Witness Name: Professor John Moore Bridges
Statement No.: WITN4569001
Exhibits: None
Dated: November 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR JOHN MOORE BRIDGES

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 24 August 2020.

I, Professor John Moore Bridges, will say as follows: -

Section 1: Introduction

1. *Name, address, date of birth and professional qualifications*

My name is Professor John Moore Bridges.
My date of birth and address are known to the Inquiry.
My professional qualifications are MD, FRCP, FRCPath.

2. *Employment history*

I graduated in 1954. I was employed as a Junior House Officer at the Royal Victoria Hospital in Belfast and then spent 3 years in the Queen's University of Belfast Department of Pathology and then as a trainee in Clinical Pathology and then a fellowship at Tufts University Medical Centre, Boston, USA.

In 1961, I was appointed as Consultant Clinical Pathologist at the Royal Group of Hospitals in Belfast and was based within the Royal Belfast Hospital for Sick Children ("the Children's Hospital"). I looked after children with a range of blood disorders including haemophilia.

In 1979, I was appointed as Chair of Haematology at Queen's University Belfast and was based at Royal Victoria Hospital. As a result of that appointment from then onwards 50% of my time was spent in clinical practice and the other 50% was taken up with academic commitments. From 1979 onwards, the bulk of my clinical work was dealing with leukaemia and general blood disorders within the adult hospital at the Royal Victoria Hospital. The role of consultant haematologist in the Children's Hospital was taken over by Dr Dempsey in 1979 or 1980.

My main professional interest was in patients with haematological malignancy.

I retired in 1994.

3. *Committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference*

I was a member of organisations such as British Society of Haematology and various local hospital boards and department committees at which there would be reference to patients with bleeding disorders but none of which was exclusive to or primarily focused on these disorders.

I was not a member of the UKHCDO.

4. *Involvement in other inquiries, investigations, criminal or civil litigation*

I have not 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.

Section 2: Decisions and actions of the Royal Belfast Hospital for Sick Children/ the Royal Victoria Hospital/the Belfast Haemophilia Centre

5. *Role and responsibilities at the Children's Hospital*

At the Children's Hospital, I was responsible for care of patients with haemophilia and related disorders as well as children with leukemia and other blood disorders. Children with haemophilia would have been looked after in the Children's Hospital up to the age of around 14 before transferring to the adult hospital (Royal Victoria Hospital), although there were no hard or fast rules and no formal process for transferring to the adult haemophilia service.

During my time at the Children's Hospital, the main treatment for children with haemophilia was cryoprecipitate. There was no register of patients as far as I can remember. I do not recall having any child patients who would have been under the ages of 5-7 approximately although I cannot be certain. Cryoprecipitate became available around the mid-1960s. This was a major development in the treatment of haemophilia. Prior to the introduction of cryoprecipitate, treatment would have been limited to measures such as bed rest and pain relief and so on.

Because my clinical experience of treating haemophilia patients involved mainly treatment with cryoprecipitate, a child who I considered might require treatment with factor concentrates, would have been referred to the adult hospital to be seen by Dr Mayne. I considered that Dr Mayne had the relevant clinical experience and knowledge to decide on the most appropriate treatment and management of such patients.

Role and responsibilities at the Royal Victoria Hospital

At the Royal Victoria Hospital, I was responsible for patients with leukemia and other blood diseases, but not for patients with bleeding disorders. If Dr Mayne was not available, I would have seen patients with bleeding disorders. In reality, only a very small proportion of my time would have been spent dealing with adult patients with haemophilia. Essentially, it amounted to providing cover on occasions when Dr Mayne was unavailable, such as annual leave.

I was not involved in the care of HIV positive patients, nor with those infected with hepatitis

I had a very cordial relationship with Dr Mayne who was in my opinion a very dedicated and competent doctor. I think her professional standing is reflected by her membership of important national organisations dealing with haemophilia. As events unfolded in the late 80s and early 90s, it was obvious that she was deeply distressed by developments at that time.

While I have addressed my professional relationship with Dr Mayne as requested, I consider it was inappropriate to ask me to comment on a professional colleague in this way.

6. *Approximate number of patients with bleeding disorders under the care of (a) the Royal Belfast Hospital for Sick Children and (b) the Royal Victoria Hospital*

It will be appreciated that at this remove in time I cannot be confident about patient numbers. To the best of my recollection, at the Royal Belfast Hospital for Sick Children I believe there were approximately 10 patients with bleeding disorders. At the Royal Victoria Hospital I was not primarily responsible for bleeding disorder patients and I cannot assist with the number of adult patients.

7 *Selection, purchase and use of blood products (in particular factor concentrates)*

When I was at the Children's Hospital, concentrates were not used. We used cryoprecipitate which, to the best of my knowledge, was supplied by the Northern Ireland Blood Transfusion Service.

In the Royal Victoria Hospital, I believe decisions about use and purchase of blood products were made in accordance with national guidelines but I was not involved in these decisions. I understood the guidelines would have come from UKHCDO, and possibly also from the Department of Health. They were available within the hospital although I do not recall seeing them. I did not receive UKHCDO minutes as I was not a member.

8. *Arrangements between the Royal Victoria Hospital/the Eastern Health and Social Services Board and the Scottish National Blood Transfusion Service/the Protein Fractionation Centre (Edinburgh) for fractionation of plasma received from Northern Ireland and for supply of products to Northern Ireland.*

I was aware that for a time plasma from the Northern Ireland Blood Transfusion Service was processed in Edinburgh and I consider this to be a reasonable and useful exercise. Northern Ireland was too small an entity to set up a fractionation centre. So it seemed reasonable to send plasma to Edinburgh to be processed. I am unable to provide further detail.

9. *Decisions taken as to which products to use for individual patients*

For the reasons already explained, I cannot assist as I was not involved in such decisions.

10. *Alternative treatments to factor concentrates available in the 1970s and 1980s for people with bleeding disorders; advantages and disadvantages of such alternatives.*

When I was at the Children's Hospital concentrates were not available. We used cryoprecipitate - there was nothing else so the question of advantages or disadvantages did not arise. Although I did not use concentrates, I know they were much more effective. They were also much more convenient, especially for Home Treatment. Cryoprecipitate had to be frozen. You needed space to store it and so on. Back then people did not have freezers that could accommodate it. Another disadvantage of cryoprecipitate was it could not be used for surgery because you would not have had the level of cover needed.

11 -13 *Policy and approach to (i) use of cryoprecipitate; (ii) home treatment; and (iii) prophylactic treatment*

I was not involved in deciding on the use of concentrates as opposed to cryoprecipitate or in formulating policy regarding home treatment. If any of the patients at the Royal Victoria Hospital were on home treatment, it was under the care of either Professor Gerry Nelson or Dr Elizabeth Mayne.

To my knowledge, prophylactic treatment may have been used if, for example, there was to be a tooth extraction but it was not used routinely every week.

Looking back everything seems informal by comparison to the approach today.

14. *Extent to which, and why, people with mild or moderate bleeding disorders were treated with factor concentrates*

I did not use concentrates.

Section 3: Knowledge of, and response to, risk

Hepatitis

15. *Knowledge and understanding of the risks of infection (in particular hepatitis) associated with blood and/or blood products*

I became aware of the risks of hepatitis associated with the use of blood and blood products but I am not sure of the exact time. I do not recall being aware of the risks of NANB hepatitis in the 1970s. I would have thought that I would have been aware of the risk of NANB hepatitis really from the mid-1980s onwards.

16. *Understanding of relative risks of infection from (i) the use of commercially supplied blood products, and (ii) the use of NHS blood products*

My understanding was that commercial products carried a greater risk of infection and that the identification of various types of viral hepatitis in the late 80s and early 90s was a major advance. Commercial products carried a greater risk because they were sourced from multiple donors, including higher risk groups such as drug addicts and others.

17. *Understanding of the nature and severity of the different forms of blood borne viral hepatitis*

I would refer to my answer at 15 above.

18. *Advisory and decision-making structures in place, or put in place in Belfast or more widely in Northern Ireland, to consider and assess the risks of infection associated with the use of blood and/or blood products*

I was not aware of such decision making structures in Belfast or more widely in Northern Ireland. I would have been guided by practice in Great Britain.

HIV and AIDS

19. *Knowledge and understanding of HIV (HTLV-III) and AIDS and of the risks of transmission from blood and blood products*

I cannot remember when I first became aware of risk of transmission of AIDS by blood and blood products. I know that Dr Mayne was involved in groups in Great Britain discussing this and also that Dr McClelland from NIBTS would

have been involved in discussions with colleagues in Great Britain. My main source of information would have been discussions with Dr Mayne.

Looking back it is hard to imagine the horror and the way it all evolved. It was thought there had been huge advances with the advent of blood products. When cryoprecipitate first appeared it represented major progress in the treatment of bleeding disorders. Then concentrates appeared and they were seen as ground breaking. There was, for want of a better phrase, a 'honeymoon period' in relation to factor concentrate products. Then came the bombshell of blood-borne viruses.

At all times I would have taken the lead from Dr Mayne who took direction from the UKHCDO and colleagues in Great Britain.

20. *First awareness that there might be an association between AIDS and the use of blood products*

See previous reply.

21. *Enquiries and/or investigations in respect of the risks of transmission of HIV or AIDS*

See previous reply.

22. *Actions to reduce the risk to your patients of being infected with HIV*

See previous reply.

23. *Use of factor concentrates to treat patients after becoming aware of the possible risks of infection of HIV*

Decisions concerning continued use of factor concentrates would have been made by Dr Mayne or Dr Dempsey. I had great confidence in them as colleagues to offer the best advice based on their knowledge and their contacts in the UK or further afield.

Response to risk

24. *Steps taken by myself and/or Dr Mayne to ensure that patients were informed and educated about the risks of hepatitis and HIV*

Dr Mayne took the lead in these matters and I am unable to assist in any meaningful way. However, I was, and remain, confident that any steps were taken after consultation with relevant GB authorities.

25. *When use of heat treated factor products began; categories of patients for which they were used.*

See 24 above.

26. *Should heat-treated products have been made available earlier?*

I do not feel able to comment as I do not have the relevant clinical knowledge or experience of using concentrates.

27. *Consideration to reverting to treatment with cryoprecipitate for some or all of the patients in response to the risk of infection*

No discussion took place between Dr Mayne and myself about the possibility of reverting to cryoprecipitate. This would not have been appropriate as I was not treating patients who were on factor concentrates.

28. *Adequacy/appropriateness of decisions and actions, in response to any known or suspected risks of infection*

There is an old saying that in medicine the most useful instrument is the 'retrospectoscope'. It is my opinion that delays in increasing the capacity of the fractionation centre at Elstree was a factor – those in the Department of Health were told of the problem but did not find the necessary funds to address it. I have deep sympathy for those colleagues involved in the

decision making at the time. They were good honest people, not casual in their work, who were doing the best they could for their patients.

29. *Decisions or actions by myself and/or by Dr Mayne that could and/or should have been avoided, or brought to an end earlier, in relation to the use of infected blood products*

I do not feel I have sufficient knowledge or accurate recall of events to offer an opinion.

30. *Actions or decisions or policies of other clinicians or other organisations, within my knowledge, that played a part in, or contributed to, the scale of infection in patients with bleeding disorders*

See 29 above.

31. *Could or should greater efforts could have been made to inactivate viruses in blood or blood products prior to 1980?*

See 29 above.

Section 4: Treatment of patients

Provision of information to patients

32. *Information to my knowledge, provided to patients at the Belfast Haemophilia Centre about the risks of infection prior to treatment commencing and about alternatives to treatment with factor concentrates.*

I was not involved in providing information of this nature to patients. The risk of hepatitis was not widely known during the time I was treating children with cryoprecipitate and therefore there was no discussion with the parents about risks.

HIV

33. *First discussion of AIDS or HIV (HTLV-III) with any of the patients of the Belfast Haemophilia Centre*

I did not discuss AIDS with any of the patients. To the best of my knowledge, Dr Mayne dealt with this aspect.

34. *Learning that patients under the care of the Belfast Haemophilia Centre had been infected with HIV.*

I cannot recall when or exactly how I became aware that some local patients were infected. I note reference to me attending a meeting with Dr Mayne with patients in relation to HIV. I believe there was a meeting with patients in the Ian Fraser lecture theatre. I am not saying that I did not attend this meeting, but due to the passage of time I do not recall attending.

35. *Meeting or series of meetings held with patients at the Centre to discuss HTLV-III in late 1984 or early 1985*

See 34 above.

36. *Provision of HIV test results to patients; significance of positive diagnosis; counselling*

I was not involved in discussing these matters with patients and cannot recall whether I ever knew how many were infected. Nor can I help with information about entry to trials or research studies.

37. *Number of patients of the Belfast Haemophilia Centre infected with HIV*

I cannot recall how many patients were infected. As just stated, I am unsure whether if I ever knew exactly how many were infected. I cannot say whether any were children.

38. *Work undertaken to establish the time period during which patients seroconverted*

I have no knowledge of work undertaken to establish the time period during which patients seroconverted.

Hepatitis B

39. *Involvement with the diagnosis, treatment and care of patients infected with hepatitis B in consequence of infected blood or blood products.*

I have no recollection of any of my patients being infected with hepatitis B in consequence of blood or blood products.

40. *Number of patients of the Belfast Haemophilia Centre infected with hepatitis B*

See 39 above.

NANB Hepatitis/Hepatitis C

41. *Involvement with the diagnosis, treatment and care of patients infected with Non-A Non-B hepatitis in consequence of infected blood or blood products.*

I was not involved in these aspects of patient care.

42. *Testing of patients for hepatitis C; informing patients of results; information provided to patients about Hepatitis C*

I was not involved in testing for hepatitis C and I was not involved in communicating test results nor providing information to patients. I do not know the number of patients tested.

43. *Steps taken by the Belfast Haemophilia Centre/the Royal Victoria Hospital to ensure that all patients who had received blood products were traced and invited to be tested for Hepatitis C*

See 42 above

44. *Number of patients of the Belfast Haemophilia Centre infected with hepatitis C*

I am not aware of the number of patients infected with hepatitis C.

Consent

45. *Blood samples taken from patients attending the Belfast Haemophilia Centre*

It was not practice to take blood tests unless there was some indication to do so. I do not believe that blood samples which were taken were stored. With regards to consent, I might have said to patients in a conversational way *"I think we should test for X"*, but formal consent, as such, was not taken. It could, however, be described as implied consent. There was no discussion about storage of samples to my recollection.

46. *Consent to treatment with factor concentrates or other blood products*

In the earlier period of my medical career, in the 1950s and 1960s, there was a very paternalistic approach to the issue of patient consent to treatment

generally. The assumption was that, in the absence of any indication to the contrary, patients were content to be guided by the clinician's advice and impliedly consented to the treatment recommended.

I did not use factor concentrates so issues of informed consent in relation to treatment with them did not arise. I did use cryoprecipitate but, to my knowledge, there were no issues with cryoprecipitate. Accordingly, I did not sit down with patients or their parents and go through all aspects of the treatment with them with a view to obtaining formal consent. That simply was not the practice at the time.

47. *Testing of patients at Belfast Haemophilia Centre for HIV or hepatitis or for any other purpose without their express and informed consent*

I was not involved in testing patients for HIV or hepatitis and I am unable to comment on what steps may or may not have been taken in relation to consent for such testing.

48. *Involvement of patients of the Belfast Haemophilia Centre in research studies without their express consent*

I am unable to comment on this suggestion as I had no involvement in research or statistics.

49. *Use of patient data (anonymised, de-identified or otherwise) for the purpose of research or for any other purpose without their express consent*

See 48 above.

50. *Sharing of patient data (anonymised, de-identified or otherwise) with third parties without their express consent*

See 48 above.

Publications

51. *Articles or studies published insofar as relevant to the Inquiry's Terms of Reference.*

I have not published any articles or studies relevant to the Inquiry's Terms of Reference.

Treatment of patients who had been infected with HIV and/or Hepatitis

52. *Management of care and treatment of patients with HIV/AIDS at the Belfast Haemophilia Centre – referral for specialist care; treatment options offered; information provided; follow-up and/or ongoing monitoring*

I cannot assist with any specific information on the care and treatment of patients with HIV/AIDS, but am confident that Dr Mayne, together with colleagues from other specialities, would have offered every possible assistance to these patients. I recall Dr Callendar was the liver specialist in relation to HIV. I do know that if any of my patients were infected with HIV, it did not show up during my time treating them in the Children's Hospital.

53. *Management of care and treatment of patients with hepatitis B Belfast Haemophilia Centre*

I have no recollection of any haemophilia patients with hepatitis B.

54. *Management of care and treatment of patients with NANB hepatitis at the Belfast Haemophilia Centre*

I cannot assist with any specific information on the care and management of patients with NANB hepatitis but, as with HIV, I am confident that Dr Mayne, together with colleagues from other specialities, would have offered every possible assistance to those patients.

55. *Management of care and treatment of patients with hepatitis C at the Belfast Haemophilia Centre*

I cannot assist with any specific information on the care and management of patients with hepatitis C but, as with HIV and NANB hepatitis, I am confident that Dr Mayne, together with colleagues from other specialities, would have offered every possible assistance to those patients.

56. *Arrangements made for the care and treatment of children infected with HIV or hepatitis*

I am not aware of any children at the Children's Hospital being infected with HIV or hepatitis during the time I worked there.

57. *Arrangements made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support.*

Arranging and providing psychological support would have been the remit of Dr Mayne.

58. *Funding for the treatment of people who had been infected with HIV and/or hepatitis C*

I am not aware of any funding difficulties in relation to treatment of patients infected with HIV and/or hepatitis C.

59. *Clinical trials in relation to treatments for HIV and/or hepatitis*

I am not aware of any such clinical trials at Belfast Haemophilia Centre.

Records

60. *Policy or practice at the Centre with regard to recording information on death certificates when a patient had been infected with HIV or hepatitis*

I am unable to comment on this aspect other than that I am aware in Northern Ireland considerable sensitivity surrounded recording HIV as a cause of death, particularly within rural communities.

61. *Retention policies of the Centre and/or the Royal Victoria Hospital in regards to medical records during the time I was working there*

I am unable to assist as I do not know the policy on retention of records.

Section 5: Pharmaceutical companies/medical research/clinical trials

62.

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

None

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

None

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

None

d. *Financial incentives from pharmaceutical companies to use certain blood products*

None

e. *Non-financial incentives from pharmaceutical companies to use*

certain blood products

None

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

None

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

None

h. *results from medical research studies provided to a pharmaceutical company*

None

I would add that Pharmaceutical companies did hold meetings to inform us about their products, but not, in my experience, specifically about blood products.

Section 6: Other Issues

Northern Ireland Blood Transfusion Agency Board

63. a. *Dates of involvement as member of the NIBTS Agency Board*

I was a member of the NIBTS Agency Board and accept the dates set out in the Rule 9 request.

b. *Role and responsibilities*

I was a member of the Agency Board appointed to supervise work of NIBTS. The Agency operated as a 'mini board'. It was created because its work did not fit in with that of the other Health Boards which had been reorganised around 1993 or 1994. The work was supervisory in nature, and involved, for example, overseeing finances and directors. It was a general management function – effectively, a governance role.

c. *Key decisions or recommendations of the Agency Board relevant to the Inquiry's Terms of Reference*

I cannot recall decisions relevant to the Inquiry.

d. *Agency Board's involvement in any decisions about the use of blood or*

blood products in response to the risk of vCJD

At this stage, I cannot recall the detail of any decisions but I am confident that they were taken in accordance with advice and guidance provided in Great Britain.

Haematology and blood transfusion Inspector

64. *Role as a trained haematology and blood transfusion inspector*

With colleagues, I would visit other transfusion centres to measure compliance with various standards and assess efficiency of the unit. The emphasis was on laboratory, rather than clinical, practice. The work involved evaluation of the laboratory system across the UK. The Government was seeking value for money – for example, when setting up a private laboratory. Another group – unfortunately I cannot remember the name of it – went out as a group of two or three inspectors to inspect other laboratories. It was essentially quality approval work. It did not last very long.

65. *Complaints against me (insofar as relevant to the Inquiry's Terms of Reference)*

I am not aware of any such complaints.

66. *Other matters*

I would like to add that I had, and still have, great respect for Dr Elizabeth Mayne. I consider that she was a dedicated and caring doctor who devoted her professional life to her patients and their treatment. It is with great sadness that I see her life's work overshadowed by the tragic consequences of infected blood.

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

Signed GRO-C

Dated 23rd Nov '20