Witness Name: Olive Redding
Statement No.: WITN4556
Dated: 16. 3. 2021

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF OLIVE REDDING

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

I, Olive Redding, will say as follows: -

Section 1: Introduction

1. My name is Olive Margaret Redding, I was born on GRO-C 1931 and I live at GRO-C GRO-C Cumbria GRO-C

2. Professional qualifications:
   Register for General Nurses by the General Nursing Council of England and Wales 28 July 1975
   Midwifery Certificate 1977
   Health Visitor Certificate 1978,
   SRN at Bury General Hospital 1975

3. Medical Appointments:
   Fairfield General Hospital Midwifery Department 1976 - 1977,
   Health Visitor, Fairfield General Hospital Midwifery Department 1980 or 1981
   Haemophilia Coordinator, Haematology Department, Manchester Royal Infirmary 1981 - 1996.

4. I was a member of the Haemophilia Society.

5. I have not provided any evidence or been involved in any other relevant enquiries or investigations.

Section 2: Manchester Haemophilia Centre ("the Centre")

6. I was responsible for looking after patients with haemophilia when they came to the department. I administered treatment ordered by a doctor and made occasional home visits from 1981 until Meg Openshaw joined the team.

7. I worked with consultants Dr Irvine Delamore, Dr Richard Wensley, Dr Charles Hay and senior staffer, Dr Monica Bolton.

8. As far as I am aware, Dr Delamore and Dr Wensley made decisions on the use and choice of which products to use and discussed treatment with patients.

Section 3: Knowledge of risk

9. At some point during my employment, the treatment changed to avoid using blood products.

10. Home treatments also changed over time to using non-blood products. I am unable to give any exact dates.

11. Children were not treated at Manchester Royal, they went to Pendlebury.

12. A haematologist faced with a patient in a life threatening or potentially life changing situation would prescribe factor VIII or IX concentrates if that was all that was available at the time.

13. When I first started, I don't recall any contraindication in relation to the products I was using. I know when problems relating to blood products were beginning to emerge but it didn't change my nursing practice. I still had to treat the patients and I was working under the direction of the haematologist.

14. I don't recall any discussions about the transmission of hepatitis. I felt my nursing practice was good in all situations.

15. Knowledge was acquired in the department and communicated to all the staff as the situation developed. The products I administered may have changed but my nursing practice was not affected by this.

16. As far as I was aware, all the blood products were sourced by the NHS but I think originally blood products were imported.

17. A lot of patients who came to us were diagnosed as children so risks had already been discussed with parents or guardians. There were regular department meetings to discuss any changes to treatment.

18. When any treatment was given to a patient, all care was always taken to reduce any risk of infection as standard.

Section 4: Testing, treatment and care of patients

19. All initial information was given to individual patients by the consultant at his clinic. I don't remember having to do this.

20. All decisions regarding what information should be provided to patients at the centre was decided by the consultant.

21. Many that were on home treatment were already on it when they left the children's hospital. Therefore the severe cases were already identified. Other than this situation, I don't recall.

22. I think advice was given to patients to have tests that were recommended by the clinicians. I just administered treatments as directed.
23. I was always instructed to provide treatment by the haematologist. Training and advice given to me was ongoing.

24. I wasn't told to withhold information from patients.

25. No it wasn't customary to routinely take blood samples when patients came for treatment.

26. As far as I remember I didn't have to give anyone the results of their tests, that was left for the doctor.

27. When we took blood from patients for testing, they were always informed as to what the tests were. I don't recall that that changed over time.

28. I wasn't involved in giving patients their test results, that was the role of the consultant. If any patients tested positive they were told by the consultant when they attended the department and I was often present.

29. It was pointed out to them that they risked passing it on to close contacts. This changed over time because Sister Meg Openshaw was employed to support and advise the families. She supported, gave advice and visited the patients that had tested positive.

30. I think testing was offered to partners but this was the role of Meg Openshaw.

31. Meg Openshaw was the counselling and psychological support made available to patients and their families.

32. Meg Openshaw was a valuable member of the team, giving support to patients and their families.

33. To my knowledge, patients were not referred elsewhere. I don't recall what treatments were offered.

34. Patients were not treated differently. Measures taken were to advise about risks to partners.

35. To my knowledge the clinical staff were made aware if they were required to treat that particular patient.

36. Infected patients were not treated any differently by me. It wasn't my role to get involved in the impact in a general way, which was Meg Openshaw.s role.

Section 5: Research

37. I have no knowledge of research.

38. I do not know if patients were made aware of research.

39. We were an adult centre so previously untreated patients were not seen. I don't recall that term being used in the centre. It would be unusual to see a patient that was previously undiagnosed.

Section 6: vCJD

40. I don't recall seeing any patients with vCJD in the haemophilia department.

Section 7: Effect on clinical staff

41. Precautions were always taken when dealing with blood products, testing patients or administering treatments, as was the case in any medical procedures as per good nursing practice.

42. I didn't report any concerns or complaints. Patients were encouraged to voice any concerns and these would be taken to the most appropriate person.

43. Personally I always think back to the times when I unknowingly gave patients infected blood products. I still think about it all these years later.

Section 8: Other Issues

44. I was not aware of any of the named trusts.

45. Patients, as members of the haemophilia society, could refer to them for support. I wasn't directly involved but I did join the haemophilia society. I didn't give advice to the society. If they had any particular worries I passed them to the appropriate person.

46. All patient notes/medical records were kept within the haemophilia centre.

47. As far as I know, there were no separate records kept.

48. Dr Monica Bolton was the haematologist mainly responsible for prescribing treatment for the haemophilia patients and any who were inpatients of the hospital. When Dr Bolton wasn't available, haematology doctors would be involved. I gave treatment that was prescribed by the doctors.

49. I have nothing more to add.

Statement of Truth

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

Signed GRO-C

Dated 11.3.2021