Witness Name: Dr Anna-Maria Rollin MBE

Statement No.: WITN6974001

Exhibits: WITN6974002-WITN6974003

Dated: 9 February 2022

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ANNA-MARIA ROLLIN

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

I, Dr Anna-Maria Rollin, will say as follows: -

Section 1: Introduction

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

1. My name is Anna-Maria Rollin.

My address is: GRO-C London GRO-C

My date of birth is GRO-C 1946

My professional qualifications are:

a. MBBS University of London 1970

b. MRCS LRCP Conjoint Board 1970

c. DA Faculty of Anaesthetists 1972

Royal College of Surgeons

d. FFARCS Faculty of Anaesthetists 1975

Royal College of Surgeons

e. FRCA Royal College of Anaesthetists 1996

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. Please see attached CV **(WITN6974002).** The relevant information can be found on pp 2-6.

2. 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. I have not been a member of any group specifically relevant to the Inquiry's Terms of Reference.

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 HIV, HBV and/or HCV in blood transfusions. Please provide details of your involvement and copies of any statements or reports which you provided.

4. I have not provided evidence to, or been involved in, any inquiries, investigations, criminal or civil litigation in relation to HIV, HBV, and/HCV in blood transfusions.

Section 2: Epsom General Hospital

5. Please describe:

a. Your role and responsibilities at the Epsom General Hospital ("the Hospital") and how these changed over time.

5. I took up my post of consultant anaesthetist at what was then called Epsom District Hospital in 1977. My primary occupation was that of a general clinical anaesthetist, but I had a special interest in anaesthesia for children and for urological surgery.

6. Over the years, I took up various management responsibilities in the department and the hospital, and these can be found detailed on page 3 of the attached CV, under the heading 'Local'.

7. I retired from the NHS in 2011, but maintain an honorary contract with the hospital.

b. Your work at the Hospital insofar as it involves treating patients with blood transfusions.

8. I was involved in treating patients with blood transfusions only when there was a surgical requirement. Patients who were admitted following trauma sometimes required immediate blood transfusion. On rare occasions, an anaemic patient would be given a blood transfusion before urgent surgery. By far the most common indication in my clinical practice was surgical bleeding, during or immediately after surgery, leading to acute anaemia and a need for blood transfusion.

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

9. I was not involved in the care of patients who were infected with HIV, Hepatitis C, Hepatitis B or other viruses associated with blood transfusion.

6. **Please:**

a. **Describe the roles, functions and responsibilities of the Anaesthesia Department ("the Department") within the Hospital during the time you worked there. Please also explain how the Department worked with other departments within the Hospital, such as critical care, emergency, obstetrics/gynaecology, or surgical units in so far as it related 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.**

10. The Department of Anaesthesia ('the Department') within the hospital was responsible for the pre-operative assessment and direct anaesthetic care of surgical patients in all surgical specialties. Postoperative care of surgical patients was a shared responsibility.

11. The Department provided anaesthetic and resuscitation services to the Emergency Medicine Department, as well as an anaesthetist who was part of the Resuscitation Team.

12. The Department provided dedicated anaesthetic services to the Obstetric Department, both for regional anaesthesia during labour and operative delivery and general anaesthesia if required for Caesarean section and other interventions.

13. The Department was responsible for providing dedicated medical cover to the Critical Care Units. Over the years from 1977 to 2011, when I retired, the doctors covering the critical care units, while trained as anaesthetists and managed by the Anaesthetic Department, became increasingly specialised as dedicated intensivists.

14. In addition to planned services, an emergency team of trainees, specialist doctors and a consultant was always available for resuscitation and emergency services.

15. The decision to commence a blood transfusion and/or the type of transfusion to give was almost always a joint decision amongst the treating clinicians. On the rare

occasions when there was disagreement, most anaesthetists would have assumed the responsibility.

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

16. The hospital blood transfusion service would provide suitable blood products on request from a senior clinician, often following direct discussion. It was the responsibility of the clinician (doctor or nurse) who commenced the blood transfusion to make the relevant checks. Care of the patient then passed, usually, to the nursing staff. If the transfusion was commenced in the operating theatre, the anaesthetist took responsibility before handing it over to the nursing staff, usually in the recovery ward.

c. 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.

17. All anaesthetists were required to assume responsibility for any blood transfusions they commenced. For trainees and specialist doctors, this was under the supervision of a consultant, the degree of supervision being specified and varying with the seniority of the clinician. I have no recollection of any colleague taking general responsibility for blood transfusions.

18. The Department was not directly involved in the care of patients infected with hepatitis and/or HIV. If such an infected patient required surgery, appropriate precautions were taken.

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

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

19. For planned surgery, the surgical team would arrange for a blood sample to be sent to the laboratory for 'group and save' i.e. the patient's blood group was identified and a sample saved for rapid cross match if needed. If the planned surgery was such that blood transfusion was likely to be needed, an appropriate number of units of blood were requested in advance, to be stored in case of need.

20. In an emergency, a clinician would liaise with the blood bank, send off a blood sample for cross-matching and request blood or blood products to be supplied urgently.

b. What the record keeping requirements were; and

21. I can only comment on the record keeping requirements for anaesthetists. The anaesthetist would check the patient details on the patient record, the patient's wristband, the form provided by the blood bank and the unit of blood itself before starting the transfusion. There would be a record of the checks. The date, time, and identifying number of the unit of blood would be recorded on the patient's treatment chart, together with the signature of the clinician who started the transfusion. Detailed instructions for the duration of infusion and any further units to be given were included on the chart, along with any other relevant specific instructions.

c. What the patient was told before the transfusion.

22. What the patient was told before the transfusion varied not only with the clinician but with the decade in which the transfusion was given. When I became a consultant in 1977, the attitude was still largely paternalistic, and the 'doctor would decide' if and when a transfusion was required. Blood for transfusion was generally regarded as safe, and warnings were not generally part of the discussion.

23. Over time, patients were increasingly informed of the requirements for transfusion, warned of the risks as we learned more about them, and were involved in the decision whether or not to transfuse, if there was an option.

24. Most discussions took place pre-operatively, often in the pre-operative assessment clinic, because the actual decision to transfuse usually had to be made during surgery while the patient was unconscious.

25. Over the years, increasing attention was paid to the requirements of Jehovah';s Witnesses or others who declined to receive blood. Their views were treated with increasing respect, and alternative arrangements were discussed with them.

26. At all times, anaesthetists were required to be aware of, and abide by, the current guidelines for consent as laid down by the GMC. Discussions were recorded in the patient's notes.

8. **Did you have, on behalf of the Department, 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.

27. I did not have a relationship with the Regional Blood Transfusion Centre. As far as I am aware, nor did anybody else in the Department. Our relationships were with senior staff in the hospital blood bank, whom we consulted occasionally to discuss specific cases preoperatively (for example, patients who had a history of transfusion reactions).

28. When large quantities of blood were required urgently in emergencies, it was usual to have a discussion with the on-call haematologist about the best way to manage the situation.

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

29. I did not have a relationship with the National Blood Transfusion Service. As far as I am aware, nor did anybody else in the Department.

10. Approximately how many patients per week would receive a transfusion under the care of the Department?

30. I have consulted colleagues both in the Anaesthetic Department and the Transfusion Service, but records of numbers prior to my retirement are not available.

11. 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.

31. I was not aware of any patients who subsequently developed HIV, HCV or HBV under the care of the Department.

12. 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.

32. As far as I am aware, no research was undertaken within the Department regarding blood transfusion patients.

13. Please list all research studies that you were involved with in any other relevant positions of employment (including any of the committees listed in your answer to question 3) insofar as relevant to the Inquiry's Terms of Reference, ensuring your answer addresses:

a. 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. Your involvement in this research; and

c. Details of any publications relating to the research.

33. I was not involved in any research studies elsewhere.

Section 3: Policies and practices regarding blood transfusions

14. To the best of your knowledge, was guidance provided to you and/or other medical professionals by the Hospital as regards transfusion policies and practices during your employment? If so, please outline in as much detail as possible the policies in place which would prompt you to transfuse in the course of surgery or critical care, and how those policies changed over time.

If possible, please refer to how many units of blood would be used, alternative treatments, autologous transfusions for planned major surgery, 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.

34. I am not aware of any local guidance provided by the Hospital in relation to transfusion policies and practices. I have consulted colleagues in the transfusion department, who were unable to identify any such policies.

35. There was an expectation that clinicians would apply the contemporaneous national standards.

36. There was an 'understanding' that blood transfusion should not be commenced if the patient needed less than two units of blood, and the aim was to transfuse up to a haemoglobin level within the normal range. Early in my career, blood transfusion was

started, or at least seriously considered, when the haemoglobin level fell to 10g/dl (100g/L). By the time I retired, the general consensus was lower, at around 8g/dl.

37. Autologous transfusion was not available in the Hospital. We did not undertake very major specialist surgery.

38. The risk of infection was not discussed until late in my clinical career. Blood was generally thought to be 'clean' and safe.

39. I was never aware of resource or cost considerations as such. Decisions were made on the best clinical opinion at the time.

15. Please outline the types of blood and blood products that were most commonly transfused to patients under your care, the circumstances in which they were used, and how this changed over time.

40. Initially, whole blood was the most commonly used product. With the passage of time, targeted blood products were increasingly used. These included red blood cells, platelets, fresh frozen plasma and cryoprecipitate.

41. Apart from red blood cells, which largely replaced whole blood, blood components were usually selected and used after discussion with a consultant haematologist.

16. How, if at all, did policies for blood transfusion differ for paediatric patients? Please explain in as much detail as you are able to, and with respect to different types of blood transfusion.

42. The Hospital undertook only minor paediatric surgery, and the only time I was aware of blood transfusion being required for children was in very rare cases of bleeding following tonsillectomy. In this case, whole blood or packed red cells were used, depending on the size and clinical condition of the child. The main consideration was volume replacement, and the anaesthetist, surgeon and paediatrician always worked together in this emergency.

17. Please outline at which level generally a patient's haemoglobin count would be considered low and thus require a blood transfusion. Please also explain how the level at which transfusion was deemed necessary may have changed over time.

43. Early in my career, blood transfusion was started, or at least seriously considered, when the haemoglobin level fell to 10g/dl (100g/L). By the time I retired, the general consensus was lower, at around 8g/dl. and there was discussion that even lower levels might be acceptable. Early on, the decision to transfuse was triggered very largely on the haemoglobin level as a number. Latterly, considerations were widened, so that the patient's clinical condition and co-morbidities were factored into the decision.

18. 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 Epsom General Hospital and in any other relevant roles, please outline in what circumstances single-unit and two-unit transfusions were administered to patients.

44. Throughout my clinical career, single unit transfusions (except, obviously, for very small patients/children, where volume was calibrated to the size of the patient) have been regarded as inappropriate, unnecessary and wasteful. Two-unit transfusions were regarded as the minimum.

45. In practice, most two-unit transfusions were the result of surgical uncertainty. If a major bleed occurred during surgery, and it looked as if it would be difficult to control, many anaesthetists thought there was virtue in 'getting ahead' and starting transfusion as soon as blood was available. If the bleeding then came under control, the patient would be given two units of blood and no more.

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?

46. I have covered part of this question above. Over time, the threshold for starting blood transfusion has been a lower haemoglobin concentration than previously thought desirable.

c. With regard to all types of blood transfusions, do you recall any instances or periods of time in which you or others raised concerns about unnecessary or excessive blood transfusions? If so, please explain in as much detail as you are able to recall, including why this may have occurred and how, if at all, this changed over time.

47. I don't recollect concern or anxiety as such. As evidence emerged of the risks of blood transfusion, and the relative safety of allowing lower haemoglobin concentrations, so practice gradually changed, with younger colleagues leading the way.

19. The enclosed document reports on a study conducted by Mallet et al (2000) titled 'Reducing red blood cell transfusion in elective surgical patients: the role of audit and practice guidelines', published in Anaesthesia [NHBT0086594_003]. The study found that 'haemoglobin was measured infrequently prior to transfusion' (p1). With respect to your experience at Epsom General Hospital, please explain the process of measuring a patient's haemoglobin count, including the frequency with which it was monitored.

48. The process for measuring a patient's haemoglobin concentration was straightforward. A blood sample was taken and sent to the laboratory, with an indication of urgency if necessary. Routine results were returned to the ward, usually on the next day. If the request was for an urgent estimation, the result was telephoned back as soon as it was available.

49. If there was major haemorrhage in the operating theatre, haemoglobin would be measured, but blood transfusion would be started immediately if that was thought appropriate.

50. If surgery and haemorrhage were prolonged, another sample might be sent within the hour. If the operation ended, a blood sample would probably be sent from the recovery ward or the critical care unit.

51. The results would be used to guide treatment, but were regarded as relatively unreliable because of other factors, such as fluid loss, or fluid overload.

20. The enclosed document contains guidance on red cell transfusion published by the Association of Anaesthetists of Great Britain and Ireland in 2001 [DHSC0020813_059]. Page 5 of the booklet (page 6 of DHSC0020813_059) notes that 'patients should not be transfused to achieve a normal haemoglobin concentration'. Please comment on this in light of your experience of practising during your tenure at Epsom General Hospital, ensuring your answer addresses the considerations that are taken into account when deciding to transfuse a patient other than haemoglobin concentration.

52. I have answered this question, at least in part, in 17 above. In addition to what I have said there, the aim was to transfuse sufficient blood to raise the haemoglobin level to within the normal range. By the time I retired, that was no longer considered to be desirable or necessary.

53. Latterly, much more consideration was given to the condition of the individual patient, including cardiac and renal function, and the likely progress of surgery (i.e. whether blood loss would stop soon).

21. The enclosed paper titled 'Lack of haematological and biochemical consequences following autologous blood transfusion' states that a primary benefit of autologous transfusion is it may 'diminish the risk of viral cross infection' [NHBT0040771_001]. Please explain:

a. The circumstances in which autologous transfusions were considered necessary or beneficial;

b. Approximately how often this practice occurred;

c. The perceived benefits and risks of autologous transfusions;

d. The process of informing patients or their relatives of the risks associated with autologous transfusions.

54. The Hospital did not undertake specialist major surgery, and, at the time I was employed there, did not have facilities for autologous blood transfusion.

22. In your experience at Epsom General Hospital, did any particular blood products or transfusion methods carry a higher risk of viral infection?

55. I was never aware of any transmitted viral infection.

23. In light of Question 14, where applicable, were any alternative treatments made available to patients under the care of Epsom General Hospital throughout the time of your employment? If applicable, please ensure your answers include treatment throughout the 1970s and 1980s at any institutions at which you have worked.

56. As far as I am aware, the only alternative treatment to blood transfusion was the use of other intravenous fluids, colloids or crystalloids.

a. In your view, were the advantages and disadvantages of alternative treatments adequately explained to patients where possible?

57. I am not aware of the level of detail provided to patients by other anaesthetists. The expectation was that the advantages and disadvantages of various forms of treatment should be explained to patients and the discussion documented. In reality, the level of detail between the discussion itself and the written record (which often amounted to 'discussion') was likely to vary.

58. Over time, the level of detail provided to patients increased and there was increased understanding of shared decision making. Speaking personally, I did try to give patients a balanced view.

b. Did the doctor/patient relationship have an effect on the way in which an agreement would be reached in selecting a treatment? If so, please explain.

59. Inevitably, the doctor/patient relationship had an effect on the way in which agreement would be reached, and inevitably, the doctor/patient relationship was different in each individual case. The population in which I was fortunate to work comprised, mostly, well-educated and engaged people and it was easy and rewarding to have detailed discussions.

c. Referencing your answer to 23(b), did any aspect of this change over time?

60. The level of detail and involvement expected by patients and acknowledged by doctors increased over time.

d. Generally, how were transfusions regarded within the Department?

61. I do not remember any specific discussion of our attitudes to transfusion. They were regarded as a useful therapeutic tool, to be used as and when required.

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?

62. With hindsight, we could have used alternatives to blood transfusion more thoughtfully. However, in the 1970s and into the 1980s, blood was regarded as a 'clean' product, quality controlled by the blood transfusion service. For anaesthetists working in district hospitals, using blood products for surgical purposes was regarded as the correct form of treatment.

24. Please consider the enclosed minutes of a meeting of the CRAG (Clinical Resource and Audit Group) Blood Transfusion Working Party held on 1 July 1992 [SBTS0003883_090]. Page 3 of the minutes contains discussion about the use of whole blood to treat paediatric patients.

a. With reference to your experience and the considerations mentioned in the meeting minutes, please explain why treatment policies regarding whole blood transfusion may differ in the context of paediatric patients.

b. The minutes state that anaesthetic staff had expressed concerns 'regarding the difficulties of administering OAS and standard RCC through paediatric cannulae'. Please explain the difficulties referred to in this statement.

63. In my clinical experience, which is confined to the use of blood transfusion for emergency situations in children (trauma or significant surgical bleeding following tonsillectomy), we used whole blood. The reasons for this were twofold, as described in the CRAG minutes (SBTS0003883_090): that there was little research guidance on the use of blood products in children and that we generally needed to transfuse quickly, with a minimum of difficulty. Whole blood is easier to transfuse through small cannulae than packed red blood cells.

25. 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, and preferable to other types of transfusion;

64. Red blood cell concentrate was used preferentially when the aim was to increase the haemoglobin content and therefore the oxygen-carrying capacity of the blood without the risk of fluid overload.

b. Approximately how often this practice occurred;

65. At the start of my consultant career, it was necessary to request red blood cell concentrate specifically because the blood bank would routinely supply whole blood if a transfusion was planned. By the end of my consultant career, the reverse was the case. I cannot put figures on the change

c. The perceived benefits and/or risks of red blood cell transfusions;

66. Please see my reply to a.

d. Any measures taken to minimise the risk of infection, including post transfusion testing; and

67. Anaesthetists would assume that the transfusion service had carried out all the tests necessary to ensure that the blood was safe to use. I never knowingly encountered any post-transfusion infections, and never conducted any post-transfusion testing. This would fall outside the normal clinical responsibility of the anaesthetist.

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

68. I have discussed standard practice for obtaining informed consent for blood transfusion, as it varied over the years, in my answer to Question 7c. It was not standard practice to discuss the use of specific blood components in detail.

26. Were there any circumstances where platelet transfusions would be used instead of whole blood? Please explain:

a. The circumstances in which platelet transfusions were considered necessary, and preferable to other types of transfusion;

69. If a patient bled heavily on the operating table or in the emergency department and the bleeding continued despite stabilisation of the cardiovascular system, it would have been routine practice to send a blood sample to the laboratory for clotting studies. Platelets would have been administered in close consultation with the duty haematologist. In my own hospital, platelets were not provided unless the haematologist had been consulted and recommended their use, based on the clotting studies.

b. Approximately how often this practice occurred;

70. I am unable to put a figure on it. It was unusual, but not rare.

c. The perceived benefits and/or risks of platelet transfusions;

71. The benefit would have been to increase blood clotting and thereby stem the bleeding.

d. Any measures taken to minimise the risk of infection, including post transfusion testing; and

72. It was assumed that precautions had been taken by the blood transfusion service to ensure that the platelets were infection free. The transfusion would have been started using a standard sterile technique. I am not aware of any post-transfusion testing specifically to look for infection as a result of the transfusion.

e. The process for obtaining informed consent and informing patients or their relatives of the risks associated with platelet transfusions.

73. As in the answer to 25e above.

27. Were there any circumstances where Fresh Frozen Plasma ("FFP") transfusions would be used instead of whole blood? Please explain:

a. The circumstances in which FFP transfusions were considered necessary, and preferable to other types of transfusion; and whether the position changed over time;

b. Approximately how often this practice occurred;

c. The perceived benefits and/or risks of FFP transfusions;

d. Any measures taken to minimise the risk of infection, including post transfusion testing; and

e. The process for obtaining informed consent and informing patients or their relatives of the risks associated with FFP transfusions.

74. Fresh frozen plasma contains clotting factors and was therefore used when bleeding was difficult to stop, or the patient had lost large volumes of blood. It was used in serious situations, frequently in the emergency department in patients admitted following trauma. It was used only in consultation with a haematologist.

75. The answers to questions b,c,d and e are as they were in Question 26 b,c,d and e.

28. **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 Epsom General Hospital? 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.

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.

In answering this question you may wish to consider the enclosed guidelines on transfusion for massive blood loss by the British Committee for Standardization in Haematology Blood Transfusion Task Force [NHBT0000037_013].

76. I am not aware of any occasion when fresh warm blood donated by hospital staff was administered to patients at Epsom General Hospital.

29. **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 policies, and the extent of your involvement.**

77. As stated in my answer to Question 3 above, I have not been a member of any group directly relevant to the Inquiry's Terms of Reference.

30. 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 in relation to transfusion practice

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 blood transfusion, 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, e.g. following audits of blood transfusion

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 groups.

78. Although I have been involved in the drafting of local and national guidelines on a number of topics, none of them are related to blood transfusion.

31. 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;

f. Sickle Cell Anaemia;

g. Bleeding disorders (Haemophilia A, Haemophilia B, or von Willebrand's disease)

79. Not applicable.

32. Was there a Hospital Transfusion Committee at Epsom General Hospital? If so:

a. Please provide a brief overview of the Committee, including when the Committee was created, its roles and responsibilities at Epsom General Hospital, and its relationship with the Anaesthesia Department at the Hospital.

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.

80. I am not aware of the existence of a Hospital Transfusion Committee during the time I worked at Epsom General Hospital.

33. 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]. During your tenure at Epsom General Hospital, 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?

81. I am not aware of patients being given blood transfusions with red blood cells imported from the USA during my tenure at Epsom General Hospital.

Section 4: Knowledge of risk

34. **When you began working as an anaesthetist, 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?**

82. When I began working as an anaesthetist, I was aware that infections could be transmitted by blood transfusion. The sources of my knowledge were what I had been taught as a medical student and what I had read in textbooks and journals.

83. I had never seen a case, and I assumed (as we had been taught) that blood for transfusion was quality assured by the blood transfusion service. It was regarded as a safe, 'clean' product.

84. It was much later, when reports began to appear in the medical press, that I began to regard blood transfusion as a potential source of infection.

35. **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?**

85. Hepatitis was always one of the potential infections associated with blood transfusion, so I was aware of it in general terms as a medical student.

86. In 1988, the Association published guidelines on the occupational hazards posed to anaesthetists by the human immunodeficiency virus (HIV) and hepatitis B virus (HBV) **(WITN6974003).** The guidance was aimed at protecting the anaesthetist from infection, rather than the patient.

87. It was only later, when cases were being reported, that I fully understood the potential for infection by blood transfusion.

36. When you began work as an anaesthetist, 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?

88. The first cases of HIV/AIDS were reported in 1981, by which time I had been a consultant for four years. Knowledge and understanding dawned gradually, with an increasing realisation of the seriousness of the condition, and the publication of guidelines from the Association of Anaesthetists (see 35 above).

89. The disease became a practical clinical consideration for anaesthetists as reports of the links to blood transfusion began to appear in the literature.

Other

37. If you were responsible for making decisions and actions on behalf of the Anaesthesiology department or any other departments 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.

90. As awareness of the risks of blood transfusion grew, procedures were tightened in accordance with national guidelines. I am not aware of any guidelines specific to Epsom General Hospital.

91. From memory, the enhanced procedures put in place (for example, universal precautions) were designed to protect staff rather than patients. It was still assumed

that the blood transfusion service would take responsibility for the quality of the blood used in transfusion.

38. Were any audits or surveillance programmes regarding the use of blood transfusions conducted at Epsom General Hospital? If so, please explain these processes and the impact they had on blood transfusion standards and practice.

92. I am not aware of any audits or surveillance programmes regarding the use of blood transfusions at Epsom General Hospital.

39. At Epsom General Hospital, were any efforts made to monitor the incidence of transfusion-transmitted infections in patients? If so, please explain these processes, the findings, and the impact they had on blood transfusion standards and practice.

93. I am not aware of any efforts made to monitor the incidence of transfusion-transmitted infections in patients. It is possible that the blood transfusion service and the medical departments made such efforts, since they treated medical, as opposed to surgical, conditions which required blood transfusion.

40. Did the Hospital 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?

94. Patients were closely monitored during and immediately after blood transfusion, and almost all surgical patients who required transfusion would have stayed in hospital for several days. Blood pressure, heart rate, respiratory rate and temperature would have been monitored regularly, and any post-operative infections noted, investigated and treated.

b. Did this procedure extend to after a patient had been discharged from Hospital?

95. Patients would have been given instructions to return if they noticed any adverse reactions or symptoms. These would have been couched in general terms, not specifically related to blood transfusion.

c. Did this procedure extend to after a patient had been discharged from Hospital?

96. I cannot be sure, but I suspect the timeframe would have been open ended.

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?

97. That would depend entirely on the nature of the adverse reactions or symptoms. It is unlikely that clinicians continued looking specifically for reactions associated with blood transfusion once the patient had left hospital.

e. Was there any mechanism for the Hospital to report any adverse reactions or symptoms to the Regional Transfusion Centre?

98. I am not aware of any such mechanism, but it would not have been within the responsibility of the anaesthetist to report such a reaction. It is unlikely that the anaesthetist would have any contact with the patient after discharge from the hospital.

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.

99. Unless the death occurred on the operating table or very soon after surgery, it is unlikely that the anaesthetist would be involved. The cause of death during or immediately after blood transfusion would be much more likely to be anaphylaxis than infection. I am not aware of any death being attributed to blood transfusion, either acutely or as a result of infection, during my tenure at the hospital.

41. At Epsom General Hospital, were you involved in any efforts made, e.g. look-back exercises, to trace potentially infected donors or recipients of

infected blood transfusions? If so, please explain these processes, the findings, and the impact they had on blood transfusion standards and practice.

100. I am not aware that any such efforts were made, or that the need for them arose.

Section 5: Treatment of patients

Provision of information to patients

42. Were you involved in discussions with patients regarding risks of infection by blood transfusion? If so, what information did you provide or cause to be provided to patients under your care at Epsom General Hospital about those risks prior to treatment commencing?

101. I was involved with discussions with patients regarding risks of infection by blood transfusion, insofar as I had discussions with each of my patients about the risks and benefits involved in whatever procedure they were about to undergo.

102. If it seemed likely that a blood transfusion would be needed, I discussed this in general terms of risk and benefit. The risk of infection would have been mentioned but not highlighted. Information was verbal. The Royal College of Anaesthetists publishes a series of patient information leaflets, but the risks of infection from blood transfusion are not among them.

103.https://www.rcoa.ac.uk/patient-information/patient-information-resources/anaesthesia-risk/risk-leaflets

43. If the nature of provision of information changed over time during your employment as an anaesthetist at Epsom General Hospital, please explain what changes occurred, and the reasons for any such change/s.

104. The nature of provision of information did change during my time at Epsom General Hospital, but this reflected a general change in practice, rather than one specifically related to blood transfusion. Over the time period, patients were provided

with increasing amounts of information, risks were discussed in clearer terms and questions were actively encouraged.

Response to risk

44. How, if at all, did a patient's infectious status (including HIV, HBV and HCV) affect their treatment and care as regards blood transfusion?

105. If a patient was diagnosed as having an active infection, including HIV,HBV or HBC, their treatment and care were affected to the extent that staff took even more precautions against the spread of infection than usual. Their treatment as regards blood transfusion was not affected, in that they were given transfusions if and when they needed them on clinical grounds.

Consent

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

106. Anaesthetists were expected to obtain valid consent for all planned procedures, following discussion with the patient, in which risks, benefits and options were explored. The discussion was documented. Only in an emergency, if the patient was unconscious, anaesthetised or lacked capacity, would a blood transfusion be started without consent.

<u>Section 6: vCJD</u>

46. 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.

107. vCJD was first described in the mid 1990s. I became increasingly aware of it as reports began to appear in the literature. It was apparent from the nature of the

infection that it could be transmitted by blood transfusion, and it was added to the list of potential risks.

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

108. I cannot recall what specific measures were put in place, other than to raise awareness and apply the existing precautions relating to other viruses as rigorously as possible.

48. 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 assessing and managing the risk of vCJD transmission by blood transfusion.

109. There are no committees named in my answer to Question 3, since I was not involved in any.

Section 7: Other issues

49. 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.

110. To my knowledge, there have been no relevant complaints made about me to my employer, to the General Medical Council, to the Health Service Ombudsman, or to any other body or organisation.

50. Please provide any further comment that you wish to provide about matters of relevance to the Inquiry's Terms of Reference.

111. I do not wish to make any further comment.

51. In addition to any documents exhibited in support of your statement, the Inquiry would be grateful to receive copies of any potentially relevant documents you possess relating to the issues addressed in this letter.

112. I have attached a copy of my CV **(WITN6974002)**.

Statement of Truth

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

Signed GRO-C

Dated 09/02/2022

Table of exhibits:

Date	Notes/ Description	Exhibit number
01/12/2021	Curriculum Vitae	WITN6974002
1998	Association of Anaesthetists of Great Britain and Ireland. AIDS and Hepatitis B Guidelines for Anaesthetists. 1988.	WITN6974003