Witness Name: Dr Patricia Chipping
Statement No.: WITN4567001
Exhibits: none
Dated: 09/11/2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PATRICIA CHIPPING

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 25 August 2020

I, Patricia Chipping, will say as follows: -

Section 1: Introduction

1. Patricia Margaret Chipping

2. GRO-C Kent GRO-C

3. Dob GRO-C 1948

4. Qualifications: - BSc, MB BS, FRCP, FRCPath

5. Employment history:

   5.1. 1976 -7 SHO in pathology Royal Free

   5.2. 1977-8 Registrar in haematology Royal Free

5.3. 1978-9 Registrar in haematology Hammersmith Hospital

5.4. 1979-82 Senior registrar in haematology North Middlesex, West Middlesex and Hammersmith Hospitals.

5.5. 1980-82 Locum consultant in blood transfusion Hammersmith Hospital

5.6. Dec 1982 – June 2009 Consultant haematologist University Hospital of North Staffordshire, Stoke-on-Trent

6. Membership of societies Member of British Society of Haematology. No other memberships.

7. I have not provided evidence to any other inquiry or investigation in relation to HIV, Hepatitis B or C or vCJD

Section 2: Decisions and actions of the Centres at Hammersmith and Stoke-on-Trent and your decisions and actions

Hammersmith hospital:

8. Please note that the I was not at any time director of the Haemophilia Centre and I am unable to provide any information as to its history. My role at the Hammersmith hospital was as a registrar and a senior registrar in haematology. Following the sudden death of Dr Sheila Worrledge, I acted as locum consultant to the blood transfusion department and was involved in the ordering and issuing of blood products.

9. Haemophilia patients at the Hammersmith were treated in a side room adjacent to the blood transfusion department. This was essentially for ease of access as blood products were stored in the blood transfusion department. The coagulation department was housed in a separate building in the Royal Postgraduate Medical School. All monitoring tests and other coagulation tests were undertaken in that department.

10. As a registrar and senior registrar, I was involved in administering Factor VIII and Factor IX to patients who presented in the department. Increasingly patients were on home treatment and as locum consultant, my department was responsible for ordering blood products including factor VIII and factor IX from the Regional Transfusion

11. Centre (RTC) and issue of factor VIII and IX to patients on home treatment. Patients were treated as outpatients and I cannot recall patients being admitted and, if they were, it would have been under the auspices of the coagulation consultant. I was not involved with the management of patients infected with hepatitis and at this stage HIV was not known to be an issue.

12. It is only fair to say that the department at the Hammersmith at the time I was acting as locum consultant was in a stage of transition following the retirement of Sir John Dacie. His replacement Professor Lucio Luzzatto was new to the department. Other senior members of the haematology department included Dr E Gordon-Smith whose main interest was aplastic anaemia. Other members of the department were involved solely in the management of leukaemia patients. I cannot recall who the coagulation consultant was although there may be some record within the current haemophilia centre.

Stoke-on-Trent

13. I am unable to provide any history of the haemophilia centre in Stoke-on-Trent. I assume it was set up by my predecessor Dr Chris Giles and was subsequently largely run by my colleague Dr R M Ibbotson. Although nominally I was co-director of the haemophilia centre and certainly assisted in the completing of haemophilia centre returns, I had little involvement with the day to day treatment of patients with haemophilia. My own role at Stoke involved the treatment of patients with malignant haematological conditions and I was only involved with the treatment of haemophilia and other bleeding disorder patients when covering for my colleague during weekends and periods of annual leave.

14. Dr Ibbotson took the lead in managing patients with bleeding disorders. I believe that he would be better placed than I am to provide further information about treatment of bleeding disorder patients in Stoke.

Number of patients

15. I cannot give figures with any certainty either for the Hammersmith or Stoke. At both centres the majority of patients were adults. In London, most children were managed at Great Ormond Street and in Stoke children were managed in conjunction with Dr Frank Hill at Birmingham Children's Hospital.

Decisions on the purchase of Blood Products.

16. I was involved in the ordering of blood products at both the Hammersmith Hospital and at Stoke and the policy in both units was the same. The supply of blood products was the role of the Regional Transfusion Centre (RTC) in both cases. Hammersmith Hospital was supplied by the North London Blood Transfusion Centre and Stoke by the West Midlands Blood Transfusion Centre. Decisions about ordering were made on the basis of clinical need but issue of products depended on their availability at the RTC. Whilst we ordered British produced Factor concentrates on the basis that we were aware the commercial products might contain plasma from paid donors, supplies of Factor VIII concentrate from the Blood Product Laboratory (BPL) were limited and until well into the 1980s it was unusual to receive what we had ordered, substitution being made with commercial factor VIII. As supply was via the RTCs, financial considerations were not a factor in our decision-making process. This is true even when cross charging for blood products was introduced.

Choice of Blood Product

17. As I have indicated above, we preferentially ordered and used British products via the RTC. I do not have details of which commercial products were issued and cannot comment on the decision-making processes adopted by the RTCs.

Treatment of individual patients

18. In the mid 1970's when I was an SHO at the Royal Free cryoprecipitate was the product in use. Making up of cryoprecipitate was time consuming and quite a large volume of product was required in order to obtain satisfactory factor VIII levels. This was a particular disadvantage in children. It was also unsuitable for use in home treatment. By the late 1970s at the Hammersmith many of the patients were on home treatment and were issued with factor VIII or Factor IX via the blood transfusion department. Factor concentrates were the product of choice by both patients and doctors because of ease of administration meaning less time at hospital. With the advent of factor concentrates home treatment became a possibility offering the chance of a relatively normal life to patients who just a few years previously would have had to attend hospital for treatment.

19. I was not sufficiently involved in the day to day management of patients to comment on what alternatives were offered except to say that in the 1980s DDAVP became available to raise factor levels in patients with mild haemophilia and patients with von Willebrand's disease and where appropriate this product was increasingly used in such patients in Stoke. This alternative was not available when I worked at the Hammersmith.

Use of Cryoprecipitate

20. By the late 1970s and 1980s cryoprecipitate was not routinely used at either the Hammersmith or in Stoke for treatment of haemophilia. As I indicate above this was because of the time required to thaw, draw up and administer the product. It was also more difficult to assess the concentration of factor VIII as this varied from bag to bag. The other major problem was the relatively large volume of product required for effective treatment. The advantage of cryoprecipitate with the knowledge we now have is that it was drawn from a smaller donor pool and therefore less likely to be infected. When factor concentrates became available the switch to their use became routine for all the reasons outlined as the disadvantages of cryoprecipitate.

Home and Prophylactic treatment

21. By the late 1970s and certainly in the 1980s it was routine for most adult patients and some children whose parents were able to administer factor concentrates to be on home treatment. This was regarded at the time as gold standard therapy.

22. I did not have sufficient involvement in the day to day management of patients to comment on prophylactic treatment. I was not involved in initiating this at any time.

Policy and Changes in the use of blood products

23. As I was not involved in day to day patient management it is difficult to comment here but certainly recommendations of the haemophilia centre directors who met regularly and in Stoke recommendations of the working party on haemophilia treatment, on which my colleague Dr Ibbotson sat, informed our decision making. When heat treated products became available they became the product of choice.

24. Patients with mild haemophilia were treated with factor concentrates as little as possible but inevitably treatment was required in the event of trauma or pre-operatively.

<u>Section 3: Knowledge of, and response to, risk</u>

Infection risks

Hepatitis

25. Whilst working at the Royal Free and then the Hammersmith as a trainee it became clear from patient reports and discussion with colleagues that patients often experienced a brief episode of jaundice after exposure to factor concentrates. It was known that hepatitis B could be transmitted by transfusion of blood products, but patients tested negative for Hepatitis B. This appeared at the time to be a minor problem and the assumed causative agent was labelled nonA nonB hepatitis. Over time the problem was reported at medical meetings, discussion with peers and in journals leading to increasing knowledge. However, it was not until the late 1980s

that Hepatitis C was identified as the causative agent. It then became clear that late onset liver disease was associated with hepatitis C.

26. Given the relatively short time I was in post at the Hammersmith no particular advisory or decision-making structures were put in place.

27. As the risk of infection from transfused blood and blood products became apparent an advisory committee (e.g. a blood transfusion committee with multidisciplinary input) was set up in Stoke. Specific permission for blood transfusion for example during surgery became routine practice in Stoke.

28. As already indicated above, it was difficult to ascertain the source of donors for commercial factor VIII products; thus, it was my assumption that these were less safe than NHS blood products. NHS products at the time were thought to be relatively safe but this was before the long-term effect of Hepatitis C was recognised and before the problem of transfusion transmitted AIDS was recognised.

29. Hepatitis B was recognised as having long-term consequences. It became clear that so-called nonA nonB hepatitis had long term consequences some years after the use of factor concentrates became routine. Increasing reports in the medical press and at medical meetings provided increasing amounts of information about the problem of long-term liver disease.

30. Once the risk of Hepatitis C was recognised and screening of donors became possible, but particularly because of the much more pressing problem of HIV, donors were screened more carefully with certain groups being excluded from being donors. Once heat treated products became available these became the choice for treatment of haemophilia and other blood disorders.

HIV/AIDS

31. I was not aware of the problem of HIV/AIDS until the early 1980's when I was working in Stoke. It became recognised that the use of factor concentrates where

multiple donors were involved meant that patients with haemophilia were at particular risk. This information became available through peer to peer communication and information in medical journals.

32. I was not involved in the day to day management of haemophilia and other blood clotting disorders by the time that HIV/AIDS became a known issue.. It is, however, clear that where serious bleeds had occurred treatment with factor concentrates did continue in order to avoid the crippling joint deformities that we had become familiar with in older patients with haemophilia.

Response to risk

33. The problem of HIV/AIDS became apparent after I had finished working as a locum at the Hammersmith. In Stoke I was not involved in the day to day management of patients with haemophilia. Dr Ibbotson may be able to address this question. The blood transfusion service responded by requiring those who posed a risk to exclude themselves from being blood donors.

34. Heat treated factor products were used as soon as they became available. I am not an expert on the heat treatment of blood products, but it is my understanding that it was not easy to develop a technique that eliminated viral load without destroying factor VIII. I believe heat treated products became available once effective technology to eliminate risk and preserve factor activity was found.

35. There was insufficient information available to switch back to cryoprecipitate whilst I was working at the Hammersmith. Dr Ibbotson may be able to comment on the policy in Stoke.

Could different decisions have been made?

36. Given my lack of involvement in the day to day management of patients with bleeding disorders I find it difficult to offer an opinion here.

37. As I have indicated we were dependant on the provision of blood products from the RTCs and were often unable to obtain British produced products. If the UK had been able to produce sufficient factor concentrates the risk of both Hepatitis and HIV/AIDS might have been less but would not have been eliminated.

Section 4: Treatment of patients

Provision of information to patients

38. As I have explained earlier, I was not involved with patient care but only with provision of blood products while I was a locum consultant at the Hammersmith. From 1977 to 1979 as a registrar and senior registrar I am unable to recall written information being provided to patients about either infection or alternative treatments to patients. Discussion with patients on the emerging problem of infection occurred on an ad hoc basis.

39. I was not involved in day-today treatment of patients in Stoke. Dr Ibbotson may be able to advise further.

40. I was never made aware of patients at the Hammersmith who had been infected with HIV and Dr Ibbotson, would on a need to know basis, make me aware of infected patients in Stoke.

41. I am unable to provide any information on these points concerning pre- and post-test counselling and informing patients of their infection.

Letter from Dr Ala regarding a donor who tested positive for HIV [NHBT0116697]

42. We received one unit of blood from a donor with HIV and we were able to trace to whom that unit of blood had been transfused by consulting our blood transfusion records. Patients affected would have been informed of this unfortunate event and tested and followed up for HIV and/or Hepatitis C.

43. From memory the unit of blood in question was transfused into a patient who had a massive transfusion and died in the post-operative period. This information was

sent back to the RTC and no further action was taken. I believe that this is the only case where we were made aware of receiving such a unit of blood and therefore any answer to points e and f would be hypothetical.

44. I have no information on points relating to testing and informing patients of Hepatitis B and NANB Hepatitis.

Consent

45. I am unable to comment on the taking of blood samples from patients at either the Hammersmith or in Stoke.

46. At the Hammersmith, consent was sought verbally before administering factor concentrates but would not have been recorded. During my time at the Hammersmith patients could not have been informed of all the risks involved as these risks were only becoming clear well after I had left the Hammersmith.

47. For the situation in Stoke you would need to refer these questions to my colleague Dr Ibbotson.

48. I was not involved in the treatment of previously untreated patients.

Research

49. I personally conducted no research into haemophilia or related blood disorders.

50. I note that my name appears as a contributor to the papers listed. I cannot recall providing any specific information for these articles and assume that the data was taken from Haemophilia Centre returns which were requested, as I recall, on an annual basis and I may well have signed them off. As I was not aware that this information was being used for publication I would not have made patients aware. I do not know whether patients were made aware of Haemophilia Centre returns, although provision of the information was expected of Haemophilia Centres. No other patient data was shared with third parties.

Treatment of patients infected with HIV

51. This was not a known issue whilst I was locum consultant at the Hammersmith – see dates.

52. In Stoke on Trent patients were managed by Dr Ibbotson in conjunction with Dr Hugh Tubbs – consultant in infectious diseases. I am unable to provide any further information on the treatment of patients who had been infected with HIV and/or Hepatitis as I was not involved in the regular care of blood coagulation patients. Children at Stoke were managed in conjunction with Dr Frank Hill at the Birmingham Children's Hospital.

53. I am not aware of any involvement in clinical trials.

54. I have no information on these points concerning counselling and psychological support for patients infected through blood products, or concerning funding for the treatment of people infected with HIV and/or Hepatitis C.

Records

55. I have no information about the recording of information on death certificates. I was not involved in any such case as such patients would not have been under my care.

56. As far as I am aware patient records were retained for a period of seven years after the last clinical contact.

57. I did not keep separate records. I have no records at home and have never kept any and I have no information or records of any patients at home or elsewhere.

Section 5: Pharmaceutical companies/medical research/clinical trial

58. I had no contact with pharmaceutical companies in any advisory or research capacity at either the Hammersmith or Stoke on Trent and no financial arrangements whatsoever.

Section 6: vCJD

59. I became aware of potential issues with vCJD in the 1990s through media coverage and medical journals.

60. Informed consent to blood transfusion including the risk of vCJD became standard practice in Stoke in the late 1990s once the risks became known. This was overseen by the blood transfusion committee. Patients were informed of the risk but also the risks of not having a blood transfusion. As I was dealing with patients with haematological malignancies this risk was small compared with their clinical diagnosis and I do not recall any patient requiring counselling. As a general rule the use of blood transfusion was increasingly avoided where a viable alternative existed.

61. I cannot recall any specific public health measures being put in place in relation to vCJD.

Section 7: The financial support schemes

62. I had no involvement with the funds listed and I would not have been the clinician referring patients. I cannot comment on whether or not they were well run.

Section 8: Other issues

63. No complaints were made about me in respect of issues connected with the Inquiry.

Statement of Truth

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

Signed GRO-C

Patricia M Chipping

Dated 09/11/2020

Table of exhibits:

Date	Notes/ Description	Exhibit number