Witness Name: Dr Adrian Minford
Statement No.: WITN4444001
Dated: 25th August 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ADRIAN MINFORD

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28 July 2020

I, Dr Adrian Minford, will say as follows: -

Section 1: Introduction

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

   I am Dr Adrian Minford of GRO-C and my date of birth is GRO-C 1948. My qualifications are as follows:

   - MBChB 1972 Queen's University Belfast;
   - Diploma in Child Health 1994 Royal College of Physicians and Surgeons of Ireland;
   - MRCP UK 1975;
   - Fellow of the Royal College of Physicians (FRCP)1995;
   - Fellow of the Royal College of Paediatrics and Child Health (FRCPCH) 2000.

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.*

My employment history is as follows:

- 1972-1973: Pre-registration house officer at Belfast City Hospital and Musgrave Park Hospital Belfast;
- 1973-1977: Junior hospital doctor posts in Belfast including paediatric registrar post at Royal Belfast Hospital for Sick Children;
- 1977-1979 Paediatric Registrar Royal Hospital for Sick Children Edinburgh
- 1979-1983: Senior registrar in Paediatrics at Leeds Teaching Hospitals;
- 1983-2010: Consultant Paediatrician at St Luke's Hospital, Bradford Royal Infirmary and Bradford Children's Hospital (until its closure in 1986) of Bradford Teaching Hospitals NHS Foundation Trust and its predecessors;
- 1 January 2010: I retired from my Consultant post at Bradford Teaching Hospitals NHS Foundation Trust.

At the outset I want to clarify that when I was appointed to my post in 1983 at Bradford I had no prior experience in Haematology. I am a trained Paediatrician with no formal haematology training. My role was unique at Bradford Haemophilia Centre ("the Centre"). I worked with haematologists and sought their advice which informed my care and treatment of children with bleeding disorders at the Centre.

I was asked when taking up this post in 1983 whether I could give paediatric input into a haemophilia clinic and I agreed to do so. My initial involvement with the Centre was through a haemostasis clinic once a month. Initially I would sit with Professor Liakat Ali Parapia (Adult Haematologist and Director of the Centre) in clinics seeing child patients and then I would carry out these child clinics myself. For several years this was an outpatient clinic at Bradford Royal Infirmary but as numbers grew it was moved to the paediatric outpatient clinic at St Luke's Hospital. This move of locations would have taken place at some point between 1986 and 1990.

3. *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.*

In terms of membership of committees; as I looked after children with thalassemia, which is an inherited severe anaemia requiring monthly blood transfusions, I attended a blood transfusion committee until I retired. I cannot recall the year I got involved in this but it was for a significant amount of time. I attended meetings but my input was minimal as the main contributors were people working in labs, haematology and blood transfusion staff. The committee was unrelated to haemophilia or bleeding disorders.

I was also a member of the United Kingdom Haemophilia Doctors Organisation Centre UKHDOC and I mainly went to their meetings to learn more about haemophilia as they gave lectures and talks. I also attended several congresses delivered in various cities over the world by the World Federation of Haemophilia (WFH). From the early 1990s I also attended congresses of the International Society on Thrombosis and Haemostasis (ISTH) and this was an important way of learning about bleeding disorders. Over the years, the number of patients with bleeding disorders that I treated increased and in many cases were rare bleeding disorders so I wanted to expand my knowledge.

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 human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement and copies of any statements, reports or documents that you provided.*

I confirm that I have not provided evidence to or have been involved in any other inquiries, investigations, criminal or civil litigation in relation to HIV,

hepatitis or Variant Creutzfeldt–Jakob disease (vCJD) and blood or blood products.

I also wish to state at the outset of my written statement that these events that I am being asked about and which form the basis of the Rule 9 request relate to my work as a Consultant Paediatrician over 35 years ago. I retired over 10 years ago and I am therefore solely relying on my recollection as I have no documentation to refer to but for the documents provided to me as part of the Rule 9 request. I have also tried my best with dates referred to and the content below is my best evidence according to my memory of events a long time ago.

For ease of reference, I refer to the relevant questions contained in the Rule 9 request in my answers below.

Section 2: Decisions and actions of those treating patients with bleeding disorders at Bradford Royal Infirmary

5. *The Inquiry understands that when Dr Liakat Ali Parapia was appointed to the Haemophilia Centre at Bradford Royal Infirmary ("the Centre") in 1982, he was responsible for treating adult patients with bleeding disorders, you took over the role of treating children with bleeding disorders, and the two of you carried out joint clinics whenever possible. Is that correct?*

In response to question 5 of the Rule 9 request, that is correct in relation to my role at the Centre; however I was not entirely responsible for the treatment of children with bleeding disorders. As I had no prior experience of haematology before joining the Trust in 1983 I would defer to Professor Parapia and ask his advice regularly and still many years after my appointment I would still seek Professor Parapia's advice. Joint clinics were carried out with Professor Parapia in the outpatient department Bradford Royal Infirmary to start with, then from sometime between 1986 and 1990 (possibly later) I started seeing children with bleeding disorders in the paediatric outpatient department at St Luke's hospital where it was more appropriate for children. Even when holding clinics

on my own, I sought input from Professor Parapia and other paediatric haematologists in Leeds from time to time.

6. *Please describe the roles, functions and responsibilities of the Centre during the time that you worked there. Please provide an account of the Centre's history, its establishment and its activities during this time.*

The work of the Centre was to care for adults and children with bleeding disorders. The Centre was established in 1982 by Professor Parapia who would be able to provide further information in relation to question 6 of your Rule 9 request in his role as Director of the Centre and operational lead.

7. *Please identify senior colleagues at the Centre and their roles and responsibilities during the time that you worked there.*

In respect of question 7, Professor Parapia enlisted an Orthopaedic Surgeon (Mr Brian Hamilton) who had an interest in orthopaedic aspects of haemophilia care and a Community Dentist (Hugh McCarthy) given the importance of good dental care in patients with bleeding disorders. Professor Parapia also recruited a Haemophilia Nurse Specialist (Sister Pauline Sharp) who retired many years ago and other nursing staff. There was also a Social Worker, Andrea Breach and a Physiotherapist, Jill Bond who also worked for the Centre.

8. *Please describe:*
    a. *Your role and responsibilities at the Centre and how, if applicable, this changed over time;*
    b. *Your work at the Centre insofar as it involved the care of patient with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.*

In respect of question 8 (a) of the Rule 9 request, my role was to look after the general care of children with bleeding disorders and to see them as outpatients in the haemostasis clinic. I also saw inpatients when they were admitted through the wards. Often I saw patients in relation to treatment with factor VIII

concentrates and I would defer to Professor Parapia's experience in this regard, especially in the period relevant to the Inquiry and Dr Parapia would have determined the type of Factor VIII and usually the dose.

In respect of question 8 (b); around 1985 I had 4 child patients infected with HIV as a consequence of receiving infected factor VIII products. I believe one patient may have received factor VIII concentrates at another hospital, possibly Dewsbury but I cannot be certain from my recollection. I do not recall any of my patients being infected with hepatitis. I looked after patients as outpatients and inpatients when they became unwell, which would have been on the paediatric ward at St Luke's hospital.

9. *What decisions and actions were taken, and what policies were formulated, by you and by the Centre, regarding the selection, purchase and use of blood products (in particular factor concentrates) for children during the time that you worked there? In addressing this question please answer, to the extent that you are able to, the following questions:*
    a. *How, and on what basis, were decisions made about the selection and purchase of blood products?*
    b. *What were the reasons or considerations that led to the choice of one product over another?*
    c. *What particular products were used for treating patients, over what period of time and for which categories of patients?*
    d. *What role did commercial and/or financial considerations play?*
    e. *What involvement did you have?*

In respect of question 9, I had no involvement in the decisions or actions taken in relation to the selection, purchase or use of blood products. Professor Parapia solely decided on what blood products were used by the Centre. Regarding my use of blood products, I would have prescribed these on advice from Haematology. In later years and with experience, I would have made more decisions myself but this would have been some time after the issue around HIV infections and infected blood products arose. In respect of the subsections

of question 9, I had no involvement in this regard and this would have all been dealt with by my colleague, Professor Parapia.

10. *What was the relationship between the Centre/you and the pharmaceutical companies manufacturing or supplying blood products? What influence did that relationship have on the Centre's actions, and on your decisions and actions?*

In respect of question 10 and the relationship between the Centre and pharmaceutical companies supplying blood products, I sometimes attended large international meetings (ISTH and World Federation of Haemophilia) and pharmaceutical companies would take clinicians to dinners. Pharmaceutical companies would often fund attendance (travel and accommodation) at ISTH and WFH meetings, which allowed clinicians and scientists to attend these educationally important meetings. However I was not the decision maker but I do not believe decisions were based around any corporate hospitality offered.

11. *How were decisions taken as to which products to use for particular patients? What role did you have in such decisions? To what extent, if at all, were patients (or their parents) offered a choice or the opportunity to express a preference as to what products would be used?*

In respect of question 11, as above, I did not have a role in deciding what blood products were used by the Centre.

12. *What alternative treatments to factor concentrates were available for children with bleeding disorders in the 1970s and 1980s? What were, in your view, the advantages and disadvantages of those alternative treatments? What use did you make of them? Do you consider that they should have been used in preference to factor concentrates so as to reduce the risk of infection? If not, please explain why.*

In answer to question 12 of the Rule 9 request and alternative treatments to factor concentrates available to children; as far as I can recall they were not offered a choice, at least from my involvement in 1983 with regards to children

with severe haemophilia. In respect of DDAVP, I am aware this would have been available from the early 1980's however this was only used for mild haemophilia and would not have worked or have been the appropriate treatment for moderate or severe haemophilia although from memory, I think some patients with moderate haemophilia may have shown a response. Oral tranexamic acid was sometimes used for mild bleeds involving mouth and nose but I don't think it works for joint bleeds and therefore wasn't an alternative treatment for joint bleeds or other more serious bleeds. For some bleeds, but not joint bleeds, it would have sometimes been used in conjunction with factor VIII.

In respect of Cryoprecipitate, I do not remember using this treatment or it being an option at that time. I would have heard about Cryoprecipitate and I recall this being given by a haematologist to 1 haemophilia patient from my registrar post in Belfast before factor VIII concentrates were used. I did not however know that Cryoprecipitate was still used in the 1980s and was still available.

The first I knew about HIV infections resulting from the use of blood products was when Professor Parapia told me and from memory, I think it was he who subsequently arranged for patients to be tested. I did not know at the time of treating with factor VIII concentrates that it carried this risk of infection of HIV and I was not aware of other alternative treatments being used.

13. *What was your policy and approach at the Centre in relation to home treatment for children with bleeding disorders? Did that policy and approach change over time and if so, how?*

In respect of question 13, I would promote home treatment where patients were not so poorly that they required an inpatient stay. Provided parents of the patients were competent to administer the blood products, families were able to administer factor VIII concentrates at home. Home treatment was considered desirable and was offered to all patients, provided training to give intravenous injections had been provided. The involvement of the haemophilia nurse was important in this regard. I do not think this approach changed over time.

14. *What was your policy and approach at the Centre in relation to prophylactic treatment for children with bleeding disorders? Did that policy and approach change over time and if so, how?*

Regarding question 14, severe haemophiliacs had prophylactic treatment though I cannot recall when this started to become usual practice. For many years factor VIII concentrates were given 2-3 times a week to prevent bleeds, at home mostly, where this was appropriate. That was the approach for many years.

15. *What was your policy and approach at the Centre as regards the use of cryoprecipitate for the treatment of children with bleeding disorders? Did that policy and approach change over time and if so, how?*

In respect of question 15, as above, I was not aware of the use of Cryoprecipitate. I had heard of it but I was not aware that it was used for haemophilia anymore. Cryoprecipitate was also not available for home use. I do not recall this being used as an option for treatment in Bradford.

16. *To what extent, and why, were children with mild or moderate bleeding disorders treated at the Centre with factor concentrates?*

Regarding question 16, I do not recall many, if any, patients with mild/moderate bleeding disorders who were treated with factor concentrates. Of the 4 patients where I am aware that they were infected as a result of blood products, 3 most definitely had severe bleeding disorders. In respect of 1 of the patients I am not sure if he had a moderate or severe bleeding disorder but suspect it was the latter. It is possible I had a small number of patients with Von Willebrand disease who were occasionally treated with factor concentrates but I am unable to recall how many patients.

17. *Approximately how many children with bleeding disorders were under the care of the Centre when you first started working there and over the years that*

followed? If you are able to give exact rather than approximate figures, please do so.

In answer to question 17, when I first started working at the Centre there were approximately 20-50 child patients under the care of the Centre but this number increased as patients were referred from other hospitals, in view of our specialist centre. By the time I retired in 2010, I estimate that there were perhaps 50-100 children under the care of the Centre. The vast majority of the patients were not haemophiliacs and the biggest group suffered from Von Willebrand disease which is a mild bleeding disorder. I also treated patients with rare bleeding disorders, for example rare platelet disorders or other factor deficiencies, for example factor 13. Child patients stay under the care of paediatrics until they reach the age of 16 when they transfer to the care of the adult haematologist (between the ages of 16-18 years old). Up until my retirement, I did not work in isolation, I sought the opinion of the haematologist, Professor Parapia regularly and also advice from Dr Mike Richards, Paediatric haematologist at St James Hospital in Leeds. After Professor Parapia retired around 2009 Dr Samuel Ackroyd, Consultant Haematologist would sit in on the haemostasis clinic and clinics became more joint clinics. Professor Parapia did not sit in on the paediatric haemostasis clinics after my initial few years in post and I carried out these myself seeking input from the Trust's Haematology team where necessary.

18. *What, if any, viruses or infections, other than HIV, HCV and HBV, were transmitted to children at the Centre in consequence of the use of blood products?*

In answer to question 18, as far as I am aware, none of the patients under my care were infected with any viruses or infections other than HIV as a consequence of the use of blood products.

Section 3: Knowledge of, and response to, risk

General

19. *Please state when you first became responsible for the treatment of children with bleeding disorders. At that time, what did you know and understand about the risks of infection associated with blood and/or blood products? What were the sources of your knowledge? How did that knowledge and understanding develop over time?*

In answer to question 19, as set out above, I started doing haemostasis clinics in 1983 when I took up my position at Bradford and started working with the Centre. In terms of the treatment decisions, for example dosage, what type of factor concentrates were to be provided to patients; this would have been a decision of the haematologist and as set out previously, I closely worked alongside the haematology team.

When I started in my post, I would have known about the risk of contracting hepatitis B from blood products/transfusions from my medical studies at University and this was common knowledge. In the mid-1980s I learnt about hepatitis C and (perhaps in the 1990's – not certain when) learned that hepatitis A was also a risk for haemophiliac patients. I can also recall immunising patients against hepatitis A and hepatitis B. There was no immunisation against hepatitis C when I was practising.

20. *What was your understanding of the relative risks of infection from (i) the use of commercially supplied blood products, and (ii) the use of NHS blood products?*

In answer to question 20, I did not think about the relative risks of infections at the time of using blood products during the relevant period and I am not sure if we used both commercially supplied blood products and NHS blood products. As above, I was not involved in the decisions around sourcing of blood products used by the Centre. At the time, I trusted that the blood products sourced by and on behalf of the Centre were safe to use and would not pose unnecessary risks to patients.

21. *What advisory and decision-making structures were in place or were put in place at the Centre and/or within the area covered by the Yorkshire Regional Haemophilia Service, to consider and assess the risks of infection associated with the use of blood and/or blood products?*

In response to question 21, I am unable to answer this as I am not aware of the advisory and decision-making structures that were in place at the Centre or within the area covered by the Yorkshire Haemophilia Service to consider and assess the risks of infection associated with the use of blood products.

Hepatitis

22. *When you first became responsible for the treatment of children with bleeding disorders, what was your knowledge and understanding of the risks of the transmission of hepatitis (including hepatitis B and NANB hepatitis) from blood and blood products? What were the sources of your knowledge? How did that knowledge and understanding develop over time?*

In answer to question 22, as detailed above, I knew of the risk of contracting hepatitis from blood products and recall that my knowledge of NANB/hepatitis C came at a later date. I cannot remember the source of my knowledge in relation to hepatitis A and B but I recall that I learnt about hepatitis C from my general reading of literature and attendance of meetings as described elsewhere in my statement.

23. *What was your understanding of the nature and severity of the different forms of blood borne viral hepatitis and how did that understanding develop over time?*

In response to question 23, I was aware that hepatitis can cause serious liver disease and in regards to hepatitis C, risks also included long term effects such as cirrhosis and liver cancer. Over the years I became increasingly aware of

the seriousness of hepatitis, though I never personally had any patients who had been diagnosed with hepatitis.

24. *What, if any, enquiries and/or investigations did the Centre and/or you carry out or cause to be carried out in respect of the risks of the transmission of hepatitis? What, if any, information was obtained as a result?*

In answer to question 24, patients would have been routinely screened as outpatients for hepatitis A, B & C as all patients with haemophilia would have been screened every 3-6 months to check for hepatitis antibodies, factor VIII inhibitors and to check their liver function.

25. *What, if any, actions did you and/or the Centre take to reduce the risk to patients of being infected with hepatitis (of any kind)?*

In response to question 25, as referred to elsewhere in my statement, patients were immunised against hepatitis A and hepatitis B and this took place before receiving blood products from the Centre, where possible. However, this was not always possible in emergency situations where haemophilia patients attended the hospital with severe bleeding. It was therefore desirable that patients were immunised before receiving any blood products. I cannot however be certain about the date from which immunising was common practice, it may have been from I joined the Centre or shortly thereafter. We may have also been immunising against hepatitis B to start with and then hepatitis A at a later date but I cannot be sure. There was however, as referred to elsewhere in my statement, no immunisation against hepatitis C and this was certainly the position when I retired.

HIV and AIDS

26. *What was your knowledge and understanding of HIV (HTLV-III) and AIDS and in particular of the risks of transmission from blood and blood products? What were the sources of your knowledge? How did your knowledge and understanding develop over time?*

In answer to question 26, I cannot recall when I became aware of the risk of HIV and AIDS transmission from use of blood products. I recall that Professor Parapia told me about the possibility of HIV being transmitted from blood products. I would have read up on HIV and would have become more knowledgeable following that conversation. I cannot recall however when this conversation took place. I confirm that the risk of HIV infection was however never in my contemplation when treating child patients with factor VIII concentrates, up until the news broke.

27. *How and when did you first become aware that there might be an association between AIDS and the use of blood products? What steps did you then take in light of that awareness? What steps were taken at the Centre?*

28. *What, if any, enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of transmission of HIV or AIDS? What information was obtained as a result?*

In response to questions 27 and 28, as above, I do not recall being aware of the link between HIV and the use of factor VIII concentrates until this was raised with me by Professor Parapia. Following the news breaking around HIV and transmission in blood products, I have a very vague recollection that all of the Centre's child and adult patients treated with blood products were tested for HIV but I cannot be certain due to the time which has elapsed.

29. *What, if any, actions did you take to reduce the risk to your patients of being infected with HIV?*

In response to question 29, I cannot recall. It is likely that the blood products would have been changed though I cannot say with certainty and Professor Parapia would be aware of steps taken. I do however recall that we started using Monoclate-P (a type of factor VIII concentrate) at that time.

30. *Did you continue to use blood products to treat patients, after becoming aware of the possible risks of infection of HIV? If so, why?*

In answer to question 30, Professor Parapia would again be best placed to answer but I do recall that Monoclate-P (a type of factor VIII concentrate) was subsequently used. I am unable to say whether this was used for all patients and I am not sure whether the type used prior to then was BPL (NHS) or a commercial one.

Response to risk

31. *Did you or the Centre take any steps to ensure that patients, their parents and/or the public were informed and educated about the risks of hepatitis and HIV? If so, what steps?*

In answer to question 31 and steps taken to inform patients/parents or the public regarding the risks, this would have been discussed with the parents of the patients at outpatient clinics. HIV would have been discussed after we became aware of the risk that factor VIII concentrates were contaminated but not before that time as I and nor I believe others were not aware of that particular infection risk. There would have also been a discussion around testing for HIV once the news broke. The risk of infection of hepatitis would however have been discussed as this was known prior to the risk around HIV. I personally did not take any steps to inform the public but I am aware that Professor Parapia did publish an article in the local newspaper which did mention HIV.

32. *Did you or the Centre revert to treatment with cryoprecipitate for some or all of your patients in response to the risk of infection? If so, how was it determined which patients would be offered a return to cryoprecipitate and which would not? If not, why not?*

In answer to question 32, I do not recall any patients having Cryoprecipitate and this is not something I would have thought about. As above, I was not aware that this was still in use.

33. *When did you begin to use heat treated factor products and for which categories of patients?*

34. *What, if any, consideration did you give to the use of heat-treated products prior to the meeting of UKHCDO Reference Centre directors on 10 December 1984 [HCDO0000394_117]? Did you (a) agree with and (b) follow the recommendations made at the meeting, including the recommendation to use heat-treated concentrates?*

In respect of question 33 and 34, again, I unfortunately do not know what type of products were used. I have mentioned above the use of Monoclate-P, however I am not sure if this was heat treated and exactly from when this was used by the Centre. In respect of the guidance issued by the UKHDCO Reference Centre directors on 10 December 1984, I do not recall attending this meeting but it is possible that the minutes may have been sent to me, though again I cannot recall due to the time passing and not having access to any of the Centre's records. In terms of following the recommendation of UKHDCO, I cannot recall any discussion with Professor Parapia regarding the use of heat treated concentrates but that it is not to say a discussion did not take place.

35. *Do you consider that heat-treated products should have been made available earlier? If so, please explain why.*

In respect of question 35, unfortunately I am unable to assist with this question.

36. *Do you consider that your decisions and actions and those of the Centre in response to any known or suspected risks of infection were adequate and appropriate? If so, why? If not, please explain what you accept could or should have been done differently.*

In answer to question 36 and 37 I am unfortunately unable to remember exactly what was done due to the passage of time since the relevant period but I am not aware of anything which should have been done differently.

37. *Looking back now, what decisions or actions by you and/or by the Centre could and/or should have avoided, or brought to an end earlier, the use of infected blood products?*

38. *What actions or decisions or policies of other clinicians or other organisations, within your knowledge, played a part in, or contributed to, the scale of infection in patients with bleeding disorders? What, if anything, do you consider could or should have been done differently by these others?*

In answer to question 38 and what actions, decisions or policies of other clinicians or organisations may have contributed to the scale of infections in patients with bleeding disorders, I am aware that many haemophilia directors were worried about factor VIII and I understand they were raising concerns but the government kept saying that there was no evidence of these concerns. In hindsight, the impression I have is that the government was slow to stop using the factor VIII concentrates affected and perhaps there was a culture of denial which contributed to this.

39. *Do you consider that greater efforts should have been made to inactivate viruses in blood or blood products prior to 1980? If so, who should have made or coordinated those efforts, what steps should have been taken, and when? If this is not your view, please explain why.*

In answer to question 39, with the benefit of hindsight, absolutely yes, inactivating viruses in blood and/or blood products would have been a very good idea and would have undoubtedly saved lives. I consider the organisation responsible would have been the body who was coordinating the use of blood/blood products.

Section 4: Treatment of patients at the Centre

Provision of information to patients

40. *What information did you provide or cause to be provided and/or what information was (to your knowledge) provided by others at the Centre, to patients with a bleeding disorder at the Centre or to their parents:*
    a. *About the risks of infection in consequence of treatment with blood products (in particular, factor concentrates), prior to such treatment commencing?*
    b. *About alternatives to treatment with factor concentrates?*
    c. *Before they began home treatment/home therapy?*

In respect of question 40 I unfortunately cannot remember what information was provided about the risks of infection in consequence of treatment with blood products prior to treatment commencing. At the relevant time, before we knew about the associated risks of HIV and hepatitis infections I would not have specifically discussed those infections risks as they were unknown to me. As above, I do recall immunisations against types of hepatitis and therefore there would have been discussion around these infection risks, where time allowed (ie. not in an emergency situation).

In respect of alternatives to treatment with factor concentrates; for some patients with severe haemophilia I do not think there were any alternative treatments (other than Cryoprecipitate) at the time. For patients with mild and some cases of moderate haemophilia, there would have been DDAVP available I used DDAVP quite often in von Willebrand disease and mild haemophilia. It is not however appropriate for patients with severe haemophilia and cannot be seen as an alternative to Factor VIII for these patients.

Before home treatment was commenced, I cannot recall what information, if any, was given aside from a discussion as part of outpatient appointments but that is not to say that no written information or leaflets were provided.

HIV

41. *When did you first discuss AIDS or HIV (HTLV-III) with any of your patients (or their parents) at the Centre?*

In answer to question 41, I do not remember when I first discussed AIDS or HIV with a patient. It would have been sometime in the mid to late 1980s when the Centre was asking patients for a blood test and once the risk of HIV infection from blood products was known.

42. *Please describe how and when you learned that patients under your care had been infected with HIV.*

In response to question 42, I first learned that there was a possibility that patients had become potentially infected with HIV under my care when Professor Parapia informed me. I cannot recall when this was. I cannot recall how the patients came to be tested and assume Professor Parapia made these arrangements.

43. *How and when were patients, or their parents, told that they had been, or might have been, infected with HIV? Were they told in person, by letter or by telephone? Were they seen individually or in groups?*

In answer to question 43, I cannot recall how patients and their parents were told that they have been or might have been infected with HIV. My usual practice would have been to see the patient (depending on age) and their parents in person individually, given the seriousness. However in respect of the 4 patients under my care who were infected with HIV, I cannot remember informing them personally and therefore suspect that it was not me that delivered the news.

44. *What information was given to them about the significance of a positive diagnosis? Were they told to keep their infection a secret? What information was provided about the infection, prognosis, treatment options and management?*

In answer to question 44, I cannot recall what information was given about the significance of a positive diagnosis. As above, I cannot recall if it was me who sat down with the patients and/or their parents. Unfortunately, I do not have access to any medical records which would also serve to prompt my memory of the process. In respect of keeping the diagnosis a secret, I cannot recall myself ever saying to a patient or their parents not to tell anyone.

45. *What, if any, arrangements were made for pre-test counselling and for post-test counselling?*

In respect of question 45, again, unfortunately I am unable to recall.

46. *What was the Centre's/your policy in relation to testing partners/family members of people known or suspected to be infected with HIV? Under what circumstances were the tests carried out?*

47. *What, if any, information or advice did the Centre provide to partners or family members of people that were at risk of infection with HIV or were infected with HIV?*

In response to questions 46 and 47, I am unable to answer this and consider this to be more relevant to adult care which I was not involved in.

48. *How many children at the Centre were infected with HIV? Of those infected,*
    a. *How many had severe haemophilia A?*
    b. *How many had moderate haemophilia A?*
    c. *How many had mild haemophilia A?*
    d. *How many had haemophilia B?*
    e. *How many had von Willebrand's disease?*

In answer to question 48, to my knowledge, 4 children were infected with HIV under my care. Of those children, 3 or possibly 4 had severe haemophilia A. Either 1 or none of the patients had moderate haemophilia A and none of the patients had mild haemophilia A, haemophilia B or von Willebrand disease. I

find the document referred to by the Inquiry confusing as I know with certainty that I had 4 male child patients who were infected with HIV who were under the care of the Bradford Centre.

49. *Was work undertaken at Bradford to establish the time period during which patients seroconverted? If so, please describe what work was done and what if any conclusions were reached.*

In answer to question 49, I am unable to answer as I do not know this information.

Hepatitis B

50. *Were patients (or their parents) infected with hepatitis B informed of their infection and if so how? What information was provided to them about the infection, its significance, prognosis, treatment options and management?*

51. *How many patients under your care at the Centre were infected with hepatitis B?*

In answer to questions 50 and 51, I do not recall any of my patients having hepatitis B.

NANB Hepatitis/HCV

52. *Were patients (or their parents) infected with NANB hepatitis informed of their infection and if so, how? What information was provided to them about the infection, its significance, prognosis, treatment options and management?*

In answer to question 52, I do not recall having any patients with NANB (Hepatitis C). As stated above, I also recall that immunisation was not an option for Hepatitis C.

53. *Please describe the process of testing patients for HCV. When did you begin testing patients for HCV? How, when and by whom were patients (or their parents) informed of their diagnosis of HCV? Were they told in person, by letter or by phone?*

In answer to question 53, I cannot remember when testing for HCV started but this would have been screened for at every 3-6 months routine outpatient appointment once the infection risk was known.

54. *When a test for HCV became available, what, if any, steps were taken by the Centre and/or by you to ensure that all patients who had received blood products were traced and invited to be tested?*

55. *What information was provided to patients infected with HCV about their infection, its significance, prognosis, treatment options and management?*

56. *How many patients under your care at the Centre were infected with HCV?*

In answer to questions 54, 55 and 56 I did not have any patients diagnosed with HCV under my care and I am therefore unable to provide any further information in respect of NANB Hepatitis/HCV. Professor Parapia may be able to assist.

Delay/public health/other information

57. *Were the results of testing for HIV and hepatitis (of all kinds) notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, please explain why.*

In answer to question 57, I am not aware of any delays but unfortunately I cannot recall where/when patients were tested and who arranged for the patients to be tested.

58. *To what extent, if at all, did you or your colleagues at the Centre take into account the public health implications of HIV, AIDS, hepatitis B, NANB hepatitis*

and hepatitis C, when taking decisions as to what information or advice to provide to patients or what treatment to offer patients?

In response to question 58 I consider that this question is mainly relevant to adults. In respect of my paediatric patients I cannot recall taking into account any public health implications.

59. *What information was provided to patients about the risks of other infections?*

In answer to question 59, unfortunately, I cannot recall, however I would have thought that I would have told the parents of my patients who were diagnosed with HIV that they would be immunosuppressed and therefore prone to contracting other infections.

60. *What information was provided to patients about the risks of infecting others?*

Again, in answer to question 60, I consider that this question is aimed more towards adult patients. As above, I cannot recall what information would have been communicated but I would have thought I would have informed the patients about needle stick injuries.

Consent

61. *How often were blood samples taken from your patients when attending the Centre and for what purposes? What information was given to them (or their parents) about the purposes for which blood samples were taken? Were patients/their parents asked to consent to the storage and use of those samples? Was their consent recorded and if so how and where?*

In answer to question 61, blood samples were taken every 3-6 months when the patients attended their outpatients' clinic appointment. I would have been taking blood samples for hepatitis antibodies and factor VIII inhibitors. I would have also carried out liver function tests and a blood count. I would have explained to the patient's parents what the blood sample was for and would

have verbally obtained consent. As far as I can recall, I would not have obtained written consent for use of the blood samples as described and I would not have asked to store any of these samples as this was not necessary.

62. *Were patients under your care treated with factor concentrates or other blood products without their (or their parents') express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent to treatment? Was their consent recorded and if so how and where?*

In response to question 62, no patients under my care were treated with factor concentrates or other blood products without their (or their parents') express and informed consent. A discussion would have taken place with the patient or their parents. It was usually obvious when they needed factor VIII concentrates, for example a joint bleed, a bleed from a tooth or nosebleed and usually patients were brought to hospital for that specific purpose.

63. *Were patients under your care tested for HIV or hepatitis or for any other purpose without their (or their parents') express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent for testing? Was their consent recorded and if so how and where?*

In response to question 63, in respect of any blood tests I would have always told the patients and their parents what the tests were for. As above, I was not aware of the issue in relation to HIV until this was brought up by Professor Parapia to me. As previously stated, I cannot recall in relation to the 4 specific patients when they were tested and when this was arranged.

PUPS

64. *Please detail all decisions and actions taken by you or with your involvement with regard to a category of people referred to as 'previously untreated patients' (PUPS).*

65. *Did you use the term PUP or PUPS when speaking about or referring to any of your patients? If so, what did you mean by the use of the term?*

In respect of questions 64 and 65, all of my patients had been previously untreated patients before receiving prophylactic treatment at the centre. PUPS however was not a term that I personally used. However it is a term I have heard others use when discussing research but even in that context, this would not have been terminology that I used. I am unclear what further information I can add here in respect of question 64.

Treatment of patients who had been infected with HIV or Hepatitis

66. *How was the care and treatment of patients with HIV/AIDS managed at the Centre? In particular:*
    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    b. *What treatment options were offered over the years to those infected with HIV?*
    c. *What information was provided to patients/their parents about the risks and benefits of specific treatments and about side effects?*
    d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?*

In answer to question 66, I cannot recall the exact details in terms of the management of the care and treatment of patients with HIV at the Centre but I think that I would have consulted with Dr McWhinney, an Infectious Diseases Consultant. Professor Parapia would have also been in discussion with him. I would have seen the patients affected very regularly at my clinic. I would have carried out blood tests including those to monitor immune function. The only treatment option I can remember was AZT but I would have consulted with other specialists with an interest in HIV. Other than AZT I have no memory of other treatments. In terms of the risks and benefits of particular treatment, I cannot remember discussing these but it would have been my normal practice to discuss side effects of any treatment especially serious side effects. After 3 of

my patients died and the 4th transitioned to adult care, I had no further involvement regarding patients infected with HIV.

67. *How was the care and treatment of patients with hepatitis B managed at the Centre? In particular:*
    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    b. *What treatment options were offered over the years?*
    c. *What information was provided to patients/their parents about the risks and benefits of specific treatments and about side effects?*
    d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis B?*

68. *How was the care and treatment of patients with NANB hepatitis managed at the Centre? In particular:*
    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    b. *What treatment options were offered over the years?*
    c. *What information was provided to patients/their parents about the risks and benefits of specific treatments and about side effects?*
    d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with NANB hepatitis?*

69. *How was the care and treatment of patients diagnosed with HCV managed at the Centre? In particular:*
    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    b. *What treatment options were offered over the years?*
    c. *What information was provided to patients/their parents about the risks and benefits of specific treatments and about side effects?*
    d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HCV?*

In answer to questions 67, 68 and 69 as far as I can recall I did not have any patients with hepatitis B, NANB or HCV. I am therefore unable to comment in

relation to the care and treatment of patients with these diseases being treated at the Centre.

70. *What, if any, involvement did you have with clinical trials in relation to treatments for HIV and/or HCV? Please provide full details.*

In answer to question 70, I had no involvement in clinical trials for treatments for HIV and/or HCV.

71. *What, if any, arrangements were made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support? What, if any, kind of counselling was made available to patients at the Centre?*

In response to question 71, I recall that there was a Social Worker already engaged through the service who I expect lead on this but I cannot recall what psychological support or counselling was offered.

72. *Was the Centre allocated, whether by the Department of Health and Social Security or another source, any funding to help with counselling of patients infected with HIV?*

73. *What, if any, difficulties did you/the Centre encounter in obtaining sufficient funding for the treatment of people who had been infected with HIV and/or HCV?*

In response to question 72 and 73, I am not aware of the funding arrangements for any of the counselling offered by the Centre and would not have been involved in funding issues given my role at the Centre.

74. *The enclosed article entitled 'Bradford Haemophilia Centre' published in the Bulletin in 1987 [HCDO0000276_037] refers to your involvement (along with the nursing sister, social worker and Dr Parapia) in a local "HIV Action Group". Please provide details of that group and details of any other attempts*

"to bring awareness to the rest of the population of the problems facing haemophiliacs".

In answer to question 74, I do not recall being involved in a "local HIV action group". I recall that I gave a talk about paediatric HIV infection which I think was to an audience of clinicians. This was at a Bradford Health Authority/University of Bradford conference in 1987. I am not sure if this was as part of the HIV action group though. I had no involvement with radio or television. The only other involvement I can recall was being a co-author of a paper "HIV Infection in General Practice" published in Health Care Management Volume 3 Number 2 1988. I think this was based on the presentation I gave at the 1987 conference.

75. *The article also states that "The HIV problem has unsettled the haemophiliacs and in some cases strained the relationships in many Centres, the staff similarly have been affected. It will take many years of hard work to rebuild the confidence of staff and patients alike in the treatment and management of bleeding disorders". What "hard work" was undertaken and did it, in your view, succeed in rebuilding confidence in the treatment and management of bleeding disorders at the Centre?*

In answer to question 75 and the reference to "hard work to rebuild the confidence of staff and patients" in the article referred to (published in the Haemophilia Society Bulletin in 1987); I had no involvement other than clinical work in regularly reviewing and treating the affected HIV patients who remained under my care.

Research

76. *Please outline the research studies that you were involved with during your time as consultant at the Centre.*

77. *What do you understand to be the ethical principles that should guide research? Did you apply those principles to the research studies referred to above and if so, how? If not, why?*

In response to question 76, the only research I did, which I am still continuing with in my retirement relates to severe congenital protein C deficiency, which is a thrombotic disorder. I have a number of publications to my name relating to this condition but these have no relevance to the terms of reference of the Inquiry. Therefore question 77 is not applicable.

78. *Were patients involved in research studies without their (or their parents') express and informed consent? If so, how and why did this occur?*

79. *Was patient data (anonymised, de-identified or otherwise) used for the purpose of research or for any other purpose without their (or their parents') express and informed consent? If so, what data was used and how and why did this occur?*

In answer to question 78, this is not applicable as no patients were involved in the research studies. Similarly, question 79 is also not applicable as no patient data has been used for research.

80. *Was patient data (anonymised, de-identified or otherwise) shared with third parties (e.g. UKHCDO or Oxford Haemophilia Centre) without their (or their parents') express consent? If so how and why did this occur, and what information was provided to whom?*

In answer to question 80, as far as I can recall, all patients with bleeding disorders were registered with the UKHCDO. Professor Parapia would have however done this and therefore I am unable to comment as to whether consent would have been obtained from patients and/or their parents.

81. *Please provide details of any articles or studies that you have published insofar as relevant to the Inquiry's Terms of Reference.*

Question 81 is also not relevant to me and therefore I have no information to add.

Records

82. *What was the Centre's policy as regards recording information on death certificates when a patient had been infected with HIV or hepatitis?*

In answer to question 82, I am not aware of what the Centre's policy was in regards to recording information on death certificates when a patient had been infected with HIV or hepatitis resulting from blood products. I am not completely certain but I do not think I was involved in certifying the deaths of these 3 patients.

83. What were the retention policies of the Centre in regards to medical records during the time you worked there?

As above, in relation to question 83, I am unable to say now what the retention period was in regards to medical records at the time I worked there.

84. *Did you maintain separate files for some or all patients? If so, why; where were those files located; and where are those files now?*

In answer to question 84, I did not maintain separate files on patients.

85. *Did you keep records or information (e.g. information being used for the purpose of research) about any of your patients at your home? If so, why, what information and where is that information held now?*

86. *Do you still hold records or information about any of your patients? If so, explain why and identify the records or information that you still hold.*

In answer to questions 85 and 86, I have no files but have anonymised data in the form of power point slides on several non-haemophilia patients with blood disorders which I have used for teaching sessions. These sessions (given before but mainly after retirement) were for haematology trainees and given in the Bradford Royal Infirmary and at St James Hospital in Leeds. The conditions involved included inherited platelet disorders, factor XIII deficiency and severe congenital protein C deficiency but not haemophilia.

Blood & Blood Components Transfusion Policy and Practice Guidelines

87. *Please consider the enclosed Blood & Blood Component Transfusion Policy and Practice Guidelines from September 2007 [BTHT0000432]. The policy identifies you as a member of the Hospital Transfusion Committee. With regard to the policy, please answer the following questions:*
    a. *When did you become a member of the Hospital Transfusion Committee and for how long did you serve on the Committee?*
    b. *What were your roles and responsibilities as a member of the Committee?*
    c. *Was this the first written policy of its kind at Bradford or were there earlier versions? (and if you have copies of any earlier versions, please provide them)*
    d. *What if any involvement did you have the transfusion of blood (as distinct from blood products) to patients at the hospital?*

In answer to question 87, I became a member of the Hospital Transfusion Committee a few years after taking up my post in 1983 but I cannot recall the exact date. I was a member of this committee for between 10 – 20 years. I attended meetings but I was not a main contributor and I did not contribute to written policies. In respect of the Blood & Blood Component Transfusion Policy and Practice Guidelines dated September 2007, I am not aware of whether this was the first written policy of this kind at Bradford. I do not recall or hold copies of earlier versions of this policy. In respect of my involvement with the transfusion of blood, I looked after a number of patients (between 20 – 30

patients) with thalassaemia who had regular blood transfusions as part of their management.

Section 5: Blood Services and BPL

88. *Please outline the interactions and dealings you had, if any, with the blood services (whether on a regional or national level) and/or with BPL in your capacity as consultant at the Centre.*

89. *What, if any, discussions or meetings or interactions did you have with any blood service (regionally or nationally) and/or with BPL in relation to:*
    a. *the risk of infection with hepatitis from blood products;*
    b. *the risk of infection with HIV/AIDS from blood products;*
    c. *the steps to be taken to reduce the risk of infection?*

In respect of questions 88 and 89, as stated above, I have had no involvement with blood services and am therefore unable to comment.

Section 6: UKHCDO

90. *Please describe your involvement with UKHCDO (including any of its working parties, committees or groups) and the dates of your involvement.*

In response to question 90, I cannot remember when I became a member with UKHCDO but I was involved for a number of years. It would have been after I joined the Trust in 1983 and I was involved for approximately between 10 – 20 years. I was also involved in a working party on inherited platelet disorders from approximately 2003 to 2006 and this involved going to Birmingham Children's Hospital which was where the working party met.

91. *During the period of your involvement with the UKHCDO, please outline:*
    a. *the purpose, functions and responsibilities of UKHCDO, as you understood them;*

b. *the structure, composition and role of its various committees or working groups;*

c. *the relationships between UKHCDO and pharmaceutical companies;*

d. *how decisions were taken by UKHCDO;*

e. *how information or advice was disseminated by UKHCDO and to whom;*

f. *any policies, guidance, actions or decisions of UKHCDO in which you were involved and which relate to: the purchase, selection or use of blood products; alternative treatments to factor products for patients with bleeding disorders; the risks of infection associated with the use of blood products; the sharing of information about such risks with patients and/or their families; obtaining consent from patients; heat treatment and other measures to reduce risk; vCJD exposure; and treatments for HIV and HCV.*

In answer to question 91 and subsection (a), my understanding was that UKHCDO's role was to formulate policies, collate information in relation to bleeding disorders and to keep a register of all patients with bleeding disorders in the UK. I understood its role was also to educate clinicians through various publications which would have been in peer reviewed journals. The UKHCDO also lead in the sharing of knowledge as representatives from Haemophilia centres attended meetings held by UKHCDO.

In regards to subsection (b), I unfortunately am unable answer this but I was involved in my working party and there was a group of 5-10 people in the party which fell under UKHCDO. I am also unable to comment in relation to subsection (c). In respect of subsection (d), those decisions would have been taken at various UKHCDO meetings and may have been taken democratically but as far as I can recall I can't remember any voting. In respect of subsection (e), information or advice from UKHCDO was disseminated by the UKHCDO writing to the directors of the Haemophilia Centres and other people who were not directors (such as me) who were involved in the work of the centres. I do recall receiving some correspondence in letter form from the UKHCDO. In respect of subsection (f), I was not involved in any of these.

Section 7: Pharmaceutical companies/medical research/clinical trials

92. *Have you ever:*

a. *provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products?*

b. *received any pecuniary gain in return for performing an advisory/consultancy role for a pharmaceutical company involved in the manufacture or sale of blood products?*

c. *sat on any advisory panel, board, committee or similar body, of any pharmaceutical company involved in the manufacture or sale of blood products?*

d. *received any financial incentives from pharmaceutical companies to use certain blood products?*

e. *received any non-financial incentives from pharmaceutical companies to use certain blood products?*

f. *received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company?*

g. *undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products?*

h. *provided a pharmaceutical company with results from medical research studies that you have undertaken?*

If your answer to any of the above questions is Yes, please provide details.

In answer to question 92 I have had some involvement with a pharmaceutical company called Takeda in relation to the rare Severe Congenital Protein C Deficiency disorder and regarding the use of protein C concentrate (a plasma derived product) since 1995 approximately. Takeda has organised various meetings regarding protein C deficiency and I have been invited to give talks on occasion over the years.

I received remuneration for the lectures I delivered on severe congenital protein C deficiency and my expenses including transport and accommodation were paid

for. The first talk I gave was in Vienna, I also delivered talks in Dubai and Istanbul as well as Switzerland, Germany, Rome and London. Some of the meetings which I participated in were classed as advisory panels.

I have never received any financial or non-financial incentives to influence any use of certain blood products at the Centre and in any event those decisions were not mine. Similarly, I did not receive any funding to prescribe, supply, administer, recommend, buy or sell any blood products from a pharmaceutical company

I have not undertaken medical research for Takeda or any other pharmaceutical company involved in the manufacture or sale of blood products.

Takeda did collate clinical data from a number of patients with protein C deficiency from UK, Germany, France, USA, Spain, Canada, Italy, Switzerland and Turkey. This resulted in a presentation "The efficacy and safety of protein C concentrate in the treatment of severe congenital protein C deficiency" by Moritz et al (from Baxter Pharmaceuticals, a precursor of Takeda) to the American Society of Hematology in 2000. I provided anonymised clinical data on my patients with protein C deficiency to Takeda.

93. *What regulations or requirements or guidelines were in place during your employment concerning declaratory procedures for involvement with a pharmaceutical company? If you were so involved, did you follow these regulations, requirements and guidelines and what steps did you take to comply with them?*

In answer to question 93, I was aware generally that I would have had to declare any commercial interests to the Centre. Before I retired I gave several talks on protein C deficiency at meetings Takeda (formerly Immuno, then Baxter Pharmaceuticals) organised where I would have received funding for expenses and sometimes a lecture fee. My employing organisation knew about these meetings because I had to submit study leave application forms before going.

94. *If you did receive funding from pharmaceutical companies for medical research, did you declare the fact that you were receiving funding and the source of the funding to your employing organisation?*

In answer to question 94, I am involved in analysing data for a multi-national research project run by ISTH regarding protein C deficiency, however my involvement has been since I have retired. As part of that work I have been involved with haematologists at Oxford University Hospitals and the Royal Free Hospital in London collecting obstetric data of mothers with protein C deficiency. Funding has been provided by Takeda but I do not receive funding; this covers other people's expenses and anyone who contributes data gets paid a set amount of £200 per patient. Given my involvement in this work has been since I have been retired and I have not received funding, I have not needed to report this to any employing organisation.

Section 8: vCJD

95. *When and in what circumstances did you become aware of the risks of transmission of vCJD associated with the use of blood and blood products?*

96. *How and by whom were decisions taken as to the information that should be provided to patients about vCJD and as to any steps which should be taken in relation to patients and their care and treatment?*

97. *What was the process at the Centre for informing patients about possible exposure to vCJD?*

98. *How and when were patients first told of possible exposure to vCJD? What subsequent notifications were provided to patients? (You may wish to consider the enclosed letter dated 18 February 2009 from you and colleagues at the Centre).*

99. *What information was provided to patients about the risks of vCJD?*

100. *What counselling, support and/or advice to be offered to patients who were informed that they might have been exposed to vCJD?*

101. *What measures were put in place, from a public health perspective, in relation to the care and treatment of patients?*

In answer to question 95, I believe I had a vague awareness of vCJD at the time of practising and I recall the letter of 18.02.2009 but I do not recall anything apart from this letter. I also don't know about any process for informing patients regarding exposure. I am therefore unable to answer the following questions 96 – 101.

Section 9: Involvement with the financial support schemes

102. *What involvement did you have with the different trusts or funds (the Macfarlane Trust, the Eileen Trust, the Macfarlane and Eileen Trust, the Caxton Foundation and the Skipton Fund) which were set up to provide financial support to people who had been infected?*

103. *To what extent did the Centre and its staff (including you) inform patients about the different trusts or funds?*

104. *Did the Centre have any policy or any guidance for staff members in relation to referring patients to the trusts and funds for support?*

105. *What kind of information did the Centre (whether through you or otherwise) provide to the trusts and funds about or on behalf of patients who were seeking assistance from the trusts and funds?*

106. *Did the Centre, or any of its staff (including you), act as a gateway for determining whether a particular patient met the eligibility criteria for the receipt of assistance from any of the trusts and funds? If so, please explain who set the criteria, what they were and how they were applied.*

107. *Was the Centre or any of its staff (including you) involved in determining applications made by patients for assistance from the trusts or funds? If so, please describe that involvement.*

108. *Based on your own dealings with any of the trusts or funds and/or based on your knowledge of the experiences of the Centre's patients in relation to the trusts or funds, do you consider that the trusts and funds were well run? Do you consider that they achieved their purposes? Were there difficulties or shortcomings in the way in which they operated or in their dealings with beneficiaries and applicants for assistance?*

In answer to questions 102 -108; I had no involvement in the different trusts or funds which were set up to provide financial support to people who had been infected with diseases from blood products and I am unsure whether any of these would have applied to our patients. It is possible that Professor Parapia or the adult haemophilia nurse specialist spoke to the patients affected about these funds and similarly they would have the relevant information regarding the Centre's policy/guidance in respect of referring patients to the trusts and funds for support and what information would have been provided to the trusts and funds.

Section 10: Other issues

109. *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.*

In respect of question 109, I do not have any details of any complaints made against me which are relevant to the Inquiry's Terms of Reference.

110. *Please explain, in as much detail as you are able to, any other matters that you believe may be of relevance to the Infected Blood Inquiry, having regard to its Terms of Reference and to the current List of Issues.*

In respect of question 110 there is nothing further I want to add.

111. As stated above, I have made this statement without the benefit of medical records or policies for the relevant period and therefore I have been limited to giving information on matters I can only recollect and provide estimates as to timings.

Statement of Truth

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

Signed GRO-C

Dated 30th September 2020