Witness Name: David Christopher Linch

Statement No.: WITN6969001

Exhibits: WITN6969002

Dated: 1 March 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DAVID CHRISTOPHER LINCH

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 9 December 2021.

I, David Christopher Linch, will say as follows:

Section 1: Introduction

Q1. Please set out your full name, address, date of birth and professional qualifications

1. Name:	LINCH, David Christopher
Address:	GRO-C
DOB:	GRO-C 1951
GMC Registration No.:	2257017
Nationality:	British

2. Educational establishments

Sir Roger Manwood's Grammar School Sandwich, Kent	(1962-1969)
Gonville and Caius College Cambridge	(1969-1972)
Middlesex Hospital Medical School London	(1972-1975)

3. Academic qualifications, awards and fellowships

1969	Chivas Adam's Scholarship to Cambridge University.
1970	Gonville and Caius College Scholarship
	1st Class Honours in Part Ia Medical Tripos
1971	Tancred Foundation Scholarship
	1st Class Honours in Part Ib Medical Tripos
1972	B.A. in Social and Political Science
	Clinical Exhibition
1975	M.B. B.Chir. with distinction
1977	M.R.C.P. (London)
1983	J.C.H.M.T. Accreditation in Haematology and Internal Medicine
1987	F.R.C.P. (London)
1993	M.R.C.Path (London)(by Publication)
1996	F.R.C.Path (London)
1998	F.Med.Sci (Founding Member of the Academy)

Q2. Please set out your employment history including the various roles and responsibilities that you have held throughout your career, as well as the dates.

4. Appointments

1975 - 1976	House Physician to Professor R.W.Gilliatt,
	Professor M J Harrison (Neurology) and
	Dr P.A.J. Ball. (Gastro and Haem) Middlesex Hospital
1976 - 1976	House Surgeon to Mr J R Garnham,
	General Surgery, Mount Vernon Hospital.

1976 - 1977	S.H.O. to Prof. J.V.Dacie/ Prof. D.A.Galton/ Prof.J.Goldman/ Prof.E.C.Gordon-Smith/ Prof. D.Catovsky. Clinical Haematology, Hammersmith Hospital.
1977	SHO to Dr F.Scadding/Dr P.A.Zorab/Dr J Collins. Thoracic and Cardiac Medicine, Brompton Hospital.
1977 - 1978	Registrar to Professor E.J.Ross/Dr L.C.A.Watson. Endocrinology and Metabolic Medicine, UCLH
1978-1979	Locum Clinical Lecturer, Department of Haematology UCL.
1979 - 1984	Wellcome Research Fellow, Hon.Clinical Lecturer and Hon.Senior Registrar.
1982- 1983	M.R.C. Travelling Fellow, Dana Faber Cancer Institute. Harvard Medical School, Boston USA.
1984	Senior Lecturer and Hon. Consultant in Haematology, Middlesex Hospital Medical School and Middlesex Hospital
1987	Conferred title of Reader UCL.
1988	Conferred title of Professor of Clinical Haematology.
1991-2019	Head of Department of Haematology, UCL
2003 -2006	Chairman of Division of Cancer Medicine, UCL
2007 -2016	NIHR Senior Investigator
2007- 2012	Cell and Gene Therapy Lead for UCL/UCLH Biomedical Research Centre (BRC)
2017- 2011	Chairman of the CRUK Cancer Centre at UCL/UCLH
2012-2021	Cancer Programme Director for UCL/UCLH BRC

Q3. 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.

5. Administrative and advisory positions

Royal Colleges

Member of Royal College of Physicians Haem. Subcommittee. 1985 -1994

Secretary of Royal College of Physicians Haem. Subcommittee.	1989 -1994
Member of the Joint Royal College of Physicians and Royal College of Pathologists Haematology Sub-committee.	1994 -1999
Member of Council of the Royal College of Pathologists	2008 -2011
MRC	
Member of MRC Leukaemia Trials Committee	1991 -1997
Chairman of the Myelodysplasia working party	1994 -1995
Member of MRC Leukaemia Trials Steering Committee	1997 - 2000
Member of MRC Stem Cell User and Clinical Liason Committee	2001 –
Member of MRC Leukaemia Trials Steering Committee	2007 - 2009
Chairman of MRC Leukaemia Trials Steering Committee	2009 - 2014
UKCCCR	
Member of the UKCCCR Sub-committee on Bone Marrow Transplantation.	1989-1994
Chairman of the UKCCCR Lymphoma Subcommittee.	1997-2001
NCRI	
Chairman of NCRI Lymphoma Study Group	2002-2005

6. *Haematology Societies*

Chairman of Scientific Programme Committee for the International Society of Haematology Congress (London)	1992.
Member of Scientific Committee of the British Society for Haematology.	1993-1997
Member of Scientific Committee of the European Haematology Ass	1994-2000
Trustee of BSH Conferences Ltd	1998-2003
Vice President of the British Society for Haematology	2007-2009
President of the British Society for Haematology	2009-2010

7. *Other Institutes*

Member of the Management Committee and Trustee of the Institute for Cancer Research	1994-1997
Trustee of the Gray Cancer Institute	2001-2006
Trustee of Leuka (now called Leukemia UK)	2017-

8. *NHS*

Member of the NHS R and D Advisory Group on Cancer 1999

Member of Chief Medical Officer's Expert Committee on Cell Cloning. 1999-2000

Member of MHRA Advisory Committee on Haematology and Oncology drugs 2006-2010

Member of NIBSC scientific Advisory Board 2006-2021

Member of HPA Biological Medicines Board Technical Committee 2010-2012

9. *Patient organisation*

President of The Lymphoma Association. 1991- 2018

The Lymphoma Association is a national information and support organisation for patients with lymphoma and their families. I provided advice to the Chief Executive and Trustees and also spoke regularly to different patient groups.

Q4. Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations, criminal or civil litigation in relation to HIV, Hepatitis C ("HCV"), Hepatitis B ("HBV") in blood transfusions.

10. I have not been involved in any inquiries relating to blood transfusion.

11. Comments on Training: My training to become a Clinical Haematologist was quite distinct from that of my peers. I gained experience in the management of patients with haematological diseases in my House Officer post at the Middlesex Hospital, Senior House Officer at the Hammersmith Hospital, and as a Locum Clinical Lecturer at UCLH. During my tenure as a Wellcome Trust Research Fellow at UCL I continued to participate in the Senior Registrar on-call rota for patients on the haematology ward at UCLH and in addition I remained on the cardiology on-call rota for temporary cardiac pacing. I received individual training in blood and bone marrow morphology (including trephine biopsies) from Dr John Richards but at no time did I receive training in other aspects of laboratory haematology including blood transfusion. During my time as Locum Clinical Lecturer and Wellcome Trust

Research Fellow I established the bone marrow/stem cell cryopreservation facility at UCLH which under-pinned the autologous bone marrow transplantation clinical programme. I wrote the first protocols for autologous transplantation of patients with acute leukaemias, Hodgkin Lymphoma and non-Hodgkin Lymphomas. In 1994 I received ad-hominem accreditation to become a consultant in general medicine and haematology. As this was a joint specialty I was not expected to have completed the full training in each individual specialty.

Section 2: UCH

Q5. Please describe:

a. Your role and responsibilities at UCH and how these changed over time;

12. When appointed as a consultant haematologist at the Middlesex Hospital I was expected to divide my time between research, teaching and the clinical care of patients with haematological diseases, particularly malignant diseases. Initially this was mainly leukaemias but after Dr Tony Jelliffe's retirement in 1986 I took over responsibility for the large lymphoma practice.

b. Your work at UCH;

13. I set up an autologous bone marrow transplantation programme at the Middlesex Hospital mirroring and working with the programme at UCLH. I did not look after patients with bleeding disorders such as haemophilia – this was carried out by my colleague Samuel Machin who had a special interest in bleeding and thrombotic disorders. In the laboratory I periodically reported on and oversaw the reporting of abnormal blood and marrow films, but had no other laboratory role or responsibility.

14. In the latter part of the 1980s the Middlesex Hospital Medical School merged with UCL and a few years later the two hospitals (Middlesex Hospital and UCLH) also

merged. After this merger the haematology service at the Middlesex Hospital was transferred to the UCLH site.

15. After the merger, the nature of my clinical commitments remained unchanged but this activity required a lesser proportion of my time. I was able to devote myself more fully to my research. After the merger I had no routine laboratory responsibilities.

c. Your work insofar as it involved the care of patients who were infected with HIV, HCV and HBV viruses and/or other diseases patients may have been exposed to as a result of receiving a blood transfusion or blood products.

16. I did not specifically look after patients with HIV,HCV or HBV, although some of my patients became infected with these agents and their anti-viral care was supervised by the relevant virology experts at UCLH.

Q6. Please:

a. **Describe the roles, functions and responsibilities of the Haematology department ("the Department") within UCH during the time you worked there.**

17. When I first joined the Department at UCLH in 1978, the Department provided a routine diagnostics service and a clinical service for patients with haematological diseases. In addition the consultant haematologists participated in the general-medicine acute-take rota, although this latter practice ceased in the early 1980s

18. The intensive chemotherapy and transplantation practice was expanding rapidly throughout the 1980s and in addition there was a large haemoglobinopathy practice so the demand for blood and platelets was high. I think UCLH was registered as a haemophilia centre but there were in fact very few haemophiliac patients, as it was standard practice to refer newly diagnosed patients to the Royal Free Hospital.

b. Please also explain how the Department worked with other departments within the Hospital, such as critical care, emergency, birth or surgical units in so far as it relates to blood transfusions. In particular, please explain which Department took primary responsibility for deciding whether or not to transfuse a patient and/or the type of transfusion to give.

19. The Department collaborated with other Departments with regard to use of blood products and decisions were made after due discussion. My involvement was restricted to the Intensive Care Unit (ITU). When one of my patients was admitted to ITU their primary care was transferred to the ITU physician. He or she would have ultimate authority to request blood or blood products but I do not have recall of anytime where there was a difference of opinion between myself and the ITU consultant.

c. Outline the facilities and staffing arrangements for the care of patients in relation to the use of, and treatment with, a blood transfusion.

20. Transfusions and blood products for my patients were either given on the wards of or in our day-care facility. Both were well staffed by highly trained and dedicated nurses and close observations were performed.

d. Identify senior colleagues within the Department and their roles and responsibilities during the time that you have worked there, insofar as they were involved with the care of patients undergoing blood transfusions and/or patients infected with hepatitis and/or HIV in consequence of a blood transfusion.

21. When I first worked as a consultant at the Middlesex Hospital, the blood transfusion laboratory was the responsibility of Dr Sam Machin. In the late 1980s we were joined by Dr Keith Patterson who had both clinical and laboratory

responsibilities. I do not remember who had specific responsibility for transfusion after his arrival. After the unification with the Haematology Department at UCLH, there was always wide-ranging discussion among the consultants about laboratory policies but I do not recall who had ultimate responsibility for blood transfusion. It is noteworthy that the size of the consultant team continued to expand and now exceeds 30 people. In the 1990s we were joined by Dr Hannah Cohen who led the national Serious Hazards of Transfusion (SHOT) programme, although I don't think she was ever in charge of the UCLH blood bank laboratory.

Q7. Please describe the practical steps that were taken when you decided that a patient required a transfusion of blood or blood components, including:

a. How blood was requested from the hospital blood bank;

22. When blood or blood products were required, the blood transfusion request forms would be filled in and if the requests were unusual in any way, there would be discussion with the senior technical staff in the blood bank, the senior registrar allotted to transfusion at that time or the consultant in charge.

b. What the record keeping requirements were; and

c. What the patient was told before the transfusion.

23. I do not know of the record requirements or recall what patients were told before transfusion.

Q8. Did you, on behalf of the Department, have a relationship with the Regional Blood Transfusion Centre? If so, please describe that relationship. Specifically please include:

a. Who within the Regional Transfusion Centre you interacted with;

b. How frequently you interacted with them; and

c. What your interactions were primarily concerned with.

24. I had no relationship with the Regional Blood Transfusion Centre

Q9. Did you, on behalf of the Department, have a relationship with the National Blood Transfusion Service ("NBTS")? If so, please describe that relationship.

25. I had no relationship with the NTBS

Q10. Approximately how many patients per week would receive a transfusion under the care of the Department? If possible, please set out the number of patients per week who received a transfusion for (a) sickle cell anaemia and (b) thalassaemia.

26. I do not know the number of patients receiving blood or blood products each week.

Q11. Were you aware of any patients who subsequently developed HIV, HCV or HBV under the care of the Department? If so, how many patients were infected?
If you are able to give exact rather than approximate figures, please do so.

27. I do not know the number of patients who developed HIV, HCV or HBV following blood transfusions in the Department. One member of the Middlesex Hospital staff, who was a haemophiliac, developed HIV but I think this followed the administration of blood products at another hospital. A significant proportion of our multi-transfused patients developed transaminitis and an investigation of 32 such patients revealed that eight (25%) had acute HCV infection (Brink et al 1993 Brit J Haematol 83: 498-503) (RLIT0000842). There was also an outbreak of HBV infection in which 5 patients who had received high dose therapy and an autologous bone marrow transplant were shown to be infected secondary to liquid nitrogen contamination in the stem cell storage vessel. This had not been previously reported and the events were published by some of my colleagues as a warning to fellow practitioners (Tedder et al 1995 The Lancet 346: 137-140) (SBTS0000463_131).

Research

Q12. Was any research undertaken within the Department regarding blood transfusion patients?

a. If so, please explain what the research entailed, what the aims of the research were, whether patients were informed of their involvement in the research and consent was obtained.

b. What, if any, involvement did you have in this research?

c. Please provide details of any publications relating to the research.

28. Pioneering research work was carried out by Professor Ernst Huehns and Professor John Porter on the diagnosis and treatment of transfusion-related iron-overload. This led to the development of oral iron chelators. I was not involved in this research. My own work included the further development of stem cell collection, storage and use, and this work contributed to the change from use of bone marrow stem cells to mobilised peripheral blood stem cells.

Q13. Please list all research studies that you were involved with in any other relevant positions of employment insofar as relevant to the Inquiry's Terms of Reference, ensuring your answer addresses:
What the research entailed, what the aims of the research were, whether patients were informed of their involvement in the research and consent was obtained;

a. Your involvement in this research; and

b. Details of any publications relating to the research.

29. I did not perform any research relevant to the Inquiry's Terms of Reference other than the co-leadership, with Professor Anthony Goldstone, of the autologous hematopoietic stem cell programme and the collection and storage of stem cells referred to in section 12

Section 3: Policies and practices regarding blood transfusions

Q14. To the best of your knowledge, was guidance provided to you and/or other medical professionals by UCH as to transfusion policies and practices during the time of your employment? If so, please outline in as much detail as possible the policies in place which would prompt the need for a patient to receive a blood transfusion.

If possible, please refer to how many units of blood would be used, alternative treatments, autologous transfusions, applicable haemoglobin threshold levels for transfusion, as well as any other considerations such as when not to transfuse, the risk of infection or adverse reactions, or resource and cost considerations.

30. I did not attend the transfusion committee meetings so I cannot comment on any specific guidance given to the non-haematology consultant body. In haematology, training in the use of blood and blood products came from the consultant staff by apprenticeship of juniors in training.

31. With regard to haematology patients there was no fixed threshold for transfusing red cells, other than that transfusion was rarely required if the Hb was >100g/l. This lack of a firm threshold was for a good reason, in that the decision to transfuse had to be based, not only on the Hb level, but also on a clinical assessment taking into account the patient's symptomology and co-morbidity and the dynamics of the changing blood parameters. For instance a patient who was 14 days out from high dose therapy and in whom the white count and platelets were starting to recover, might not receive a blood transfusion if the Hb was 99g/l. A patient who was 6 days out from the completion of high dose therapy and in whom there was no evidence of hematopoietic recovery would be transfused if the Hb was 99g/l. There was no effective alternative in this situation. When blood was given it was usually 3 or 4 units. The risks of infection were fully appreciated. With regard to platelets , in the late 1970s these were transfused if the platelet count was less than 20x109/l. Over

time we became 'braver' and the threshold fell to 10x109/l if there were no signs of bleeding.

Q15. Please outline the types of blood and blood products that were most commonly transfused to patients under your care and how this changed over time.

32. The blood products most commonly used in my patients were packed red blood cells and platelets. In the early 1980s freshly collected granulocytes (by leukapheresis) were given to patients with life-threatening infections not responding to antibiotics. Donors were fully screened. This practice declined and stopped by the following decade because of the lack of strong evidence of efficacy and the availability of recombinant G-CSF.

Q16. In your experience at UCH, did any particular blood products or transfusion methods carry a higher risk of viral infection?

33. At UCLH, as in any other hospital, pooled blood products carried a higher infection risk. We were fully aware of the particular risk of pooled products coming from the USA, and the failure to bring a UK production facility online in a timely manner was frequently commented upon.

Q17. In the enclosed document [NHBT0117504], Dr Patricia Hewitt states: "While I would not deny that in the past blood transfusion may have been used excessively, I really believe that since the advent of HIV infection and AIDS this is no longer the case".

a. **With reference to your experience at UCH and in any other relevant roles, please outline if you believe that blood transfusions were provided excessively?**

34. I do not believe that blood products were used excessively at UCLH in the Clinical Haematology Department. The small decline in use of blood products over

the latter part of the 20th century was due to greater confidence that patients were still safe at lower blood levels. I do not think it was due to the awareness of infection risks although this was undoubtedly important in other scenarios.

Q18. Please outline at which level generally a patient's haemoglobin count would be considered low and thus require a blood transfusion. Please also explain:

a. **How this level may have changed over time; and**
b. **How a patient's haemoglobin levels were monitored before, during and after a transfusion.**

35. See section 14 above. All patients receiving intensive chemotherapy received daily blood counts.

Q19. Where applicable, were alternative treatments made available to patients under the care of UCH throughout the time of your employment but specifically in the 1970s and 1980s?

a. **In your view, were the advantages and disadvantages of alternative treatments adequately explained to patients where possible?**
b. **Did the doctor/patient relationship have an affect on the way in which an agreement would be reached in selecting a treatment? If so, please explain.**
c. **Did any aspect of this change over time?**
d. **Generally, how were transfusions regarded within the Department?**
e. **Do you consider that alternatives could have been used in preference to blood transfusions so as to reduce the risk of infection? If not, why?**

36. Not relevant to my practice. There were no efficacious alternatives.

Red cell concentrates

Q20. Were there any circumstances where red blood cell concentrate transfusions would be used instead of whole blood? Please explain:

a. **The circumstances in which red blood cell concentrate transfusions were considered necessary by the Department, and if applicable, preferable over other blood components?**

37. Red cell concentrates were routinely used as our patients had no requirement for blood volume expansion.

b. **The benefits and/or risks associated with red blood cell concentrate transfusions;**

38. The concentrates were less likely to result in fluid overload.

c. **Any measures taken by the Department to minimise the risk of infection, including post transfusion testing.**

39. I do not understand how any post-transfusion test could have prevented a complication of the transfusion.

d. **The process for obtaining informed consent and informing patients or their relatives of the risks associated with red blood cell concentrate transfusions.**

40. It was our practice to discuss all therapies with patients and answer all questions honestly, but I do not recall specific written consent being requested for transfusion. It must be appreciated that patients having high dose therapy and an autologous bone marrow transplant were told in 1980 by myself and other consultants that the procedure carried a treatment related mortality of 10%, and in allografts it was in excess of 20%, and the risks of transfusion were a very minor component of this risk. By 2000 the procedure-related mortality associated with an autograft had fallen to 2.5% and patient advice was amended accordingly.

e. **How many units of red cell concentrates would be administered in one sitting to one patient, and what factors would be taken into account in determining this number?**

41. It was usual to give 3 or 4 units.

Q21. Were guidelines circulated to clinicians concerning the use of red cell concentrate? If so, did the usage pattern of red cell concentrate change as a result of these guidelines? If not, why were guidelines not provided?

You may wish to consider [BWCT0000120_001] when answering questions about red cell concentrates.

42. See section 14

Platelets

Q22. Please consider [NHBT0113679_002]. In particular, the concern that platelet concentrate "which is used to treat bleeding in patients", was being administered without full testing. Please outline:

a. **Whether you used platelet concentrates to treat patients;**
b. **How often patients would require a transfusion of platelet concentrates**

43. Platelets were used frequently in our patients during periods of severe myelosuppression and were often required on a daily basis.

c. **Whether full testing was undergone before administering platelet concentrates?**
d. **How you or the Department knew or could have known whether the platelet concentrates being administered to patients had undergone full testing.**

e. **The perceived benefits and/or risks associated with platelet transfusions known to the Department.**

44. The platelets were obtained from the Regional Blood Transfusion Centre and donors were subject to the usual risk assessment.

f. **How many units of platelets would be administered in one sitting to one patient, and what factors would be taken into account in determining this number?**

45. Typically, 5 units of platelets would be administered at any one time.

e. **Was there ever any difficulty in obtaining platelets?**

46. Occasionally there was a shortage of platelets particularly over long bank holidays and at these times risk based 'rationing' was applied with considerable trepidation.

Fresh Frozen Plasma

Q23. What considerations were made by the Department for the use of FFP transfusions? In particular:

a. **In what circumstances would FFP transfusions be considered necessary by the Department and if applicable, necessary over other blood components? You may wish to refer to the FFP debate in [DHSC0017189]**
b. **The benefits and/or risks of FFP transfusions known to the Department.**
c. **Any measures taken by Department to minimise the risk of infection, including post transfusion testing; and**
d. **The process for obtaining informed consent and informing patients or their relatives of the risks associated with FFP transfusions.**

e. **How many units of FFP would be administered in one sitting to one patient, and what factors would be taken into account in determining this number?**

47. FFP was rarely required in my patients and would only be given if recommended by my colleagues specialising in bleeding and thrombosis. The risk/benefits of FFP were known.

Q24. Were guidelines circulated to clinicians concerning the use of FFP? If so, did the usage pattern of FFP change as a result of these guidelines? If not, why were guidelines not provided? You may wish to consider [NHBT0004335_004] when answering questions about fresh frozen plasma.

48. I cannot comment on guidance and use of FFP in the hospital at large.

Single Unit Transfusions

Q25. Please consider the enclosed document on the use of single unit transfusions of blood in the UK [DHSC0035471], which discusses concerns about unnecessary single unit transfusions of blood in the UK

a. **With reference to your experience at the Hospital and in any other relevant roles, please outline in what circumstances single-unit and two-unit transfusions were administered to patients.**
b. **What did you understand to be the risks and benefits of single-unit transfusions and two-unit transfusions? How, if at all, did this understanding change over time?**
c. **Approximately how often single unit transfusions would be administered**

49. As a rule of thumb we operated on the premise that if a patient only required one or two units of blood then they did not require blood at all. Exceptions to this are rare.

Autologous transfusion

Q26. Were there any circumstances where autologous transfusions would be used instead of donor transfusions? You may wish to refer to [BSHA0000017_021] in your answer. Please explore:

a. **The circumstances in which autologous transfusions were considered necessary;**
b. **Approximately how often this practice occurred;**
c. **The perceived benefits and/or risks associated with autologous transfusions; and**
d. **The process of informing patients or their relatives of the risks associated with autologous transfusions.**

You may wish to consider [NHBT0000033_013] when answering questions about autologous transfusions.

50. I have no information or knowledge about autologous blood transfusions at UCLH.

Fresh Warm Blood

Q27. The Inquiry has received evidence that on some occasions when a blood transfusion was needed urgently, fresh warm blood donated by hospital staff or other local authorities was administered to patients. To your knowledge, did this practice occur at UCH? If so, please explain in as much detail as you are able to, ensuring your answer addresses:

a. **The circumstances in which fresh warm blood transfusions were considered necessary;**
b. **Approximately how often this practice occurred;**

c. **The perceived benefits and risks of fresh warm blood transfusions (you may wish to refer to [NHBT0000037_013], page 8);**
d. **Any measures taken to minimise the risk of infection, including assessing donor suitability and post transfusion testing; and**
e. **The process for obtaining informed consent and informing patients or their relatives of the risks associated with fresh warm blood transfusions.**

51. I am unaware of fresh warm blood being administered at UCLH. In the 1970s some of the cardiac surgeons at the Middlesex Hospital used fresh warm blood if there was uncontrollable post-operative bleeding. My colleague Sam Machin put a stop to this practice when he became a consultant.

Q28. With reference to any of the groups outlined in question 3, please identify any significant policies created by those groups in which you were involved, insofar as relevant to the Inquiry's Terms of Reference. Please describe the reason for and impact of the policy, and the extent of your involvement.

52. Not applicable.

Q29. With reference to all of the committees named in your answer to question 3, please outline the extent to which any of those committees were involved in the following matters:

a. **Awareness of national guidelines for promotion of good transfusion practices;**
b. **Development of local hospital guidelines;**
c. **Transfusion policy induction procedure for new staff;**
d. **Review of nursing procedures for administration of blood and blood products;**
e. **Promotion of new information regarding transfusion matters;**

f. **Ensuring patients are adequately informed of matters relating to transfusions, such as availability or alternative treatments;**
g. **Blood transfusion record keeping and documentation;**
h. **Review and notification of post transfusion complications (included adverse reactions and transfusion associated infections);**
i. **Assessment of transfusion practices in light of product usage; and**
j. **Consent for blood transfusion.**

Please ensure your answer includes any significant policies, guidelines, decisions relevant to blood transfusion practices or blood safety that were proposed, created, implemented and/or overseen by the group.

53. Not applicable

Q30. With reference to all of the committees named in your answer to question 3, please outline any specific transfusion policies created by those committees in relation to:

a. **Obstetrics;**
b. **Trauma and emergency care;**
c. **Surgery;**
d. **Haematological cancer treatment;**
e. **Thalassaemia; and**
f. **Sickle Cell Anemia.**

54. Not applicable

Q31. Was there a Hospital Transfusion Committee at UCH? If so, insofar as you are able:

a. **Please provide a brief overview of the Committee, including when the Committee was created, its roles and responsibilities at UCH, and its relationship with the Department at UCH.**
b. **With reference to any of the matters identified in Questions 28 and 29 of this request, please outline any significant policies or practices established by the Committee.**
c. **Please explain the relationship between the Hospital Transfusion Committee and the Regional Transfusion Centre.**

55. I believe there was a Hospital Transfusion committee at UCLH but I was not involved in its activities.

Q32. During Parliamentary questions on 10th December 1985, Mr Hayhoe stated that 'supplies of whole blood are not imported since the United Kingdom is self sufficient in its needs for blood for transfusions; it is only certain blood products which are imported' [HSOC0018830]. To your knowledge, was the UK self-sufficient in its need for whole blood for transfusions?

56. I agree that the UK was self-sufficient in the provision of whole blood, although there could have been very rare exceptions to this that I am not aware of.

Q33. During your tenure at UCH, were you aware of patients being given blood transfusions with red blood cells imported from the USA? If so, was there any concern about its use at the time?

57. I do not know of any patient receiving whole blood donated in the USA

<u>Section 4: Knowledge of risk</u>

General

Q34. When you began working at the Department, what did you know and understand about the risks of infection associated with blood transfusions? What were the sources of your knowledge? How did your knowledge and understanding develop over time?

58. The infective risks of transfusion were outlined in the undergraduate lectures in haematology given at the Middlesex Hospital Medical School. Whilst still a junior doctor at UCLH I co-authored an undergraduate textbook of Haematology (Richards JDM, Linch DC, Goldstone AH. A synopsis of Haematology. John Wright and Sons Bristol 1983). Chapter 27 (WITN6969002) was devoted to 'Hazards and Complications of blood Transfusion' and the agents listed as being transmitted by blood were, HBV, HAV, NANB (particular attention drawn to role of transmission by pooled factor VIII concentrates), CMV, infectious mononucleosis, brucellosis, a number of 'tropical infections' and syphilis'. This text was actually written in 1981/2 and thus did not include HIV or vCJD. Over time it became clear that NANB (HCV) was a major problem in the multiply-transfused.

Hepatitis

Q35. What was your knowledge and understanding of the risks and transmission of hepatitis, including HBV and HCV from blood transfusion? What were the sources of your knowledge? How did that knowledge and understanding develop over time?

59. See section 34 above

HIV and AIDS

Q36. When you began work at the Department, what was your knowledge and understanding of HIV and AIDS and in particular of the risks of transmission through blood transfusions? How did that knowledge and understanding develop over time?

60. Knowledge of the AIDs outbreak became apparent while I was still a junior doctor at UCLH. I learned more about this issue whilst working at the Dana Faber Cancer Institute in Boston in 1983.

Other

Q37. If you were responsible for making decisions and actions on behalf of the Department in response to any known or suspected risks of infection, please explain what decisions were involved. If applicable, do you consider that those decisions were adequate and appropriate? If so, why? If not, please explain what you believe could or should have been done differently.

61. Not applicable to me

Q38. Were any audits or surveillance programmes regarding the use of blood transfusions by the Department conducted at UCH? If so, please explain these processes and the impact they had on blood transfusion standards and practice.

62. There were frequent audits by all sections of the Haematology Department and I presume this will have included blood use, although I have no precise knowledge of this.

Q39. Did UCH have any procedures in place to ensure patients reported any adverse reactions or symptoms? If so, please explain:

a. **What procedure did the Hospital have in place?**
b. **Did this procedure extend to after a patient had been discharged from Hospital?**
c. **Were patients asked to report any adverse reactions or symptoms within a certain timeframe?**

d. **If clinicians were informed and/or became aware of a patient having suffered any adverse reactions or symptoms, who were they required to report this to?**
e. **Was there any mechanism for the Hospital to report any adverse reactions or symptoms to the Regional Transfusion Centre?**
f. **In the event of a patient's death after receiving a blood transfusion, what process was followed? Specifically, in relation to the registration of the death and/or any consideration of what was recorded on the death certificate.**

63. I am ignorant of these procedures and unable to answer this question.

Section 5: Treatment of patients

Provision of information to patients

Q40. What information did you provide or cause to be provided to patients in the Department about the risks of infection by blood transfusion prior to treatment commencing?

64. I do not recall giving specific advice to my patients about the risks of infection by blood transfusion prior to treatment i.e. chemotherapy. They were advised of the overall risks of any chemotherapy they were about to receive.

Q41. If the nature of provision of information changed over time whilst at the Department, could you please explain how this was so and why changes were made?

65. I don't think this changed over time unless it was in the last few years.

Q42. Please describe if the Department had a process of informing patients that they had been, or might have received infected blood through a

transfusion If so, how were patients or their relatives informed? What if any involvement did you have in this process?

66. I am unable to answer this question due to lack of knowledge.

Consent

Q43. Were blood samples taken from patients under the care of UCH and if so, for what purposes? Was this information shared with patients? Was patient consent recorded and if so how and where?

67. Most in-patients received near daily blood tests when they were myelosuppressed. This was a component of their chemotherapy regimen and separate consent for venesection was not sought.

Q44. Are you aware if patients under the care of UCH were treated with blood transfusions without their express or informed consent? If so, how and why did this occur?

68. I do not know of blood being administered to patients without their verbal consent, but presumably this did happen if the patient was unconscious.

Section 6: vCJD

Q45. When and in what circumstances did you become aware of the risks of transmission of vCJD associated with the use of blood transfusions? Please explain how your knowledge developed over time.

69. I became aware of vCJD soon after it was identified in 1996. Clinicians at UCLH were well informed of the developing situation because Sir John Pattison led the government committee reviewing this disease and was a Professor of Virology at

UCLH. I think the potential transmission of vCJD by transfusion was acknowledged very soon although formal proof of this sequence of events took several years.

Q46. 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 in the Department for informing patients about the risks of or possible exposure to vCJD?**
b. **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?**

70. I was not involved in discussions about providing information about vCJD.

Q47. What measures were put in place from a public health perspective at UCH in relation to the care and treatment of patients in light of the risk associated with vCJD transmission by blood transfusion?

71. I cannot answer this question.

Q48. With reference to all of the committees named in your answer to question 3 above, please outline the extent to which any of those committees were involved in assessing and managing the risk of vCJD transmission by blood transfusion.

72. Not applicable.

<u>Section 7: Other Issues</u>

Q49. 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.

73. None.

Statement of Truth

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

Signed GRO-C

Dated 01/03/2022.

Exhibits

URN	Date	Description
WITN6969002	01/01/1983	Chapter 27 'Hazards and Complications of blood Transfusion', 'A synopsis of Haematology', Richards JDM, Linch DC, Goldstone AH, 1983.