Witness Name: Dr Cecil Reid
Statement No.: WITN5248001
Exhibits: WITN5248002-
WITN5248004
Dated: 1 March 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR CECIL REID

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 21 January 2021

I, Cecil Reid, will say as follows: -

Section 1: Introduction

1. *Please set out your name, address, date of birth and professional qualifications.*
   Cecil Reid GRO-C; dob GRO-C 1942:
   MBBS DCH FRCP FRCPath

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.*
   Surgical HO Royal Infirmary Stoke on Trent Jan-June 1967
   Medical HO Hackney Hospital Oct-April 1968
   GP Maalot Israel Oct 1968 – August 1970
   Paediatric SHO Whittington Hospital Sept 1970-April 1971
   Paediatric SHO Paddington Green Childrens' Hospital April-Oct 1971
   Paediatrician/GP Carmiel Israel Nov 1971-July1972
   Medical staff officer Israel Navy July 1972-April 1974

Paediatric registrar Rothschild Hospital Haifa Israel April 1974-September 1975
SHO Haematology Northwick Park Hospital Oct 1975-1976
Registrar and Senior Registrar Haematology Northwick Park Hospital 1977-1982
Consultant Haematologist and Honorary Senior Lecturer Northwick Park Hospital and Imperial College January 1983- August 2007
(Part time (5/11) Medical Research Council fellow at Northwick Park Hospital, Clinical Research Centre, 1983-1990)
After retirement in August 2007, I was part-time locum NHS Consultant Haematology Northwick Park Hospital to April 2011 (Out-patient duties only)

Retired fully from NHS April 2011

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.*
Attended Haemophilia Directors annual meetings 1983-1992

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 or reports which you provided.*
None.

Section 2: Decisions and actions of the Northwick Park Hospital (Harrow Haemophilia Centre)

5. *Please:*
    a. *describe the roles, functions and responsibilities of the Northwick Park Hospital ("the Hospital") during the time that you worked there;*
    From my commencement as consultant (1983) to the early 1990s we functioned as a local Haemophilia centre and acquired and administered products to the few patients in our care with coagulation

disorders. I took over this role from Dr Diana Samson when she left NPH. I do not however recall the numbers but of the severe cases I do not believe there were more than 5. Later, in the early 1990s (I am unsure as to the precise date), the overall care of patients devolved to the Comprehensive Haemophilia Care centre at Royal Free hospital (RFH). This has been confirmed in two e-mails from Debra Pollard Lead Nurse Haemophilia Royal Free Hospital who says that most of our patients were "dual registered by 1991" and "it appears that all of the severe haemophilia's were dual registered with RFH, and essentially had most of the care with RFH from the early 1990's" **[See exhibits WITN5248002 and WITN5248003]**

RFH monitored our patients, did the necessary investigations including viral monitoring, and advised patients over the many aspects of their care. Our role then was to issue the factors to patients for home care and, on occasion, administer treatment in emergencies such as bleeding episodes.

b. *outline the facilities and staffing arrangements for the care of patients with bleeding disorders;*
This was comprised of myself and the other haematology consultants (see below) and junior staff (usually an SHO and two haematology trainee registrars) at Northwick Park hospital. There was no dedicated nursing or other ancillary staff dedicated to these patients.

c. *identify senior colleagues at the Hospital and their roles and responsibilities during the time that you worked there.*
Dr Diana Samson until 1983/1984: general haematology and care of haemophilia patients (and perhaps also blood transfusion – I am not certain about this)
Dr Israel Chanarin until 1989: general haematology
Dr Gerald Smith until 1983: general haematology and blood transfusion
Dr Misha Brosovic until 1976: general haematology and care of haemophilia patients

Dr Martin Pippard 1985-1989: general haematology and blood transfusion
Dr Patricia Skacel: 1989-1994: general haematology and blood transfusion
Dr Shubha Allard: 1994-2003 general haematology, blood transfusion and care of haemophilia and coagulopathy patients
Dr Nikki Panoskaltsis 2003-: general haematology
Dr Chara Kiriyakou 2004-: general haematology
Dr Gavin Cho (Central Middlesex Hospital): I believe that he looked after blood transfusion for NW London Hospitals Trust following Dr Allard's departure

6. *Please describe:*

a. *your role and responsibilities at Hospital and how, if applicable, this changed over time;*
General and laboratory haematology, haemato-oncology and care of haemophilia patients from 1983: their comprehensive care was devolved to the centre at the Royal Free in or around 1990 (see above 5a: I am unsure of the exact dates as were my correspondents Professor Tuddenham and Ms Debra Pollard at RFH, see 5a)

b. *your work at Hospital insofar as it involved the care of patients with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.*
I dealt with the acute care of bleeding episodes in patients with haemophilia or VWD and the provision of products (cryoprecipitate and later factor concentrates or recombinant factors) issued through our blood transfusion department. HIV status was monitored where appropriate though I cannot recall this in any detail (but see my correspondence with Dr Snape in 1985 your refs CBLA0001990 and CBLA0002033). HCV monitoring would, I believe, have been done through the Comprehensive Care Centre at Royal Free from the early

1990s. In the case of children, we operated a shared care system with the pediatricians until at least 1990.

7. *Approximately how many patients with bleeding disorders were under the care of the Hospital when you began your work there and over the years that followed? (If you are able to give exact rather than approximate figures, please do so).*

Only 4-5 in any one year I would estimate. I requested but have not received any annual returns from Professor Charles Hay director of UKHCDO as, following discussion with his executive, they did not think they could "release them in their original form because they include personal information relating to individual patients" **[See exhibit WITN5248004].**

Although no precise figures are available to me, two UKHCDO returns for 1983 and for 1986 have been provided to me by the IBI (your refs HCDO0000165_008 and HCDO0000281_002). These show that in 1983 there were 4 severe haemophilia A patients and one haemophilia B patient receiving treatment with either cryo or NHS FVIII or FIX. In 1986 there were 5 severe haemophilia A patients and one carrier treated with cryo or FVIII (NHS FVIII or Alpha FVIII, Profilate). In that year: there was also 1 Haemophilia B patient who received NHS FIX and no VWD patients who received treatment. These documents are not appended as they emanate from the Inquiry itself.

8. *To the best of your knowledge, what decisions and actions were taken, and what policies were formulated by the Hospital, regarding the selection, purchase and use of blood products (in particular factor concentrates) during the time that you worked there? In addressing this issue, please answer the following questions:*

   a. *How, on what basis, and by whom, were decisions made about the selection and purchase of blood products?*

   By myself, in consultation with my consultant colleagues and in accordance with the best practice guidelines of the UK Haemophiila directors. To the best of my knowledge, once we stopped using cryo

routinely in treatment we switched to vitally inactivated NHS (8Y) or commercial (Profilate) fractionated concentrates in around 1986. There may have been one patient who continued with cryo beyond 1986 but I have only indirect (hearsay) evidence of this and no detail whether this was the case, when or why.

b. *What (if any) other bodies or organisations or individuals (e.g. other centres in the same region, or the Regional Health Authority) were involved in the arrangements for the selection, purchase or use of blood products?*
As above 8a

c. *What were the reasons or considerations that led to the choice of one product over another?*
Efficacy and safety – especially with regard to possible known (or unknown) viral contamination. Until the advent of NHS/BPL mid-high purity products (8Y) became available in early 1985, we used cryoprecipitate in most or all cases.

d. *What role did commercial and/or financial considerations play?*
None.

e. *What if any involvement did you have?*
As above in 8a-c.

9. *What was the relationship between the Hospital and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Hospital's decisions and actions? In answering this question, please describe the kinds of interactions and communications (such as visits from sales representatives) you had with pharmaceutical companies which supplied factor concentrates. You may wish to consider the enclosed letter from a Cutter sales representative [BAYP0000008_190].*
That is, as far as I know, the only such contact if my memory serves me right. I don't believe we ever took up their Koate product (though I cannot document

this) – witness our first request for the NHS heat treated factor VIII in January 1985 (see my correspondence with Dr Snape in Jan-Feb 1985 [CBLA0001990, CBLA0002033] and my statement at 8c).

10. *If the responsibility for the selection and purchase of blood products lay with an organisation other than the Hospital, please specify which organisation and provide as much information as you can about its decision-making.*
None.

11. *Please describe your relationship/the Hospital's relationship with the local Regional Transfusion Centre. Please explain whether the Regional Transfusion Centre supplied the [institution] with cryoprecipitate and with NHS factor concentrates and whether (and if so to what extent and with what frequency) there were shortages or other difficulties in obtaining sufficient supplies. Please confirm whether the Regional Transfusion Centre had any involvement in supplying commercial factor concentrates or whether those were obtained from the pharmaceutical companies directly.*
We obtained, as far as I recall, all our products from the Transfusion Centre. I do not recall any shortages being a problem.

12. *How were decisions taken as to which products to use for individual patients? What involvement did you have in such decisions? To what extent, if at all, were patients offered a choice as to which products to use?*
In fact our product policy was determined by what we perceived to be in the best interests of our patients. I do not recall consulting with them over our decisions though that does not mean that we did not discuss any of their concerns with them.

13. *What alternative treatments to factor concentrates were available in the 1980s for people with bleeding disorders? What were, in your view, the advantages and disadvantages of those alternative treatments? What use did the Hospital 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?*

We were reliant on cryopreclpiitate in the 1970s - early 1980s. Until the NHS heat treated products came along, I was unhappy and did not consider using any other alternative, except for DDAVP in mildly affected cases or in VWD.

14. *What was the Hospital's policy and approach as regards:*

    a. *the use of cryoprecipitate for the treatment of patients with bleeding disorders? Did that policy and approach change over time and if so how?*
    As explained in [13]

    b. *home treatment? When was home treatment introduced?*
    I do not recall

    c. *prophylactic treatment? To what extent and when was treatment provided on a prophylactic basis? Did the policy and approach change over time and if so how?*
    I do not exactly recall. I believe that prophylactic factor VIII would have been provided once home treatment with factor concentrates became available

15. *To what extent, and why, were children with mild or moderate bleeding disorders treated with factor concentrates?*
    I cannot recall the detail of individual cases, however, concentrates would only have been administered in case of urgent clinical necessity.

Section 3: Knowledge of, and response to, risk

General

16. *What advisory and decision-making structures were in place, or were put in place at Hospital, to consider and assess the risks of infection associated with the use of blood and/or blood products?*
    This was the remit of the hospital's Blood Transfusion committee of which I was not a member.

17. *What was your understanding of the relative risks of infection from commercially supplied factor concentrates and NHS factor concentrates?*
I remember not being convinced of the safety of early commercial preparations because of their American provenance and what I understood about their donor pool. I was happier therefore to persist with cryoprecipitate until the UK product became available, though I note we used Profilate in 1986; I cannot recall the reason for this at the time.

18. *How did you keep up-to-date with relevant scientific and medical developments in knowledge? What journals did you regularly read?*
Attendance at most annual UK HD and many other UK haematology meetings as well as at the American (ASH) meetings. I did carry out extensive CPD and journal reading, especially the New England Journal, BMJ and Lancet as well as the Haematology monthlies. I more than satisfied my CPD annual requirements.

Hepatitis

19. *When you began work as a Consultant Haematologist at the Hospital, what was your knowledge and understanding of:*

    a. *the risks of the transmission of hepatitis (including hepatitis B and NANB hepatitis/hepatitis C) from blood and blood products?*
    Quite limited in the early 1980s

    b. *the nature and severity of the different forms of blood borne viral hepatitis?*
    As above

20. *What, if any, actions did you and/or the Hospital take to reduce the risk to patients of being infected with hepatitis (of any kind)?*
Only with regard to the use of factor concentrates and much later recombinant factors and switching treatments away from cryo in the later 1980s.

HIV and AIDS

21. *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 during your time working at the Hospital? What were the sources of your knowledge? How did your knowledge and understanding develop over time?*
    My main clinical specialisation and workload was in the field of haemato-oncology: as indicated above, we had only a small practice in bleeding disorders. Most of my knowledge of viral transmission came for the UK directors' meetings and from my colleagues who were directing blood transfusion practice within the Trust (see above 5c). As seen in my letters to Dr Snape in 1985 [CBLA0001990, CBLA0002033], I was aware of the need for HIV testing on receipt of the new NHS concentrates (see my letter to him of 11 Feb 1985).

22. *How and when did you first become aware that there might be an association between AIDS and the use of blood products?*
    I believe it was around 1983 and hearing Dr Craske's reservations about viral safety.

23. *What, if any, enquiries and/or investigations did you and/or the Hospital 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?*
    I cannot recall.

Response to risk

24. *Did you or your colleagues at the Hospital take steps to ensure that patients were informed and educated about the risks of hepatitis and HIV? If so, what steps? What information was provided to patients, and when, about such risks?*
    I cannot recall at this distance of more than 30 years

25. *What, if any, actions did you and/or the Hospital take to reduce the risk to your patients of being infected with HIV? What changes (if any) did you make to the way in which patients were treated?*

I believe that our practice was, as I have indicated, as safe as could be achieved in relation to the existing state of knowledge and the availability of virally inactivated concentrates.

26. *Did the Hospital continue to use factor concentrates to treat patients, after becoming aware of the possible risks of infection of HIV? If so, why?*
Yes – by 1988 the expert opinion seems to have been in favour of heat-treated materials versus cryoprecipitate (see minutes of the 1988 meeting in Dublin, although I did not attend on that occasion).

27. *Did you or your colleagues at the Hospital revert to treatment with cryoprecipitate for some or all of the 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?*
No I do not believe that we did. However, a colleague reminds me of a patient (a young man) who may have continued with cryo but was switched to concentrate on transferring to the Hammersmith Hospital. I do not, myself, remember that case nor the applicable dates nor whether this was our or the patient's decision (see 8a)

28. *At the 14th Meeting of Haemophilia Centre Directors on 17 October 1983, there was a discussion of whether to revert to the use of cryoprecipitate [PRSE0004440, page 10]. Dr Chisholm raised the problem of patients refusing to take commercial Factor VIII concentrate because of the AIDS scare, and queried whether directors should revert to using cryoprecipitate for home therapy, and referred to problems in her region getting large amounts of commercial concentrates, whereas she could get unlimited amounts of cryoprecipitate. Other directors reported the same problem.*

    a. *Please set out what you recall of this discussion. What if any contribution did you make to it?*
    I cannot recall the discussion: I was present and heard the opinions expressed but I do not think I contributed.

b. *Did patients raise with you concerns about factor concentrates, because of the AIDS scare? If so, when and what was your response?*
I cannot recall but see above 27.

c. *Did you (like Dr Chisholm and other unnamed directors) have regional problems in getting sufficient amounts of commercial concentrates? If so, please describe them.*
This was not an issue for us

d. *Were you (like Dr Chisholm and other unnamed directors) able to get unlimited amounts of cryoprecipitate?*
Yes – but our practice was very small

e. *The decision recorded in the minutes of the meeting was that patients should not be encouraged to go over to cryoprecipitate for home therapy but should continue to receive NHS or commercial concentrates. Did you agree or disagree with this decision?*
I did not agree with the large-scale resort to commercial concentrates

29. *At the 16th meeting of Haemophilia Centre Directors on 21 October 1985, it was recorded that most Centres were using heat-treated materials [PRSE0001638, page 6]. When did the hospital begin to use heat-treated factor products and for which categories of patients? Did you experience difficulties in obtaining such products? You may wish to consider:*

a. *The letter from yourself to Dr T Snape dated 21 January 1985 [CBLA0001990]*
b. *The letter from Dr T. J. Snape to all Haemophilia Centres dated 24 January 1985 [CBLA0001998]*
c. *The letter from yourself to Dr T Snape dated 11 February 1985 [CBLA0002033]*
d. *The letter from Dr B Brozovic to Mr N Pettet dated 8th May 1985 [BPLL0002369_002]*

I think the letters are self-explanatory: we did not, as I recall, have problems in obtaining the relatively small requirements needed by our practice.

30. *In the above letters from yourself to Dr Snape dated 21 January 1985 and 11 February 1985 [CBLA0001990, CBLA0002033], you applied for heat-treated Factor VIII for three patients. Please explain the process for obtaining heat-treated product from BPL, what you can recall about BPL's protocol for the product, and how you decided for which patients you would request heat-treated product.*
I am unable to confirm details for the patients treated in the 1980s, but I believe all except possibly one man in his 50s received the NHS heat treated factor VIII or Profilate

31. *Do you consider that heat-treated products should have been made available earlier? If not, why not?*
That would have been good

32. *Looking back now, what decisions or actions by you and/or by the Hospital could and/or should have avoided, or brought to an end earlier, the use of infected blood products*?
None in particular

Section 4: Treatment of patients at the Hospital

Provision of information to patients

33. *What information did you provide or cause to be provided to patients at the Hospital about:*

    a. *The risks of infection in consequence of treatment with blood products (in particular, factor concentrates) prior to such treatment commencing?*
    I and the department had a lesser role in managing haemophilia patients from 1990/91 as comprehensive care was transferred to the Royal Free as indicated in 5a and 6. I cannot recall conversations or the written

information we may have given 30-40 years ago to our patients, nor to what if any literature, conversations or other media were provided at the Royal Free visits.

b. *alternatives to factor concentrates?*
See 33a above

Please describe whether, and if so, how this changed over time?
See above

HIV

34. *When did you first discuss AIDS or HIV (HTLV-III) with any of your patients?*
See answer to question 33 above

35. *How many patients at the Hospital were infected with HIV? How and when did you learn that patients under your care/the Hospital's care had been infected with HIV?*
None that I can recall.

36. *Please describe the arrangements that were made for the testing of the patients. Were they tested without their knowledge? What, if any, arrangements were made at the Hospital for pre-test and post-test counselling.*
We did test for HIV in the 1980s (see my letter to Dr Snape 1985 [CBLA0001990, CBLA0002033]) but I cannot recall the information given to patients or to parents

37. *How and when and by whom were patients told that they had been, or might have been, infected with HIV? What if any involvement did you have in this process?*
None I believe

38. *What information was given to them about the significance of a positive diagnosis? Were patients told to keep their infection a secret?*
Not applicable: see 5a above

NANB Hepatitis/Hepatitis C

39. *How many patients at the Hospital were infected with hepatitis C in consequence of their treatment with blood products?*
    I do not have this information: it may be available from the Royal Free who took over comprehensive care from 1990/91

40. *Were patients infected with NANB hepatitis informed of their infection and if so, how and by whom? What information was provided to patients about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?*
    See 5a and 39 above

41. *When did the Hospital begin testing patients for hepatitis C and over what period of time were such tests first carried out? Please describe the Hospital's process for HCV testing, including pre-test and post-test counselling. What if any involvement did you have in this process?*
    Such monitoring from the 1990s on would, I believe, have been at the Comprehensive Treatment Centre (RFH)

42. *When the test for HCV became available, what if any steps were taken by the Hospital and/or by you to ensure that all patients who had received blood products were traced and invited to be tested?*
    This information may be available from our Transfusion leads at the time (see 5c above)

43. *At the 24th Meeting of the Haemophilia Centre Directors on 18 September 1992 [HCDO0000248_013, page 7], Professor Preston reported that, of the 100 Haemophilia Centres that had responded to a questionnaire, 77 carried out HCV testing, "44% indicated that they discussed the results with their patients but 8% said the results were not discussed."*

    a. *If you/the Hospital carried out HCV testing at this time, did you discuss the results with your patients? If not, why not? So far as you are aware,*

why did a significant number of Haemophilia Centres either not carry out HCV testing or not discuss the results with their patients?
If we did test any patients for HCV in the early 1990s, we would have discussed the results with patients or carers. Unfortunately I do not have any recollection or any evidence to indicate whether or when this might have occurred.

b. *It was also agreed at the meeting that patients should be tested annually for HCV. Did you or the Hospital implement this measure and what was its purpose?*
Before passing comprehensive care over to RFH and if the test were available I believe we would have done this (I was at the meeting in Norwich): I do not have access to any records to confirm this however.

Delay

44. *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, explain why.*
Not to my knowledge or recollection

Consent

45. *How often were blood samples taken from patients attending the Hospital and for what purposes? What information was given to patients about the purposes for which blood samples were taken? Were patients asked to consent to the storage and use of the samples? Was their consent recorded and if so how and where?*
I cannot recall this

46. *Did the Hospital have a bank of stored samples? If so, was that storage undertaken with patients' knowledge and consent?*
No

47. *Were patients under your care/under the Hospital's care treated with factor concentrates or other blood products without their express and informed consent? If so, how and why did this occur?*

Either the patient or their carer would have been fully informed as to the treatment given since this was the case in all areas of our practice. However, to the best of my recollection we had no written format for consenting haemophilia patients in the 1980s to early 1990s when care was transferred to the Comprehensive Care Centre at Royal Free

48. *At the 27th Meeting of the Haemophilia Centre Directors held on the 29 September 1995, consent for first treatment of concentrates was discussed and it was agreed that "Directors accepted that informing patients was important but there was no agreement as to whether or not written consent should be obtained." [HCDO0000495, page 4]*

    a. *What was your approach to obtaining consent to treatment? Was patient consent recorded and if so how and where?*

    Please see answer at 47.

    b. *Did this approach change after this meeting? Did you agree or disagree with the proposal for formal written consent?*

    I cannot recollect

49. *Were patients under your care ever tested for HIV or hepatitis or for any other purpose without their 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?*

No, but details of any consent are not available to me

PUPS

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

I cannot recollect and do not have access to records of any such patients

Research

51. *Please list all research studies that you were involved with during your time at the Hospital insofar as relevant to the Inquiry's Terms of Reference, and provide a brief summary of the purposes of the research and your involvement.*
None

52. *The Inquiry understands that you may have contributed to or provided data for the following:*

    a. *An article published in September 1995: "Mortality before and after HIV infection in the complete UK population of haemophiliacs" [HCDO0000264_095]*

    b. *An article published in 1996: "The Importance of Age at Infection with HIV-1 in Determining Survival in the Complete UK Population of Haemophiliacs" [HSOC0002661]*

    c. *An article published in November 1997: "Mortality from liver cancer and liver disease in haemophilic men and boys in UK given blood products contaminated with hepatitis C" [HCDO0000264_150]*

    d. *An article published in 1998: "Immune status in HIV-1-infected men and boys with haemophilia in the United Kingdom" [HCDO0000017_001]*

    e. *An article published in 2001: "Treatment of haemophilia in the United Kingdom 1981-1996" [HSOC0023510]*

Please set out what if any involvement you had in them.
None that I know of

53. *Were patients involved in research studies without their express consent? If so, how and why did this occur?*

No.

54. *Was patient data (anonymised, de-identified or otherwise) used for the purpose of research or shared with third parties without their express consent? If so, what data was used and how and why did this occur?*
Not applicable

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

55. *How was the care and treatment of patients with HIV/AIDS managed at the Hospital? In particular:*

    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    Not applicable

    b. *What treatment options were offered over the years?*
    Not applicable

    c. *What information was provided to patients about the risks and benefits of specific treatments and about side effects?*
    Not applicable

    d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?*
    Not applicable

56. *How was the care and treatment of patients with NANB hepatitis or hepatitis C managed at the Hospital? In particular:*

    a. *What steps were taken to arrange for, or refer patients for, specialist care?*
    Not applicable

    b. *What treatment options were offered over the years?*

Not applicable

c. *What information was provided to patients about the risks and benefits of specific treatments and about side effects?*
Not applicable

d. *What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis C?*
Not applicable

57. *What, if any, arrangements were made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support?*
Not applicable

58. *Did the Hospital receive funding from the Department of Health and Social Security or from any other source to help with the counselling of patients infected with HIV?*
Not applicable

59. *What (if any) difficulties did you/the Hospital encounter in obtaining sufficient funding for the treatment of people who had been infected with HIV and/or hepatitis C?*
Not applicable

60. *What if any involvement did you or your patients have with clinical trials in relation to treatments for HIV and/or hepatitis? Please provide full details.*
Not applicable

Records

61. *What was the Hospital's policy with regards to recording information on death certificates when a patient had been infected with HIV or hepatitis? Were you involved with any inquests in relation to patients who had been infected with HIV or hepatitis in consequence of their treatment? If so, please provide details.*

Not applicable and not involved in any inquests

62. *What were the retention policies of the Hospital in regards to medical records during the time you were practising there?*
I cannot say but I assume they were in line with national NHS policy

Section 5: UKHCDO

63. *Please describe your involvement with UKHCDO (including any of its working parties, committees or groups). Did you usually attend the annual general meetings?*
I attended many but not all annual meetings of the UKHCDO. Was not involved in any working parties

Section 6: Pharmaceutical companies/medical research/clinical trials

64. *Have you ever:*

    a. *provided advice or consultancy services to any pharmaceutical company involved in the manufacture and/or sale of blood products?*
    No

    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?*
    No

    c. *sat on any advisory panel, board, committee or similar body, of any pharmaceutical company involved in the manufacture or sale of blood products?*
    No

    d. *received any financial incentives from pharmaceutical companies to use certain blood products?*
    No

e. *received any non-financial incentives from pharmaceutical companies to use certain blood products?*
No

f. *received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company?*
No

g. *undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products?*
No

h. *provided a pharmaceutical company with results from medical research studies that you have undertaken?*
No

If so, please provide details.

Section 7: vCJD

65. *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?*
I believe I was not any more involved with the treatment of bleeding disorders by the time that vCJD acquired through blood products became an issue

66. *Did you have any involvement in decisions as to what information to provide to patients about vCJD? If so please answer the following questions:*

a. *What steps were taken to inform patients about possible exposure to vCJD and to provide information to them about vCJD?*
Not involved

b. *What steps were taken to arrange for counselling, support and/or advice to be offered to patients who were being informed that they might have been exposed to vCJD?*
Not applicable

67. *What measures were put in place at the Hospital from a public health perspective, in relation to the care and treatment of patients? If patients at the Hospital were identified as at risk for public health purpose, did that impact detrimentally upon them in terms of their ability to access treatment and care (whether at the Hospital or elsewhere)?*
I am not aware of this

Section 8: Interaction with the trusts and schemes

68. *Please as fully as you can any involvement you have had in relation to any of the trusts or funds (the MacFarlane Trust, the Eileen Trust, the MacFarlane and Eileen Trust, the Caxton Foundation, the Skipton Fund) which were set up to provide financial assistance to people who had been infected. Relevant involvement may include:*

a. *Occupying a formal position with any of the trusts or funds;*
Not applicable

b. *Providing any advice to any of the trusts or funds, including for the development of any eligibility criteria or policies;*
Not applicable

c. *Informing patients about or referring patients to the different trusts or funds;*
Not applicable

d. *Determining or completing any part of applications made by patients.*
Not applicable

69. *At the 20th meeting of the Haemophilia Centre Directors held on 29 September 1988, there was discussion of the establishment of the Macfarlane Trust [BART0002329, page 2]. The minutes record that a register of those infected was needed. Haemophilia Centre Directors were asked to encourage patients to register with the Macfarlane Trust. What, if any, steps were taken by you/the Hospital to encourage patients to register?*

Not applicable

Section 9: Other Issues

70. *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.*

None.

71. *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.*

None

Statement of Truth

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

Signed GRO-C

Dated 2/03/2024

Table of exhibits:

Date	Notes/ Description	Exhibit number
04/02/2021	Email from Debra Pollard	WITN5248002

08/02/2021	Email from Debra Pollard	WITN5248003
09/02/2021	Email from UKHCDO	WITN5248004