Witness Name: Dr Olive Hazel Baugh
Statement No.: WITN5316001
Exhibits: N/A
Dated 02/04/21

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF OLIVE HAZEL BAUGH

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28 January 2021

I, Olive Hazel Baugh, will say as follows: -

Section 1: Introduction

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

1.1. Dr Olive Hazel Baugh. MBBS, FRCPath. GRO-C 1941. GRO-C GRO-C Essex GRO-C

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.

2.1. Qualified MBBS June 1966 St Georges Hospital , London.

2.2. I have held the following positions:

2.2.1. House Officer Surgery. St Georges Hospital, Tooting, 1966-19671, workng for Surgeons specialising in thyroid and thoracic surgery in addition to general surgery.

2.2.2. House Officer Medicine, St Georges Hospital, London, 1966-67, working for Professor Dornhorst. The duties were in clinical medicine with a shared on-call commitment..

2.2.3. Senior House Officer Medicine 1967-68, Chase Farm Hospital. General medicine, including respiratory medicine, cardiology, renal disease and endocrinology.

2.2.4. Senior House Officer Pathology 1968-69, St Georges Hospital, Tooting. This involved a three-month rotation through the four Pathology Disciplines and evening and weekend on-call for Haematology, Biochemistry and the Public Health Laboratories. The haematology rotation was based mainly on laboratory work, blood transfusion, microscopy and coagulation studies.

2.2.5. Registrar in Haematology 1970-72, St Georges Hospital, Tooting. This was a training post in laboratory haematology, involving blood transfusion, haemostasis and thrombosis studies,bone marrow biopsies, microscopy and some research. I assisted in the anticoagulant clinics. At this time the department had no haemophilia centre, no outpatient clinics and no inpatient beds.. Haematologists attended ward rounds and advised on the management of patients with haematology problems as requested by clinicians.

2.2.6. Lecturer / Honorary Senior Registrar in Haematology. St Georges Hospital, London.1973-75 . This post involved general laboratory and clinical haematology duties. During this time I spent six months on rotation to the Blood Transfusion Centre, Tooting and six months as sole haematologist at the nearby St James Hospital, Balham, to cover the consultant haematologist's sick leave. St James Hospital had a high number of patients with sickle cell anaemia and thalassaemia. As other teaching hospitals with haemophilia centres were close to St Georges Hospital, London, this department had never developed a haemophilia centre. Laboratory diagnosis of bleeding and thromboembolic disorders was available.

2.2.7. Consultant Haematologist, Broomfield Hospital (Mid-Essex) 1975-2007. Initially based at the Chelmsford and Essex Hospital. This post included general clinical but mainly diagnostic and advisory laboratory haematology services. My predecessor was a consultant in histopathology with an interest in haematology. I was a single-handed

consultant with no junior medical staff or nursing staff. I had responsibility for the blood transfusion service, the anticoagulant clinics and haematology inpatients and out-patients.. There were four other hospitals under our care, St John's Hospital (mainly Obstetrics and Gynaecology, Paediatrics and Surgery.) St Michael's Hospital, Braintree and St Peter's Hospital, Maldon. (each mainly caring for long stay elderly patients or the young severely disabled, (St Peter's Hospital also had obstetric wards) and Broomfield Hospital which had been a regional TB hospital. The Associate Haemophilia Centre developed in 1978 to provide day to day care and on-demand treatment for patients with bleeding disorders living in the area, functioning as a treatment centre.My first patient with haemophilia was diagnosed in late 1976 and referred for registration to Professor Jenkins at the London Hospital. The haematology department moved to the Broomfield site in 1984 and over time acquired eight inpatient beds, a five day treatment ward, two outpatient clinics a week, two very large anticoagulation clinics weekly and treatment of outpatients in the oncology treatment centre. A clinical nurse specialist was appointed and later I was assisted by a junior doctor. Although the haematology service expanded the associate haemophilia centre, in view of the small number of patients, remained essentially a treatment unit.

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. Please ensure your answer addresses your involvement with the UKHCDO.**

3.1. The Chelmsford and Essex pathology discussion group.1975-84

3.2. Member British Society for Haematology 1975-2007.

3.3. Member of the Broomfield Hospital pathology discussion group. 1984- 2007.

3.4. Member of the Hospital Blood transfusion Committee 1975-2007.

3.5. NETR Association of Haematologists Haemophilia Working Party 1979-2001

3.6. Ordinary member of the UKHCDO 1979-2001

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.

4.1. I have had no involvement with any inquiries, investigation, criminal or civil litigation in relation to the human immunodeficiency virus (HIV) or hepatitis B (HBV) or hepatitis C (HCV) infections or variant Creutzfeldt-Jacob disease, vCJD, in blood or blood products.

Section 2: Decisions and actions of the Haemophilia Centre at Broomfield Hospital ('the Centre')

5. Please:

a. describe the roles, functions and responsibilities of the Haemophilia Centre at Broomfield Hospital ('the Centre') during the time that you worked there.

b. outline the facilities and staffing arrangements for the care of patients with bleeding disorders;

c. identify senior colleagues at the Centre and their roles and responsibilities during the time that you worked there, insofar as they were involved with the care of patients with bleeding disorders and/or patients infected with hepatitis and/or HIV in consequence of infected blood or blood products.

5.1. Roles:

5.1.1. Providing as comprehensive as possible clinical and laboratory haematology service, including responsibility for blood transfusion and anticoagulant clinics, in-patients care, day ward patients, out-patients clinics and oncology out-patients therapy in the oncology centre.

5.1.2. Associate Haemophilia Centre director, providing an on-demand service for patients with bleeding or thromboembolic disorders. I was assisted from 1982 by an associate specialist whose training was in

histopathology and cytology .There were no designated areas for consultations or treatment other than the consultant's office or a small area in the laboratory at the Chelmsford and Essex Hospital. Patients at risk of adverse reactions, for example on DDAVP or cryoprecipitate, were initially treated on one of the medical wards. After the move to Broomfield hospital in 1984 a waiting area and designated treatment rooms were available. My small number of patients were all registered with a reference haemophilia centre, The Royal London Hospital mainly or The Royal Free Hospital on a shared care basis. The major centre directors at the time were Dr Brian Colvin and Dr Peter Kernoff. I had no haemophilia outpatient clinic: patients were seen on demand.

5.1.3. The major centres, the reference haemophilia centres, provided comprehensive care, including registration, information, management of serious bleeding problems, dental and surgical care, counselling, physiotherapy and social care, selection of blood products, selection and training of patients for home treatment and provision of their treatment. The directors gave advice and help freely when requested. Patient treatment regimes were discussed and advice given on product usage. The blood products used were cryoprecipitate, fresh frozen plasma or NHS Factor VIII and Factor IX concentrate, (and later, heat treated Factor 8y and factor 9A) which were obtained from the Blood Transfusion Laboratory, Brentwood on a by name patient basis. We held no commercial concentrates and had no access to any blood products other than NHS fresh frozen plasma, cryoprecipitate or concentrates obtained from the Brentwood Blood Transfusion Laboratory.

5.1.4. Record keeping and returns to Miss Spooner at Oxford.

5.1.5. To administer blood products to haemophilia patients and ensure correct storage and reconstitution of blood products in the coagulation laboratory.

5.1.6. To ensure safe handling of samples by laboratory staff, To review factor assays and other laboratory coagulation tests

5.1.7. Some teaching, training, laboratory accreditation and quality control.

5.1.8. Counselling and information to patients and family members, but mainly on practical matters, I have no recall of giving specific advice of the risks of viral transmission in the early years although I had long conversations with patients later as risks became more apparent.

5.2. Staffing

5.2.1. One Consultant Haematologist. There were no junior medical staff or nursing staff until the 1990s. I had a good working relationship with the domiciliary haemophilia nurse, originally based at Brentwood, later at the RLH. My chief MLSO supervised factor assays, maintained blood product supplies, kept records of usage, batch numbers and collated annual returns on my behalf for the Oxford Haemophilia Centre.

5.2.2. From 1982 I was assisted by an Associate Specialist whose training was in Histopathology/Cytology and by Locum Consultant Haematologists from 1995-1997.

5.2.3. A Consultant Colleague was appointed in 1998. We covered out of hours on-call on a shared rota. My Consultant Colleague was not involved in the day to day activity of the centre which closed in 2001.

6. The enclosed document is a letter from you to Rosemary Spooner dated 4 May 2001 discussing the closure of the Centre [HCDO0000012_170]. Please explain the circumstances of the Centre's closure, including:

a. When and why the Centre closed;

b. How the treatment of patients under your care/the Centre's care was managed after its closure; and

c. Any consequences the limited facilities of the Centre, and its eventual closure, may have had on the treatment of haemophilia patients.

6.1. In 2001.

6.2. By 2001 I had, as I recall, only one or two patients requiring hospital treatment or a home visit, who attended infrequently. (One came for treatment post closure to

avoid a long journey to the RLH.) Other factors were staffing and the pressure of other haematological commitments, mainly a further expansion of the oncology service.

6.3. I am unaware of any adverse consequences.

7. Please describe:

a. your role and responsibilities at the Centre and how, if applicable, this changed over time;

b. your work at the Centre 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.

7.1. I provided diagnosis of haemostatic / thromboembolic conditions and treatment on demand for patients and this remained the pattern for the future. Once patients started home treatment they no longer attended for my care and their registering major centre arranged follow up, testing and counselling at 3 -6 monthly intervals. I remained available for patients who wished to talk over their current situation and how infection with blood products might affect their health and families. One patient had requested that his HIV status should not be revealed to him. His wife remained HIV negative. I cannot now recall when or how much information I gave on viral transmission by blood products at the relevant times.

7.2. I occasionally treated two young haemophiliac brothers on home treatment, if their mother had difficulty with venous access. By the time we met both proved to have tested HIV positive. To my regret, I inadvertently revealed this to their mother who had not yet been informed when I offered support and further counselling.

8. Approximately how many patients with bleeding disorders were under the care of the Centre 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.

8.1. When I was first appointed there were no known patients with bleeding disorders in the district. Our first patient was diagnosed in late1976, a second treated patient moved into the district from Oxford three or four years later. With the lapse of time and with no access to records, my best estimate was that the maximum number was 6 patients with severe haemophilia A, including the two brothers

previously mentioned, Four (or more) were on home treatment. Two patients decided, when aware of the risk of blood transmitted infection, (HIV), to avoid all further treatment for the time being. Fortunately neither suffered major bleeds. One, an elderly patient, by then on F8y, died of other causes several years later and one (HCV positive, HIV negative) came in to restart treatment when heat treated products became available.

8.2. I treated a visiting Australian with severe haemophilia A with his own commercial factor VIII concentrate and one other patient with a factor VIII inhibitor was treated with commercial FVIII concentrate (Armour). As I had no access to other than NHS products I assume this patient also had his own therapy available.

8.3. 3 patients with severe haemophilia B.

8.4. 1 von Willebrand's Disease

8.5. I can now recall no mild or moderate haemophilia patients registered. The annual returns to Oxford or the numbers collated by the domiciliary haemophilia nurse based at the Blood Transfusion Laboratory, Brentwood and later at the RLH haemophilia centre may be of value.

9. To the best of your knowledge, what decisions and actions were taken, and what policies were formulated by the Centre, 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, and on what basis, and by whom were decisions made about the selection and purchase of blood products?

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?

c. What were the reasons or considerations that led to the choice of one product over another?

d. What role did commercial and/or financial considerations play?

e. What if any involvement did you have?

f. What products or treatments were generally used for treating (i) patients with severe haemophilia A; (ii) patients with moderate haemophilia A; (iii) patients

with mild haemophilia A; (iv) patients with haemophilia B; (v) patients with von Willebrand's disease?

9.1. Apart from patients treated with cryoprecipitate or DDAVP,the decisions were made on behalf of their registered patients by the reference haemophilia centre directors. Arrangements were made for associate centres to collect designated blood products, cryoprecipitate or NHS factor VIII and factor IX, and later, factors 8y and 9A on a by name patient basis from the Blood Transfusion Laboratory, Brentwood, for patients attending hospital for treatment. Home treatment patients, on NHS concentrates, mainly had their supplies delivered to their homes. No patients were treated with commercial concentrate other than the visiting patient with a factor VIII inhibitor with his own therapy previously mentioned. I am unaware if other authorities played a part in selection or purchase of blood products by the reference centres or of financial considerations other than information gained from the NETR haemophilia working party meetings..

9.2. Severe haemophilia A patients were treated initially with cryoprecipitate followed by NHS FVIII concentrate, later with F8y when it became available. From May 1984 the advice was, until testing for HIV was available, to avoid the use of blood products except for essential treatment and to use cryoprecipitate or FFP whenever possible.

9.3. Moderate haemophilia A patients were generally treated with cryoprecipitate or with NHS FVIII concentrate if the severity of bleeding required high sustained levels of FVIIIc. After 1985 Factor 8y was available. (I have now no recall of treating patients with moderate haemophilia.although I can not be sure about this)

9.4. Mild haemophilia patients were generally treated with DDAVP or cryoprecipitate, later Factor 8y (I have no recall of treating patients with mild haemophilia but may have done so).

9.5. Haemophilia B patients were treated initially with fresh frozen plasma, then NHS factor IX concentrate and later factor 9A from 1985.

9.6. Von Willebrand's Disease patients with DDAVP, or cryoprecipitate if unresponsive to DDAVP or unsuitable for DDAVP on clinical grounds..

9.7. From my attendance of the NETR HWP. Advice was given by the reference haemophilia centre directors on which products should be used for patients with moderate or mild haemophilia, children, new patients and those minimally treated until heat treated product (NHS factor 8y of 9A) became available in 1985. Home treated patients remained exclusively on NHS products. It was recognised that commercial factor concentrates were needed to meet the shortfall in the larger centres. Consideration of availability of NHS products and safety were major factors. Insufficient NHS products (including cryoprecipitate) and funding remained a problem for the reference centre directors,

9.8. I played no part in selection of concentrates.

9.9. I have no personal knowledge of what role commercial and/or financial considerations played in the purchase of blood products by the major haemophilia centres.

9.10. I had no involvement in these decisions.

10. What was the relationship between the Centre and the pharmaceutical companies manufacturing/supplying blood products? What influence did that relationship have on the Centre 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.

10.1. None.

11. If the responsibility for the selection and purchase of blood products lay with an organisation other than the Centre, please specify which organisation and provide as much information as you can about its decision-making.

11.1. The NETR reference haemophilia centres. I have no information on the directors' decision making other than guidance issued to them by the UKHCDO and the reference centre directors' meetings.

12. What alternative treatments to factor concentrates were available in the 1970s and 1980s for people with bleeding disorders? 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?

12.1. Cryoprecipitate, fresh frozen plasma, haemostatics for local application tranexamic acid and DDAVP when it became available in the late 1970s. I originally treated haemophilia A patients with cryoprecipitate. It took longer to prepare, larger volumes to infuse, factor VIII levels post treatment were less predictable and allergic reactions could be a problem but it had the advantage of exposure to fewer donors and a lower risk of viral transmission. In the late 1970s, with reliance on careful NHS donor selection, I did not see viral transmission as a major problem until evidence of non-A/non-B Hepatitis became known to me.The change-over to NHS factor VIII concentrate made storage, preparation and infusion easier and post treatment FVIII levels more reliable. And, it enabled patients with severe haemophilia A to change to home treatment, a significant step in their amenity and independence. Haemophilia B patients were treated with fresh frozen plasma and later with NHS factor IX concentrate,mainly on home treatment. Heat treated products F8Y and 9A became available in 1985 Other patients were generally treated with cryoprecipitate or DDAVP.

12.2. In retrospect, in the late 1970s and early 1980s, when volunteer donor NHS products were regarded as lower risk than paid-donor commercial Factor VIII concentrate, an early return to cryoprecipitate for suitable severe and moderate haemophilia A patients might have been advisable at least for bleeds not requiring high or sustained levels of clotting factor VIII and for patients who did not react seriously to cryoprecipitate.

13. What was the Centre'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?

b. home treatment? When was home treatment introduced?

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?

13.1. See above.

13.2. I cannot recall the exact date in my district when home treatment was introduced, Probably 1980.

13.3. I did not take part in the prophylactic treatment programme.

14. What was the Centre's policy and approach 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 had no young children with haemophilia A under my care until the haemophiliac brothers, previously mentioned, started to attend around late 1984 or 1985. They were already established on NHS factor VIII concentrate for home treatment. I can recall one young patient with severe factor IX deficiency on factor IX concentrate. I understand children with severe haemophilia A were initially treated with cryoprecipitate which proved difficult in small children due to venous access, adverse reactions, viscosity and the volumes required. Factor VIII concentrates allowed home treatment. In May 1984 we were advised that children and PUPS, previously untreated patients, should be treated with alternative products, DDAVP or cryoprecipitate for essential treatment until heat treated NHS products were available. I had no children or PUPS under my care at that time

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

15.1. The advice was whenever possible to use DDAVP, unless contraindicated, or cryoprecipitate for patients with mild haemophilia A until heat treated products were available unless treating a major bleed where high or sustained Factor VIIIc

levels were essential and to use cryoprecipitate or NHS FVII concentrate for patients with moderate haemophilia A depending on the severity of the bleeding episode. I can now recall no mild or moderate haemophilia patients under my care at the relevant time but I am unsure of this. By May 1984 the advice was to use cryoprecipitate in preference to NHS concentrate for moderate haemophilia A patients if possible and if treatment was essential.

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 know of no infections other than HIV or HCV transmitted by blood products at the centre.

Section 3: Knowledge of, and response to, risk

17. When you began work as a consultant haematologist at the Centre, what did you know and understand about the risks of infection associated with blood and/or blood products? What were the sources of your knowledge? How did your knowledge and understanding develop over time?

17.1. I was aware of the risk transmission of HBV in blood following my blood transfusion training at St Georges Hospital and the Tooting Blood Transfusion Centre and that this became low risk once hepatitis B screening of donors was instituted by the blood transfusion laboratories.

17.2. By the late 1970s or possibly early 1980s, I believe I was aware from discussion with colleagues and journal articles of the risk of other viral transmission in blood products including a non A /non B hepatitis in treated patients. I was of the opinion that cryoprecipitate was of lower risk due to small donor pools and believed that NHS blood products, including concentrates,were of lower risk than commercial products due to the NHS blood transfusion service donor selection. Neither proved to be true, although I later understood that cryoprecipitate, although potentially infected with HCV, was a lesser risk for HIV transmission, presumably due to lower prevalence of HIV positivity in the NHS donor population.

17.3. I was aware probably by the early 1980s from reports in journals and discussion with colleagues, that non A /non B hepatitis associated with abnormal fluctuating

LFTs led, in some patients, to a significant risk of developing chronic liver disease leading to cirrhosis and possibly hepatoma. (I recall an informal talk with Dr Peter Kernoff and other haematologists after attending a lecture at the RFH. Probably in 1982 or 1983.)

17.4. I was aware of AIDS cases in the USA from the Lancet Article in 1981 with reports of a new immunodeficiency disease in the gay population, but remained unaware of possible HIV blood transmission until around 1982-83 when haemophiliacs in the USA were reported to have AIDS symptoms, presumed following use of commercial paid-donor Factor VIII concentrate. A test for anti HTLV-III became available in 1984.

17.5. I cannot confirm the exact dates. I may be confusing later knowledge with what I knew and understood then.

18. What advisory and decision-making structures were in place, or were put in place at the Centre, to consider and assess the risks of infection associated with the use of blood and/or blood products?

18.1. I am not aware of the nature of decision-making structures in place at the reference haemophilia centres. Advice was disseminated from the reference centres by the RLH and RFH directors, and via the NETR Haematologists meetings. There was discussion of perceived relative safety of the blood products available and the problems caused by the inadequacy of supplies of NHS products, including cryoprecipitate, for patients requiring treatment.

18.2. Treatment with DDAVP and/or cryoprecipitate was advised for patients with von Willebrand's Disease and mild haemophilia A. It was recognised that DDAVP or cryoprecipitate might be inadequate in severe and moderate haemophilia A and sometimes in patients with mild haemophilia A in the treatment of all but minor bleeds.

18.3. Cryoprecipitate was recommended for children and PUPS with severe or moderate haemophilia A but was not seen as a viable replacement of concentrates for the majority of patients in view of loss of treatment efficacy (particularly for severe bleeds), allergic reactions, effect on home treatment programmes, and serious doubts about adequacy of supply.

18.4. DDAVP and cryoprecipitate are not effective in haemophilia B.

18.5. I am unsure if steps were taken to stop elective surgery and prophylaxis treatment, or reduce overall dosage where possible (up to May 1984) or if early commercial heat inactivated products were sought.

18.6. It was a difficult and confused time with many conflicting views, needs and requirements to consider.

19. What was your understanding of the relative risks of infection from commercially supplied factor concentrates and NHS factor concentrate

19.1. I believed that NHS factor VIII posed a lesser risk than commercial factor VIII concentrate based on the recruitment and more effective selection of NHS unpaid donors and the supposition that HIV infected donors entered the donor pool at a later date and in lesser numbers. In retrospect, by the time the first cases of AIDS were reported in the gay community in the USA (1981-82) the NHS blood transfusion service was possibly already compromised by HIV positive donors who were infected, asymptomatic and unaware. No test for HTLV-III was available to the NHS blood transfusion service until 1984 and HCV identification was later in 1991.Prior to this time no identification of HCV positive donors was possible other than on clinical history.I believed then that NHS blood products also presented a lower risk of nonA/nonB hepatitis depending on frequency and volume of treatment.

20. How did you keep up-to-date with relevant scientific and medical developments in knowledge? What journals did you regularly read?

20.1. I attended meetings and seminars, including local meetings and those held by the Hammersmith Postgraduate Centre and the British Society of Haematology. I subscribed to The BMJ, The Journal of Haematology and Blood. A Consultant Histopathology colleague took the New England Journal of Medicine and The Lancet among others and brought to my attention relevant articles.

21. When you began work as a consultant haematologist at the Centre, 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?

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

21.1. I was already aware of blood transmitted Hepatitis B infection. I believe I became aware of a nonA/nonB hepatitis probably by the late1970s or early 1980s. I heard from Dr Peter Kernoff in 1982 or 1983 that infection with the nonA/nonB virus could cause acute hepatitis, mild hepatitis or be asymptomatic and, in some patients, infection would be followed by progressive liver disease culminating in cirrhosis, liver failure and possibly hepatoma. LFTs were not a reliable guide to severity or progression of disease. I cannot recall the exact date of this informal discussion at the RFH between Dr Kernoff and our fellow haematologists.

22. What were the sources of your knowledge? How did that knowledge and understanding develop over time?

22.1. As above and from journal articles and discussions with colleagues. Later by the identification of the hepatitis C virus in 1991.

23. What, if any, actions did you and/or the Centre take to reduce the risk to patients of being infected with hepatitis (of any kind)?

23.1. As the Blood Transfusion Centre, Brentwood, was testing donors for HBV, this form of hepatitis constituted a minor if present risk. Active HBV vaccination was in place from 1983-4. NonA/nonB hepatitis remained a risk to patients on unheat treated NHS products, including those treated with cryoprecipitate, until heat-treated products became available in 1984-1985. Patients on concentrate were maintained on single batches, depending on the extent of the supplies held by the Brentwood Blood Transfusion Centre which were shared with four other associate centres. I do not now think reduction in dosage, advice on activities or the use of cryoprecipitate or DDAVP/tranexamic acid for minor bleeds in severe or moderate haemophilia A patients would have altered the eventual outcome.

24. How and when did you first become aware that there might be an association between AIDS and the use of blood products?

24.1. I became aware of the association between AIDS and the use of blood products on the publication of an article in The Lancet in 1982 or 1983 of haemophilia patients in the USA treated with factor VIII concentrates who had developed AIDS. At the time I had no knowledge of the aetiology, the incubation period or of how many infected patients would later go on to develop AIDS

25. 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 Centre? What were the sources of your knowledge? How did your knowledge and understanding develop over time?

25.1. From journals, discussion with colleagues and haematology meetings. I believed that NHS products were safer than paid-donor imported commercial concentrates and endeavoured to ensure patients did not receive commercial products. (Home treatment patients were on NHS concentrates.) Patients attending their reference centre for surgery or major bleeds may have had commercial factor cover due to the inadequacy of NHS supplies. I became more fully aware of the nature and extent of the problem as reports of affected patients in UK haemophilia centres became known and as patients were tested by their reference centres.

26. Did you and/or your colleagues at the Centre 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?

26.1. I recall discussing the risks of hepatitis with patients when they started a particular treatment under my care but do not now recall if timely discussion of the risks of HIV infection took place and if so, when. I have no knowledge of the extent of information given to patients attending their reference centre but patients were well informed early either by the reference centre or the Haemophilia Society and came in or were asked to come in for further information.

27. Please consider the enclosed letter from Professor Bloom and Dr Rizza to the UKHCDO dated 24 June 1983 [HCDO0000270_004]. Do you recall receiving a copy of this letter? What steps, if any, were taken by you/the Centre to comply with the treatment policy recommended by this letter?

27.1. I cannot remember this letter from the UKHCDO. I note that Dr Colvin offered copies at a NETR haemophilia working party meeting in 1983. I now understand that it contained advice and recommendations on which blood products were regarded as safer prior to heat treated products becoming available and the management of von Willebrand's Disease, moderate and mild haemophilia, children and previously untreated or minimally treated patients. I believe I was in line with the recommendations made at that time.

28. Did you or your colleagues at the Centre revert to treatment with cryoprecipitate for some or all of the patients in response to the risk of infection? If so, when and how was it determined which patients would be offered a return to cryoprecipitate?

Patients with von Willebrand's Disease or those with mild haemophilia A (if any were treated) would already have been on DDAVP/ cryoprecipitate. I believe that patients with severe haemophilia A or B, most on home treatment, remained on NHS concentrate up to the NETR haemophilia working party recommendation on the use of cryoprecipitate/ FFP of May 1984.

29. What, if any, actions did you and/or the Centre 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?

29.1. Apart from my usual advice to patients with severe haemophilia A or B to avoid treatment with commercial concentrates I can recall no specific changes until May 1984, possibly due to a reliance on NHS products.Two older patients with severe haemophilia A elected to avoid treatment with any blood product until safety could be assured.

30. Did the Centre continue to use factor concentrates to treat patients after becoming aware of the possible risks of infection of HIV? If so, why?

30.1. I can no longer recall the urgent discussions which must have taken place on the choice of treatment or possible change to cryoprecipitate. I believe I and others may have relied on the (relative) safety of NHS blood products including concentrates. (I later heard that no patients on NHS products had been known to become HTLV-III antibody positive by September 1984 although this did not indicate that some would not later become positive.) I understand that the advice from the UKHCDO in 1983 was for severe or moderate haemophilia A patients to continue on (NHS) factor concentrates until heat treated products were available. Centres were free to make their own decision on this. By May 1984 I believe I followed the advice to use cryoprecipitate or DDAVP for my hospital treated patients where ever possible until heat treated NHS blood products were available. Patients with severe haemophilia B continued on FIX concentrate. Other patients would have been treated with DDAVP or cryoprecipitate.

31. When did the Centre begin to use heat treated factor products and for which categories of patients? Please set out what steps were taken to obtain heat treated products. Please also set out whether steps were taken to recall any stores of unheated products which patients had.

31.1. Heat treated factor 8y and 9A was available from mid 1985, initially for children, patients with moderate or mild haemophilia and patients who had received no or minimal treatment in the past. I have no information on attempts to obtain heat treated products. Recall of all unused non-heat treated concentrate took place as soon as NHS heat treated products became available. The exchange was made for home treatment patients by the domiciliary haemophilia nurse.

32. Looking back now, what decisions or actions by you, the Centre or any other relevant organisations or individuals, could have avoided, or brought to an end earlier, the use of infected blood products?

32.1. The use of alternate treatments earlier where possible, e.g. cryoprecipitate, DDAVP, use of haemostatics applied locally for minor skin bleeds, use of tranexamic acid and DDAVP for minor dental work or minor surgery, reduction in dosage, maintenance on single batches of product, avoidance of commercial concentrates, delay of all elective surgery, advice on sports activities, cessation of prophylaxis... Pressure on the Department of Health to better fund the National Blood Transfusion laboratories to achieve self sufficiency, much earlier use of viricidal steps in fractionation of concentrate. I have no information on how many of these or other responses were carried out or when. It must be recognised that serious disabling or life-threatening bleeds had to be treated with whatever blood product was available at the time even if risk was perceived.

33. What actions or decisions or policies of other clinicians or other organisations, within your knowledge, played a part in, or contributed to, the scale of infection in patients with bleeding disorders? What, if anything, do you consider could or should have been done differently by these others?

33.1. I do not have enough information to comment other than to wish viral inactivated products had been available much earlier and that the NHS had been able to become self-sufficient by the mid 1970s.

33.2. Although indications of the risk of HIV infection were available to all from mid 1983, expressed in meetings and publications, it would have been helpful if earlier prescriptive advice had been given and widely disseminated by the better informed UKHCDO.

Section 4: Treatment of patients at the Centre

34. When did you first discuss AIDS or HIV (HTLV-III) with any of your patients?

34.1. I am not sure. Later with patients who had already been tested, counselled and most informed of their status by their reference centre/CCC in 1984-85.

35. How many patients at the Centre were infected with HIV in consequence of the treatment with blood products? Of those infected,

a. How many had severe haemophilia A?

b. How many had moderate haemophilia A?

c. How many had mild haemophilia A?

d. How many had haemophilia B?

e. How many had von Willebrand's disease?

f. How many were children?

35.1. Severe Haemophilia A. I recall four who became HIV positive including two children who were anti HTLV-III antibody positive before transferring to my care and two patients on home treatment. A document supplied to the Inquiry by Dr Brian Colvin states four of my patients were anti- HTLV-III positive. Without patient identification I cannot confirm the number.

35.2. I can now recall no patients registered with mild or moderate haemophilia.

35.3. Factor IX deficiency, none to my knowledge.

35.4. von-Willebrand's disease, none.

35.5. Two of the patients with severe haemophilia A were children.

36. How and when did you learn that patients under your care/the Centre's care had been infected with HIV?

36.1. I was informed by the patients' reference centre/CCC by phone or in person probably 1984-1985. (letter Dr B Colvin BARTO0000577_003. January 1987. This letter included two patients whose names I did not recognise.)

37. How and when were patients told that they had been, or might have been, infected with HIV? What if any involvement did you have in this process?

37.1. I have no information on when or how patients were informed and counselled by their reference centre. I discussed the implications for their health and family with patients and family members after their reference centre consultations.

38. Please describe the arrangements that were made for the testing of the patients including pre-test and post-test counselling. Were they tested without their knowledge? What if any arrangements were made at the Centre for pre-test counselling? In your answer, please consider the enclosed letter from Dr Colvin to you dated 6 January 1987 discussing post-test counselling [BART0000577_002].

38.1. I have no knowledge of the consent obtained or the extent of pre or post-test counselling of patients or the information they were given at the reference centre apart from Dr Colvin's letter of 1987.

39. What was your policy/the Centre's policy in relation to testing partners/family members of people known or suspected to be infected with HIV? Under what circumstances were the tests carried out?

39.1. Testing of partners/family members was carried out at the reference centre. I arranged follow up visits with patients to offer information, advice and support.

40. What information was given to them about the significance of a positive diagnosis? Were patients told to keep their infection a secret?

40.1. I have no personal knowledge of the extent of information and counselling given by the reference centre. I understand that patients positive for HIV were advised to be careful who they told, as was the practice with other HIV positive patients, in view of the fear and stigma associated with AIDS at that time.

41. In the enclosed minutes of a meeting of the UKHCDO held on 17 October 1983 [page 10 of PRSE0004440], Dr Chisholm remarked that patients were refusing to take up commercial factor VIII concentrate because of the AIDS scare. Did any patients or parents of patients under your care at the Centre raise this concern with you or your colleagues?

41.1. All my patients were on NHS concentrates or cryoprecipitate.. One older patient, mainly on the advice of his haemophiliac cousin, chose not to attend for treatment with any blood product including cryoprecipitate until a safe treatment was available. Another elderly patient stopped treatment. One later was found to be HCV positive and HTLV-III negative. Both patients were diagnosed in the pre-treatment era (with consequent severe disabilities) and had confidence in their

ability to judge their need for treatment. Fortunately, neither suffered any serious adverse effect of cessation of treatment.and both restarted treatment whem F8y was available.

42. Were patients infected with hepatitis B in consequence of their treatment with blood products informed of their infection and if so, how? What information was provided to patients infected with hepatitis B about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?

42.1. I do not recall any patient under my care who was HBV positive.

43. How many patients at the Centre were infected with hepatitis B?

43.1. None to my knowledge.

44. How many patients at the Centre were infected with hepatitis C?

44.1. Five patients with severe haemophilia A were HCV positive.
44.2. Haemophilia B – none that I remember.
44.3. Von Willebrand's Disease – none that I remember..

45. Were patients infected with hepatitis C informed of their infection and if so, how and by whom? What information was provided to infected patients about the infection, its significance, prognosis, treatment options and management? What if any involvement did you have in this process?

45.1. HCV positive patients were tested and informed by their reference centre and I understand were referred to hepatology colleagues for further assessment and management. I was not involved in the management of patients with hepatitis.

46. When did the Centre begin testing patients for hepatitis C? Please describe the Centre's process for HCV testing, including pre-test and post-test counselling. What involvement did you have in this process?

46.1. I cannot recall being involved in the testing or counselling of HCV positive patients. I understand that testing was available from 1991.

47. Were the results of testing for HIV and hepatitis C notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, explain why.

47.1. I am not sufficiently informed to comment on when HIV or HCV positive patients were informed of their test results by their reference centre.

48. How often were blood samples taken from patients attending the Centre 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?

48.1. Blood samples for pre and post treatment factor levels, FBCs, LFTs etc were routinely collected. Patients were aware of the purpose of the tests but were not asked for formal consent. I retained no stored samples. The hepatitis and HIV follow up was via the reference centre. I am not sufficiently informed on their practice to comment. (I later checked full blood counts and T4/T8 levels for patients on zidovudine therapy with the patient's knowledge and consent.)

49. Did the Centre have a bank of stored samples? If so, was that storage undertaken with patients' knowledge and consent?

49.1. I had no stored blood samples. I am not sufficiently informed to comment on the practice of the reference centres.

50. Were patients under your care/under the Centre's care treated with factor concentrates or other blood products without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent to treatment? Was their consent recorded and if so, how and where?

50.1. Patients started by me on cryoprecipitate treatment were given an explanation of the nature of the product, its purpose, efficacy and the risks or complications of treatment but were not asked for formal or written consent. Patients on, or transferring to, NHS factor concentrate were mainly seen and advised by their reference centre. I would ask permission to collect blood samples not collected at the time of infusion of therapy but did not request formal consent prior to treatment.

51. Were patients under your care 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?

51.1. Testing for HIV or hepatitis was carried out by the patients' reference centre. If other blood samples were collected by me the patient was asked permission and aware of the reason but not asked for formal or written consent..

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

52.1. I can recall no previously untreated patients under my care other than the patient with severe haemophilia A diagnosed in 1976, initially treated with cryoprecipitate and later on home treatment with NHS FVIII concentrate and F8y.

53. How was the care and treatment of patients with bleeding disorders and HIV/AIDS managed at the Centre? In particular:

a. What steps were taken to arrange for, or refer patients for, specialist care?
b. What treatment options were offered over the years?
c. What information was provided to patients about the risks and benefits of specific treatments and about side effects?
d. What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?

53.1. Management, referrals and follow-up monitoring were carried by the patients' reference centre. I continued to see affected patients to offer what information and advice I could..

54. What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis B?

54.1. I not aware of any patients with HBV hepatitis..

55. How was the care and treatment of patients with bleeding disorders and hepatitis C managed at the Centre? In particular:

a. What steps were taken to arrange for, or refer patients for, specialist care?

b. What treatment options were offered over the years?

c. What information was provided to patients about the risks and benefits of specific treatments and about side effects?

d. What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with hepatitis C?

55.1. Patients with hepatitis C were managed and referred for specialist care by their reference centre. I understand that treatment options, information and monitoring would have been carried out by the hepatologists to whom they were referred.

56. What arrangements, if any, were made to provide patients infected through blood products with counselling, psychological support, social work support and/or other support?

56.1. Patients were offered professional support by their reference centre. The RLH centre had a very good professional counsellor, shared possibly with the RFH haemophilia centre, who also gave talks and advice to medical and nursing staff on how best to support affected patients. I offered whatever support and information I could to patients post diagnosis.

56.2. A HIV counsellor and advisor was available locally, based in the Public Health Laboratory, for all HIV positive patients from 1984.

57. Did the Centre 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?

57.1. No

58. What, if any, difficulties did you/the Centre encounter in obtaining sufficient funding for the treatment of people who had been infected with HIV and/or hepatitis C?

58.1. No funds applied for. The reference centres may have more information.

59. 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. If applicable, please explain and address your involvement, if any, in the inclusion of 'first exposure' patients in clinical trials discussed on page 4 of the enclosed minutes of a meeting of the North East Thames Regional Association of Haematologists Haemophilia Working Party, dated 25 June 1986 [BART0000673].

59.1. I had no involvement with the clinical trials mentioned.

60. What was the Centre'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.

60.1. I was not involved with any death certificates or inquests in relation to patients who had been infected with HIV or hepatitis.

61. What were the retention policies of the Centre in regards to medical records during the time you were practising there?

61.1. Relevant laboratory records were retained up to closure of the associate centre in 2001. I am unsure if hospital or departmental notes have been retained.

62. As far as you are able to recall, did you:

a. maintain separate files for some or all patients? If so, why; where were those files located; and where are those files now?

b. keep records or information (e.g. information being used for the purpose of research) about any of your patients at your home or anywhere other than the Centre? If so, why, what information and where is that information held now?

62.1. Entries were made in patients' hospital notes which were held in the haematology office. A separate informal information pack for each patient with identification details, condition, severity, recommended therapy, high risk stickers and other relevant information was held in the laboratory for out of hours and as an annexe if hospital notes were needed elsewhere. Hospital notes were not released until the nature of the up-coming consultation was known. I have no information on hospital policy on retention of notes. I am not aware of any patient information

used in research. I did not keep patient records or information anywhere other than the haematology office or laboratory.

63. Please list all research studies that you were involved with as a consultant haematologist at the Centre (or any other relevant positions of employment) insofar as relevant to the Inquiry's Terms of Reference, and please:

a. Describe the purpose of the research.
b. Explain the steps that were taken to obtain approval for the research.
c. Explain what your involvement was.
d. Identify what other organisations or bodies were involved in the research.
e. State how the research was funded and from whom the funds came.
f. State the number of patients involved.
g. Provide details of steps taken to inform patients of their involvement and to seek their informed consent.
h. Provide details of any publications relating to the research.

Please provide the same details in relation to any other studies in which you were involved or articles you have published, insofar as relevant to the Inquiry's Terms of Reference.

63.1. I was not involved in any research with reference to the haemophilia service.

64. Please consider the enclosed memorandum dated 19 April 1991 [BPLL0005964]. The memorandum concerns products issued from PFL being provided to haemophilia centres "mostly without charge" in return for the provision of clinical data, and your name is included on the list of Factor XI users on page 7. As far as you can recall, please explain the arrangement discussed on page 1 of the memo, including:

a. How much product was given to your Centre;
b. Whether the product was provided free of charge;
c. What types of products were provided;
d. What, if any, information or clinical data was sent by you, to whom, and for what purposes; and
e. Whether patient consent was obtained for the sharing of this data.

64.1. I have no recall of the memorandum. No product was used by me or clinical information shared.

65. Please consider the enclosed Clinical Trial Exemption Application, in which you are named as a potential participating physician [page 51 of OXUH0000608_002]. Did you participate in this trial? If so, please explain the nature of your involvement and that of any patients under your care, including whether and how patient consent was obtained.

65.1. I did not participate in the trial. I had no peviously untreated patient(s).

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

66.1. I did not take part in research studies.

67. 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, please explain what data was used, and how/why it was shared.

67.1. I did not take part in research studies. Returns were made to Miss Spooner at Oxford annually. Patients were not asked for their consent and were probably unaware that the information had been shared. At the time I saw no problem in providing information in confidence to a colleague at the haemophilia centre tasked with collating blood product usage.

Section 5: UKHCDO

68. Please describe your involvement with UKHCDO (including any of its working parties, committees or groups). Did you usually attend the annual general meetings?

68.1. I attended as an ordinary member only. I was not on any of the working parties, committees or groups. The purpose of the UKHCDO appeared to be collating the use of blood products and investigating complications of such use, discussion of current problems, dissemination of information, often derived from specific working parties, and the production of guideline advice. It had contact with the Department of Health, the Haemophilia society and the Haemophilia Nurses Association. Later, I understand its officials acted as a collating centre for notification of known or suspected cases of HIV infection and AIDS. I had no involvement in policy or decision making.

68.2. I have no memory of having any direct communication from the UKHCDO other than minutes of the annual meetings but accept that other guideline advice was sent. The directors of the CCC/ reference centres relayed information from other meetings

69. During the period that you belonged to UKHCDO, please outline:

a. The purpose, functions and responsibilities of UKHCDO

b. Any involvement which you had in the development of policies or advice by UKHCDO which are relevant to the Inquiry's Terms of Reference; and

c. How information or advice was disseminated by UKHCDO and to whom.

69.1. As above

Section 6: Pharmaceutical companies/medical research/clinical trials

70. Have you ever:

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

b. received any pecuniary gain in return for performing an advisory/consultancy role for a pharmaceutical company involved in the manufacture of sale of blood products?

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

d. received any financial incentives from pharmaceutical companies to use certain blood products?

e. received any non-financial incentives from pharmaceutical companies to use certain blood products?

f. received any funding to prescribe, supply, administer, recommend, buy or sell any blood product from a pharmaceutical company?

g. undertaken medical research for or on behalf of a pharmaceutical company involved in the manufacture or sale of blood products?

h. provided a pharmaceutical company with results from medical research studies that you have undertaken?

70.1. I have never provided advice or consultancy service to a pharmaceutical company. The answer to questions b - h is no involvement or association.

71. What regulations or requirements or guidelines were in place at the time concerning declaratory procedures for involvement with a pharmaceutical company? If you were so involved, did you follow these regulations, requirements and guidelines and what steps did you take?

71.1. I was not involved with any of the pharmaceutical companies.

72. If you did receive funding from pharmaceutical companies for medical research, did you declare the fact that you were receiving funding and the source of the funding to your employing organisation?

72.1. I have never received any payment, reward or gift from a pharmaceutical company involved in the manufacture and sale of blood products. I attended no meetings and received no funding.

Section 7: Interaction with the financial assistance trusts and schemes

73. What if any involvement did you have with the different trusts or funds (the Macfarlane Trust, the Eileen Trust, the Macfarlane and Eileen Trust, the Caxton Foundation, the Skipton Fund, EIBSS) which were set up to provide financial support to people who had been infected?

73.1. I had no involvement with the trusts or funds.

74. To what extent, during your time at the Centre, did staff (including you) inform patients about the different trusts or funds?

74.1. I did not give advice on available trusts or funds. Patients were advised by the RLH's social worker and by the Haemophilia Society

75. Did the Centre have any policy or any guidance for staff members in relation to referring patients to the trusts and funds for support?

75.1. No.

76. What kind of information did the Centre provide to the trusts and funds about, or on behalf of, patients who were seeking assistance from the trusts and funds?

76.1. I did not give information to trusts or fund on behalf of patients.

Section 8: vCJD

77. 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?

77.1. I am not sure when I became aware of the risk of transmission of vCJD. I took no part in patient information or counselling.

78. Did you have any involvement in decisions as to what information to provide to patients about vCJD? What steps were taken to inform patients about possible exposure to vCJD and to provide information to them about vCJD? 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?

78.1. I took no part in patient information or counselling about vCJD.

79. What measures were put in place at the Centre from a public health perspective, in relation to the care and treatment of patients? If patients at the Centre were identified as at risk for public health purposes, did that impact detrimentally upon them in terms of their ability to access treatment and care (whether at the Centre or elsewhere?).

79.1. I am not aware that any patient was unable to access treatment.

Section 9: Look-back and tracing exercises

80. In as much detail as you are able to, please explain your knowledge and involvement in HCV look-back or tracing exercises. In answering this question, you may find it useful to refer to the enclosed letter from you to Dr Corless dated 28 August 1991 which concerns a hepatitis C tracing exercise [NHBT0025424].

80.1. I cooperated with the Blood Transfusion Laboratories, Brentwood, in tracing patients who had received blood units or products potentially infected with HCV, tracing patients through our Blood Bank records, informing clinicians and GPs. Dr Angela Gorman, a haematologist at the BTL, Brentwood, had offered to see, inform and counsel any patients so traced. In addition I expect that the centre also took part in the HCV and HTLV-III haemophilia treatment lookback but have no specific details to offer.

81. In as much detail as you are able to, please explain your knowledge and involvement in HTLV-III/HIV look-back or tracing exercises. In answering this question, you may find it useful to refer to the enclosed letter from Dr Knowles to you dated 9 April 1996 which concerns a HTLV-III tracing exercise [NHBT0027609].

81.1. I cooperated with the Blood Transfusion Laboratories, Brentwood, in tracing patients who had received blood units or products potentially infected with HTLV-III /HIV, tracing patients through our Blood Bank records, informing clinicians and GPs. Dr Angela Gorman, haematologist at the BTL, Bentwood, had offered to see, inform and counsel any patients so traced.

Section 10: Other Issues

82. 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.

82.1. I am unaware of any complaint made against me, either made in person or to my employer or any other body.

83. 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.

83.1. I have no useful contribution to make over and above that which may be made by colleagues.

83.2. Without access to personal or clinical notes my memory of the events at the relevant times nearly 40 years ago is imperfect.

Statement of Truth

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

Signed: GRO-C

Dated: 02/04/2021