. I was sorry to be made aware of this now as that was not, and never would have been my intention. It may be

that the patient was upset because I was direct in telling her the treatment had to be stopped. However this was the only course of action possible.

20. In paragraph 5.4 witness statement, it is stated that I was *"unable to ascertain what was wrong"* and that my clinical management yielded no results. The clinical management described in the available correspondence confirms that results were obtained, and documents what procedures were done, and in what order. SG was treated entirely according to the National Guidelines.

21. In paragraph 5.8 of the witness statement it is asserted SG's treatment *"was based on a financial decision"* made by me and that this caused *"significant expense within the NHS."* SG was treated according to the National (NICE) Guidelines at that time. None of the financial decisions were made by me, Dr Brooks or, by the hospital. They were made according to national protocols and by the Commissioning Groups. The suggestion that this caused significant expense to the NHS is incorrect.

Statement of Truth

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

Signed GRO-C

Dated 18/9/2020

Table of exhibits:

Date	Notes/Description	Exhibit number
Current	Dr John Ramage: Curriculum Vitae	WITN4134015
29.05.03 to 15.11.07	Correspondence from the available hospital records	WITN4134016