Witness Name: Dr Sarah Rann
Statement No.: WITN4740001
Exhibits: N/A
Dated: 3 February 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR SARAH RANN

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

I, Dr Sarah Rann, will say as follows: -

Section 1: Introduction

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

1.1 I am Sarah Frances Rann of GRO-C
GRO-C
DOB: GRO-C 1958

1.2 Qualifications: MBBS.FRCGP. DCH DFFP DRCOG Cert Med Ed
Medical Training:
1977 - 1982. MBBS. University of London, Royal Free Hospital, London NW3.

2. **Please set out your employment history, including the positions you have held, the dates that you held these positions, the haemophilia centres and other organisations in which you held these positions and your role and responsibilities in these positions.**

2.1 1982 - 1983: HO General Surgery King George Hospital, Ilford
1983 - 1983: HO Cardiology, General Medicine Royal Free Hospital
1983 – 1984: S.H.O ITU and A&E Royal Free Hospital
1984 – 1987: GP Training Royal Free Hospital. London NW3, Dr M Peters 111, Adelaide Road, London NW3
1988 – 1988: Clinical Assistant Haemophilia to Prof. A. Bloom, University Hospital of Wales, Cardiff
1989 – 1991: Clinical Assistant / registrar in Haemophilia to Prof. H. Ekert and Dr. A. Street. Royal Children's Hospital & Alfred Hospital, Melbourne, Victoria, Australia
1991-1995: GP retainer, Harston Practice, Cambs. (4 sessions per week)
A scheme to support GPs who might otherwise leave medicine due to other commitments – (Childcare)
1991-1995: Clinical assistant Sexual Health clinic Addenbrookes Hospital, Cambridge. Testing and treatment for sexually transmitted infections (STIs/STDs) (including HIV)
1995 – 2016: GP Partner. Shelford Medical Practice, Ashen Green, Great Shelford, Cambridge, CB225FY (Primary Medical Care service)
1997 – 2007: Director (company secretary until 2006) CAMDOC – (Out of Hours Service - local GP co-operative for out of hours unscheduled primary care)
1997 – 2011: GP Tutor Cambridge - (post graduate professional development support for Primary Care)
2003 – 2013: GP Appraiser for Cambs PCT. (Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work. It is a protected time, once a year, for each doctor to focus, with a trained colleague, on their scope of work)
2007 – 2014: Committee member Cambridge Local Medical Committee.
(LMCs are local representative committees of NHS GPs. LMCs interact and

work with – and through – the GPC (general practitioners committee) as well as other branch of practice committees and local specialist medical committees in a variety of ways, including conferences, and in providing guidance for practice)
2008 – 2013: Appraisal lead, (GP CG and patient safety lead. NHS Cambridgeshire)
2008 – 2010: British Heart Foundation. Fact - file reviewer
2008 – 2010: member - GP Advisory Group Nuffield Hospital, Cambridge
2009 - 2015: GP trainer East of England Deanery (Post graduate training for General Practice)
2012 – 2020: East of England coach (NHS)
2012 – current: Lead for a coaching and mentoring network for primary care within the East of England http://akeso.org.uk
2013 – Sept 2020: Assistant Medical Director. Professional Standards. NHS England East (relating to concerns or difficulties in relation to a doctor's practice. These concerns may come to light through appraisal or clinical governance processes and may relate to one or more issues around conduct, performance or health. For a small number of individuals who may struggle to meet the professional standards described in General Medical Council Good Medical Practice 2013)

2016 – Sept 2020: I was the Regional Lead Controlled Drugs Accountable Officer (CDAO) for the East of England. CDAOs are responsible for all aspects of Controlled Drugs management. The roles and responsibilities of CDAO's are governed by the Controlled Drugs (Supervision of Management and Use) Regulations 2013)

2015– 2016: CQC inspector (part of a team that inspected GP practices to ensure services provided care that's safe, caring, effective, responsive to people's needs and well-led)

2018 - 2019: Associate Dean Health Education England, supporting trainees referred for Professional Support, retained Doctors, the Induction and Refresher scheme for GPs and international recruitment scheme.

3. **Please set out your membership, past or present, of any committees, groups, associations, societies or working parties relevant to the Inquiry's Terms of Reference (which can be found on the Inquiry's website at www.infectedbloodinquiry.org.uk), including the dates of your membership and the nature of your involvement.**

3.1 I have not been a member past or present, of any committees, groups, associations, societies or working parties relevant to the Inquiry's Terms of Reference

4. **Please confirm whether you have provided any evidence or 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. If you have, please provide details of your involvement and copies of any statements that you made.**

4.1 I have not provided evidence or 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: The Cardiff Haemophilia Centre at the University Hospital of Wales ("the Centre")

As can be seen from my previous answers, I have not worked in this field for many years. November 2020 was effectively the first time that I have been asked to recall circumstances spanning a period of 12 months 32 years ago. I am therefore unable to answer some of the questions in this section (and indeed the whole of the Rule 9 request). Some of the answers I can give may not be accurate due to the passage of time. I have seen none of the medical records for the patients that I saw during this period (some of which have been referenced in question 17) nor any documentation from the Centre for this period. My answers in this section and this statement are therefore subject to this caveat.

5. **Please provide details of your role within the Centre, including the dates when you worked there, your responsibilities and, if you can remember, names of significant or senior staff members who were working there at the time.**

5.1 I worked at the Cardiff Haemophilia Centre at the University Hospital of Wales ("the Centre") from January 1988 - December 1988 as a part time clinical assistant (perhaps 5 sessions per week- I cannot now recall the exact number).

5.2 In NHS practice, the title 'clinical assistant' refers to a doctor, usually a GP, who provides care at a level below that of consultant. Except in designated GP beds, a consultant retains overall responsibility for the patient's care, but delegates some elements of day-to-day care according to their assessment of the capability of the clinical assistant. I was involved with outpatient care within the Haemophilia Centre alongside 2 nurses and a social worker (Mary Dykes). I reviewed notes of patients about to attend outpatient clinics to ensure any monitoring blood tests were noted and requested by those doctors seeing the patients. These clinics were separate to the Haemophilia Centre function and were attended by the consultant and registrars.

6. **Please explain the hierarchy and dynamics at the Centre, identifying in particular who was responsible for (a) decisions as to the selection and purchase of blood products, (b) decisions as to use of blood products (including factor VIII and IX concentrates) for patients' treatment and (c) decisions as to what information to provide to patients about treatment, testing and/or diagnosis.**

6.1 The Centre was led by Professor Bloom. Haematology registrars rotated through the department providing specialist advice. There was support from a social worker who set up a monthly support meeting for those with HIV. I was invited to these and went regularly. Two nurses provided the day to day care of those attending the centre.

6.2 Decisions regarding which blood products were purchased and used were not decided by me. I believe these were taken by consultant staff and hospital management.

6.3 I believe those who were new diagnoses/low users were prioritised to receive UK blood products. DDAVP was used for relevant patients – e.g. Von Willebrand's disease/mild Haemophilia. I remember one patient chose to continue to use cryoprecipitate rather than Factor 8 following previous discussion with the consultant. As far as I can now recall he was aware of the issues.

7. What was the relationship between the Centre and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Centre's decisions and actions?

7.1 I do not know.

8. How were decisions taken as to which products to use for individual patients? What involvement did you have in such decisions?

8.1 Decisions regarding which blood products were used were not decided by me. I believe these were taken by consultant staff and hospital management.

9. What alternative treatments to factor concentrates were available for people with bleeding disorders?

9.1 I believe those who were new diagnoses / low users were prioritised to receive UK blood products. DDAVP was used for relevant patients – e.g. Von Willebrand's disease / mild Haemophilia. I remember one patient chose to continue to use cryoprecipitate rather than Factor 8 following a previous discussion with the consultant. He was aware of the issues.

9.2 Topical thrombin was available on named patient basis and used e.g. dental procedures.

9.3 I don't remember what specific information was provided re alternative to treatment with factor concentrates other than DDAVP if clinically appropriate, lifestyle and 'bleed' risk reduction.

10. What were, in your view, the advantages and disadvantages of those alternative treatments? What use did the Centre 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, why?

10.1 I was aware that the risk of Blood Borne Virus ("BBV") was less in especially heat-treated UK blood products than those not heat treated or imported and that for some non-blood medicines e.g. DDAVP were an appropriate alternative, and that certain patients were prioritised to receive these (please see my answer to question 9). I do not recall other choices.

11. What was the policy and approach at the Centre and the approach of Dr Bloom as regards the use of cryoprecipitate for the treatment of patients with bleeding disorders? Did that policy and approach change over time and, if so, how?

11.1 I recall one patient continuing to attend for regular cryoprecipitate infusions. He had preferred to stick with this rather than change to Factor 8 products. I do not recall any changes in approach during 1988.

12. What was the policy and approach at the Centre and the approach of Dr Bloom in relation to home treatment? Did the policy and approach change over time and, if so, how?

12.1 I recall supporting families and children to become ready to administer home treatment. I was not involved in the decisions regarding its appropriateness, nor changes over time.

13. What was the policy and approach at the Centre and the approach of Dr Bloom in relation to prophylactic treatment? Did the policy and approach change over time and, if so, how?

13.1 Prophylactic treatment was used especially for children and I was involved in supporting families to learn about this in order to treat at home. I was not involved in any decisions to start prophylactic treatment whilst working at the Centre.

14. What was the policy and approach at the Centre and the approach of Dr Bloom in relation to the use of factor concentrates for children? Did the policy and approach change over time and, if so, how?

14.1 I refer to my answer to question 13. I do not recall any changes during 1988.

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

15.1 I recall patients with mild bleeding disorders being treated preferentially with non-blood products. I do not recall enough to distinguish those with moderate disorders.

16. What viruses or infections, other than HIV, HCV and HBV, were transmitted to patients at the Centre in consequence of the use of blood products?

16.1 I was not aware of any other viruses / infections transmitted during 1988.

17. The Inquiry is aware, from individual patient records that it has seen, that

you were working with Professor Bloom in Cardiff, at least in late 1988. Please provide an account (in as much detail as you are able to) about Professor Bloom's policies, decisions and actions, during the time that you worked there, as regards the use of factor concentrates, the selection and purchase of blood products, the risks of infection, the treatment of patients, the provision of information to patients and any other matter relevant to the Inquiry's Terms of Reference.

17.1 I have not seen any patient medical records from 1988 for the purpose of preparing this statement. I refer to my answers to questions 6, 7, 8, 9, 10, 11, 12, 13, 14 and 15. As a junior doctor I reviewed patient notes and noted the blood test monitoring needed. I offered HIV tests for partners. Monitoring of tests such as CD4 counts would have been communicated to and discussed with those individuals on receipt at appointments. I was not aware of any patient who did not already know their HIV nor Hepatitis status. (I do not recall what children under 10 knew). Some patients had told me they were aware that they had become HIV infected in years prior to the HIV test becoming available, as stored blood had been tested. Whilst at the centre I communicated with patients to ensure that blood samples were taken and stored to provide support for genetic testing for family members in the future if needed. As far as I can recall the patients were aware of this and the reasons for taking blood samples.

18. Do you recall any policies or standard operating procedures (written or otherwise) relating to the use of blood products being in place? If so, please describe what they were and whether they changed or developed over time.

18.1 I do not now recall any policies or standard operating, procedures or processes other than what I have referred to in answers to previous questions, and the process I refer to below.

18.2 I set up a file with all the blood work for those with HIV and ensured that relevant tests were undertaken on a regular basis.

18.3 I also recollect one child was commenced on gamma globulin as a result of dropping CD counts. AZT was started for one as a result of dropping CD counts. These were in line with limited guidance at the time. These patients were monitored whilst receiving treatment. One patient with HCV attended the centre regularly for interferon treatment.

Section 3: Knowledge of risk

19. **When you first began working at the Centre, what was your general understanding as to the risks of infection associated with the use of blood and blood products? What was the source of your understanding? Were you provided with any information or training, whether at the Centre or elsewhere, about the risks of infection and, if so, when? How did your understanding develop over time? How did your knowledge affect your practice?**

19.1 My knowledge in this area, at this time, would have been relatively basic. I trained at the Royal Free Hospital which had a 'liver' unit and a Haemophilia Centre. There was limited exposure to bleeding disorders during my medical student training. I had not undertaken any specific haematology training, and this was not a requirement for the Clinical Assistant role at the Centre. As a result of training at the Royal Free, I was aware of the risk of Hepatitis B and the role of vaccination in prevention / minimisation of harm. I believe the Centre offered and administered vaccinations to patients and families during 1988. I was supported in my professional development for the role by reading and discussion with colleagues and specialists at the Centre.

20. **What was your understanding as to the risks of the transmission of hepatitis (including Hepatitis B and Non-A Non-B Hepatitis C) from blood and blood products? What was the source of your understanding? When did you first become aware that hepatitis could be transmitted by blood or blood products? Were you provided with any information or training,**

whether at the Centre or elsewhere, about the risks of the transmission of hepatitis and, if so, when? How did your understanding develop over time?

20.1 Please see my response to question 19. I am sorry that I am unable to provide a more detailed answer.

20.2 In 1989 I moved and worked with people with bleeding disorders in Melbourne, Victoria, Australia. I don't believe there was a test for Hepatitis C until after I had left this field of work. I do not recall any changes during my time working in this field. My understanding after this time is only as GP - investigation of abnormal liver function, follow up and referral as appropriate.

21. What was your understanding as to the risks of the transmission of HIV from blood and blood products? What was the source of your understanding? When did you first become aware that HIV could be transmitted by blood or blood products? Were you provided with any information or training, whether at the Centre or elsewhere, about the risks of the transmission of HIV and if so when? How did your understanding develop over time?

21.1 I refer to my answer to question 10 above. I attended a week's training on HIV at the Royal College of Physicians, London in I think April 1988, although I am not sure of the date. I cannot now specifically recall the content of this training. Previously I had had little exposure to HIV cases. Whilst in GP training in London I supported the care of a patient who was HIV positive.

22. What was your understanding of the relative risks of infection from (a) the use of commercially supplied blood products and (b) the use of NHS blood and blood products? How did your understanding change or develop over time?

22.1 The risks of commercially versus NHS supplied products were noted by the policy of choice for different patients as stated above and refer to my answers to questions 9 and 10 above.

22.2 My understanding was that there had been plans for the UK to be self-sufficient in blood products years before (I only worked at the centre in 1988) and that due to a delay in self-sufficiency, the subsequent use of product from the USA resulted in more people becoming infected with BBV.

23. When did you begin to use heat treated factor products at the Centre and for which categories of patients?

23.1 I believe heat treated products were in use when I arrived in 1988. These were prioritised to those with mild bleeding disorders and those who had not received blood products

24. Do you consider that heat-treated products should have been made available earlier? If not, why?

24.1 I am not sure that I am the appropriate person to opine on this question as I am not a haematologist. I recall being told that if heat treated products had been in use earlier fewer people would have been infected. I believe the risk of such infections with heat related products is reduced.

25. Was any training or advice provided (and if so, what training or advice) to clinical staff at the Centre in relation to advising patients of the risks of infection associated with the use of blood and blood products? Who provided this training or advice?

25.1 Patients and staff were aware of risks. These risks of BBV were discussed with patients and partners when attending especially for relevant blood test screening, and I sourced supplies of condoms for those who wanted them. Many were too scared to have significant ongoing sexual relationships. One couple wished to have more children and options were discussed.

25.2 I do not recall what training others already working the Centre had had. I had advice from the staff, and subsequently during the HIV course I attended.

26. Were any steps taken by the Centre or Dr Bloom to mitigate or reduce the risk of infection from the use of blood or blood products? If so, please detail what steps were taken and when.

26.1 As I have indicated I was only at the centre for a year 32 years ago. I did discuss risks of BBV with patients and partners when attending especially for relevant blood test screening, and I sourced supplies of condoms for those who wanted them. Many were too scared to have significant ongoing sexual relationships. One couple wished to have more children and options were discussed.

26.2 A monthly support group provided a safe space for those with HIV to discuss and share their anxieties.

26.3 I was responsible for ensuring a child with HIV had sex education as requested by the secondary school prior to his starting – due to anxiety at the school. We also discussed BBV and what this meant to him. He was aware of his diagnosis.

26.4 With the nurses I attended a secure school where one of the boys was to be resident, to discuss BBV risks. I also refer to my answers to questions 6,8, and 15 above.

Section 4: Testing, treatment and care of patients

27. What information was provided to patients at the Centre about the risks of infection (generally and/or specifically in relation to hepatitis and/or HIV) associated with the use of blood and blood products, and by whom?

27.1 Please see my previous answer to question 26. I do not remember being involved with information sharing with new patients. For those already under the

care of the centre there were discussion with patients when they attended for blood tests or results. I do not know what was discussed at Outpatient clinics nor in-patients. I do not remember what was in the information given for those starting home treatment.

28. What information was provided to patients at the Centre about alternatives to treatment with factor concentrates, and by whom?

28.1 I do not recall what information was given to patients regarding alternatives to treatment with factor concentrates. This was not part of my role. I believe this was part of the role of the consultants. I do not know if other staff were able to make these decisions as a routine.

29. What information was provided to patients at the Centre before they began home treatment, and by whom?

29.1 I do not remember what was in the information given for those starting home treatment.

30. Do you consider that your decisions and actions, and those of the Centre and Dr Bloom, 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.

30.1 I believed that the Centre had already discussed these issues with patients, and I continued to have conversations about aspects of infection risk where relevant e.g. HBV vaccination, risk of transmission to partners and others. I believe my actions and decisions were based on the custom and practice at the Centre. I cannot comment on the actions of others

31. What was the Centre's approach and the approach of Dr Bloom to obtaining patient consent to treatment and to testing? What information would be provided to patients and by whom? To what extent were

decisions about treatment and testing taken by the doctors rather than the patients? Did this change or develop over time and, if so, how?

31.1 I can only comment on my approach to any tests with a person, which was to explain what tests I was requesting. It was and has always been my routine to ask patients to enquire about test results if they do no hear within an appropriate time. In relation to treatment, I refer to my answers to questions 8 and 9.

32. **Was any training or advice or instruction provided to you at the Centre in relation to obtaining patient consent to treatment and to testing? If so, please describe the training, advice or instruction given.**

32.1 Any training I received with regard to obtaining patient consent was as a result of GP training, discussion with staff at the Centre, and the HIV course that I referred to in the answer to question 21. With the benefit of hindsight, it would helpful to have had an initial formal induction in this at the start of my job and to be more networked with others undertaking care of people with bleeding disorders and BBV both within the hospital and beyond.

33. **Were you ever told to withhold information from a patient or patients about risks, or treatment, or testing, or diagnosis, or their condition? If so, by whom and in what circumstances?**

33.1 I do not recall any issues with information being withheld nor being asked to do this.

34. **Was it customary to take blood samples from patients when they attended the Centre and for what purpose? What information was given to patients about the purposes for which blood samples were taken, and by whom?**

34.1 I worked to ensure that monitoring blood tests were taken on a regular basis.

These would not have routinely been taken by me – but by nurses / outpatient / inpatient staff. These tests related to ongoing monitoring of the bleeding disorder – e.g. inhibitors, HIV relevant tests, liver function full blood counts and genetic sample storage

35. What information would routinely be given to patients about liver function tests and the results of such tests?

35.1 I can only comment on my approach to any tests with a person, which was to explain what tests I was requesting. It was and has always been my routine to ask patients to enquire about test results if they do not hear within an appropriate time. Liver function tests were part of the information I recorded on patient specific spreadsheets (which I referred to earlier in the answer to question 18) in order to notice changes.

36. Were patients informed if their blood was going to be tested for HIV, HBV and/or HCV and, if so, by whom? Did the approach to informing patients change over time?

36.1 Please see my answer to question 31, I can only comment on my approach to any tests with a person, which was to explain what tests I was requesting.

37. **What was the practice at the Centre about informing patients of test results (whether positive or negative or inconclusive) for HIV, HBV and/or HCV? Were patients informed of the test results promptly or were there delays in test results being communicated to them? How, as a matter of usual practice, were they advised of their test results (e.g. by letter, or by telephone, or in person at a routine appointment or at a specific appointment) and by whom? What, if any, involvement did you have in informing patients of test results? HIV tests were only given in person during my time. In relation to other test results, I do not recall letters being sent out with results. I believe that the results were communicated at subsequent attendances/on request. I believe that for results requiring urgent attention patients were contacted by phone by staff at the centre asking them to attend for an appointment for a review of the result/action.**

37.1 Patients were able to obtain results from the centre. It was and has always been my routine to ask patients to enquire about test results if they do not hear within an appropriate time. HIV test results were only given in person at the centre usually within 1-2 weeks of the test. (This was usually undertaken by me)

38. **What information or advice was provided to patients diagnosed with HIV, HBV and/or HCV regarding the management of their infection including the risks of infecting others? How did this change or develop over time?**

38.1 Please see my response to questions 35 and 37. In 1988 we offered routine HBV vaccination to appropriate patients and I believe partners / family. I believe we also arranged vaccination for other infections in line with limited guidance for HIV at the time.

39. **What was the practice at the Centre as regards testing and/or providing information to the partners and/or family members of people known or suspected to be infected with HIV, HBV or HCV?**

39.1 I asked patients without stored blood for 'genetics for family members' in the future, if they would provide samples at their next blood test. I undertook the offer

of testing and follow up of partners. The test results were discussed at the appropriate consultations/reviews.

40. Was any form of counselling or psychological support made available to patients infected with HIV, HBV and/or HCV or to their families? If so, please detail what support was available.

40.1 Please see my answers to questions 5, 6, 25 and 26 above. I supported a partner to find support following HIV diagnosis. – they had to go to London at the time. The monthly peer support meeting had already been set up by the social worker – Mary Dykes - and I attended this during 1988. My memory is that that this was well attended despite the miles some people would have had to travel to get there.

41. Was any form of social work support made available at the Centre to patients infected with HIV, HBV and/or HCV or to their families? If so, please detail what support was available.

41.1 Please see my answers to questions 5, 6, 25, 26 and 40 above.

42. How was the care and treatment of patients diagnosed with HIV, HBV and/or HCV managed at the Centre? What treatment options were offered over the years to those diagnosed with HIV, HBV and/or HCV? What follow-up and/or ongoing monitoring was arranged? To what extent were patients at the Centre referred for specialist care elsewhere? How did any of this change or develop over time?

42.1 There was a regular multi - disciplinary meeting at which some patients were discussed – this was led by Prof Bloom; cases were presented by the registrar, with the centre nurses and social worker(s) present.

42.2 I do not recall how these were minuted, nor how actions were logged. I do not recall patients being referred elsewhere for specialist care.

42.3 I do not recall any patients being commenced on specific treatment for HBV. I do recall that one patient was started on interferon for HCV as stated above.

42.4 I set up a test spreadsheet for each patient with HIV so that changes could be noted and discussed, and actions taken as stated above e.g. starting new treatments.

43. Do you recall patients diagnosed as HIV, HBV and/or HCV positive being treated differently to others? If so, in what respects? What if any measures were implemented to address any risks of cross-infection?

43.1 I do not recall patients being treated differently at the centre if they had a BBV. We used the same precautions for all patients.

44. To your knowledge, were clinical staff made aware of patients' infected status in relation to HIV, HBV and/or HCV?

44.1 I believe BBV status of any patient was freely available in the notes, referral letters for clinical staff at the hospital at the time.

45. Please describe as fully as you can your involvement in the treatment and care of those who were infected with HIV, HBV and/or HCV and what you can recall about the impact of the infection(s), and/or of treatment for the infection(s), and/or of the stigma associated with the infection(s), upon them and upon their families over the years.

45.1 Please see my previous answers to questions 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 25 and 26

Section 5: Research

46. Please detail any knowledge you have of any research that may have taken place at the Centre including the names of clinicians who were involved in or leading the research.

46.1 I was not involved in any research whilst working at the centre.

47. **To your knowledge, were patients made aware of their being involved in research? What was the approach taken with regards to obtaining their consent to such involvement?**

47.1 I was not involved in any research whilst working at the centre.

48. **What does the term 'PUPS', an acronym for a category of patients referred to as 'Previously Untreated Patients', mean to you? Was the term used at the Centre and if so by whom and in what respects?**

48.1 I don't recall the term 'PUPS', an acronym for a category of patients referred to as 'Previously Untreated Patients', although I believe there was policy regarding treatment products for such patients, please see my response to question 9. I recall this being part of what I learnt from staff and I recall patients talking to me about this. I recall that patients were prioritised to receive heat treated products if they were new diagnoses or infrequent user.

Section 6: Other Issues

49. **Were you aware of any of the trusts or funds that were set up to provide financial assistance to people who had been infected (such as the Macfarlane Trust, the Eileen Trust, the Skipton Fund and the Caxton Foundation)**?

49.1 I believe the Macfarlane trust was being set up during 1988. I believe others were set up at later dates after I had left.

50. **Were patients at the Centre provided with any information about these organisations or with any assistance to obtain financial support from them? If so, what information and/or assistance was provided?**

50.1 I was aware of discussions during 1988 to provide some financial support for those with HIV from the NHS / government.

51. Please detail any involvement or dealings you had with any of these organisations.

51.1 I had none

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

52.1 Whether I knew these at the time I was at the Centre, I cannot now recall.

53. Did the Centre, or any clinicians at the Centre, keep any separate records or files or information about patients who had been treated with factor concentrates and/or patients who had been infected with HIV, HBV and/or HCV?

53.1 I do not know beyond what I have already said in answer to question 18 and 35. I did not retain any patient information of data when I left in late December 1988. The spread sheets of patient's blood pathology results remained in an A4 file in the Centre

54. If you have had, at any time, any discussions or conversations or interactions with Dr Bloom, about any of the matters set out in paragraphs 5 to 53 above, please provide (to the extent that you are able to) details of those discussions or conversations or interactions.

54.1 I have no memory of the content of any such conversations with Professor Bloom.

55. Please provide, in as much detail as you are able to, information about any other issues associated with your work at the Centre that may be relevant to the Inquiry's investigation. You will find the Inquiry's Terms of Reference and List of Issues on the Inquiry's website. If you are in doubt as to whether or not to include something, do not hesitate to contact the Inquiry Team.

55.1 I have no additional comments.

Statement of Truth

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

Signed GRO-C

Dated 3 February 2021

Table of exhibits:

Date	Notes/ Description	Exhibit number
none		