Witness Name: Dr Archibald Grant Prentice
Statement No.1: WITN5422001
Exhibits: NIL
Dated: 25 April 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ARCHIBALD GRANT PRENTICE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 22 February 2021.

I, Dr Archibald Grant Prentice, will say as follows: -

Section 1: Introduction

1. My full name is Archibald Grant Prentice. My date of birth is GRO-C 1946. My address is known to the Inquiry. My professional qualifications are set out in a Curriculum Vitae which the Inquiry has a copy of as document MHRA0007582_35.

2. My employment history is set out in my Curriculum Vitae (MHRA0007582_35) which is a document produced for an application to the MHRA in about 1994 whilst I was working in Plymouth. I left Plymouth in 2006 to move to the Royal Free Hospital in London where I stayed until my retirement in 2013 having stopped full clinical duties in 2012. I was Clinical Director there from 2008 – 2010 for blood and cancer services.

3. Memberships of past committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference are generally set out in my Curriculum Vitae (MHRA0007582_35), certainly up to 1994. I was also elected to the Fellowship of the Royal College of Physicians of Edinburgh in 2012. I was President of the British Society for Haematologists from 2002 – 2004 and later President of the Royal College of Pathologists between 2011 – 2014. I hold no memberships of any committees, associations, parties, societies or groups now.

4. I have not previously given evidence to any other inquiries, investigations or litigations whether criminal or civil in relation to the Inquiry's terms of reference, to the best of my recollection.

Section 2: Decisions and actions of the Plymouth Haemophilia Centre ("PHC")

5. The invitation to provide a response to the Inquiry characterises the department in which I worked in Plymouth as the "Plymouth Haemophilia Centre". There was no physical or functional centre as such. That is a title only. There was no description of a "Centre". I was appointed to the District General Hospital as a Consultant Haematologist. I don't recall the South West Regional Health Authority having any Haemophilia Centre. There was no such formality in the region which had the longest blood supply chain in the UK stretching as it did from Bristol to Truro.

6. I have referred above to the fact that the "Plymouth Haemophilia Centre" was not a formal entity. The title of "Director" was informal. I cannot recall the roles, functions and responsibilities of the Plymouth Haematology Department during my tenure there. I do not remember ever having seen documents setting any of this out.

7. I treated all haemophiliac disorders, except for children. Children were dealt with by the Paediatricians and I was not directly involved in their care.

8. I do not recall any facilities or particular staffing arrangements for the care of patients with bleeding disorders. The departmental staff all had general haematology duties. The hospital was a big District General Hospital, with a thousand beds. The care of patients with haemophilia was a very small part of its work.

9. I am asked about senior colleagues in my department and their roles and responsibilities during the time I was there. I joined the Plymouth Haematology Department in 1981. I joined a senior colleague in the department, but I worked effectively single-handed until Dr Adrian Copplestone joined me in 1987 following Dr John Stafford's retirement. We were then joined by Dr Michael Hamon in 1993 who set up the Stem Cell Transplant Unit. When I joined the department, I was the first properly trained haematologist (as opposed to Consultant Pathologist) in the department. I trained both as a clinical and a laboratory haematologist. In the early 1970s training in haematology was formalised

between the Royal Colleges of Physicians and the Royal College of Pathologists to include internal medicine and laboratory practice.

10. The next colleague to join us was Dr Tim Noakes from Basingstoke. We needed a consultant for the clotting disorders. His arrival was a big boost to our service.

11. The next consultant, Dr Simon Rule, joined us from Western Australia and he really focussed on Oncology.

12. We later employed a sixth consultant, Dr Edward Kaminski, an Immunologist.

13. I joined the Department as a Consultant Haematologist and dealt with all aspects of haematological disorders. I developed an increasing interest in clinical management so I took on increasingly senior roles. My main interest was to establish all haematological care on a modern footing, including care of patients with haemophilia. We did not run "Haemophilia Clinics". There were very few patients in Plymouth. Patients came up initially to the portacabin outside the laboratory (an old, converted, Police Station) and the laboratory would call me to see the patients when they had arrived with bleeds. Sometimes they would call my secretary and the calls to me would come through her. A clinical unit within the hospital was established in 1986 in which patients were subsequently seen.

14. I do not recall having any patients with hepatitis.

15. I do not recall the exact number of patients we had and find it very hard to provide even an approximate number. The "returns" to the Oxford Haemophilia Centre which were sent regularly may assist with that information, although the redactions make it difficult for me to be clear. The document HCDO0000217_002 seems to disclose six Von Willebrand patients. It also seems to disclose two pages of Haemophilia A patients. I would be very surprised if there were that many patients but I cannot remember. I do know that we did get holiday visitors so the sheets might disclose tourists rather than regular patients. Those which are shown with a lot of ticks in the columns may disclose regular patients as they were seen more regularly. It should be noted that on the second page of the Haemophilia A patients there is a patient who had three ticks who was a visitor and was in fact registered with Bristol. That comment is added in manuscript.

16. I do not remember policies being formulated by the Plymouth Haematology Department and I do not recall us having any. In terms of the selection, purchasing and use of blood products we went for what was available. We used commercial product as it was often all we could get. I remember constantly trying to find a source of Factor VIII and having difficulty with the availability of the supply. I looked for what was the safest product, but I cannot recall any other criteria. Thus generally decisions were based on what products we could source.

17. I do remember discussing the supply of blood and blood products with the South West Centre of the National Blood Service. I cannot remember whether there were discussions with the Regional Health Authority. The Regional Health Authority was a very difficult body to deal with.

18. The decisions to choose one product over another were not decisions as such. It was as a result of availability of product. Commercial and/or financial considerations played no part whatsoever in any sourcing of blood supply.

19. I do not remember giving patients a choice as to which product they would be provided with. I may have asked but I do not remember. I do not remember if I could even give a choice. As I have already set out, we had to use what we had.

20. Bleeding disorders needed different products. Patients with severe Haemophilia A required Factor VIII. Those with moderate Haemophilia A might require Factor VIII if they suffered a severe bleed and could often be managed using cryoprecipitate or DDAVP. Patients with mild Haemophilia A would normally be managed with cryoprecipitate or DDAVP.

21. Haemophilia B patients would be treated with Factor IX and I do not remember any difficulties with the supply of that.

22. I do not recall any relationship between the Plymouth Haematology Department and the pharmaceutical companies. We bought products on a commercial basis if we required to do so. I do not recall visits from sales reps and if I was asked to see sales reps, I would generally say no.

23. The Cutter letter referred to (BAYP0000009_030) does not particularly help me. I do not recall if there was a meeting, I simply cannot remember. If we did meet the

representative, I cannot recall doing so. The letter does seem to be a response to questions about the products, but I cannot now remember the context.

24. It may be that the selection and purchase of blood products was occasionally carried out by the National Blood Service in Bristol. We would certainly get advice from them from time to time. We may also have got it from the Blood Products Laboratory in Borehamwood.

25. The alternative treatments to Factor concentrates available in the 1970s and 80s were cryoprecipitate and DDAVP to the best of my recollection. I always preferred not to give blood or blood product if it could be avoided. I was taught that a pint of blood is a potential biological time bomb. One can never be sure of all consequences however safe a blood product is made.

26. I was keen to reduce the use of blood wherever possible. When I was in Plymouth I was concerned that surgeons were wasting blood by having too much cross-matched for any particular operation. Over a six month period I was able to demonstrate that for a particular operation the average amount of blood product used was a certain level, much lower than generally requested by the surgeons and we agreed that it was sensible to cross-match at a reduced level. It reduced usage of blood and blood products in operations by around 25%.

27. An advantage of using cryoprecipitate is that it comes from a single donor and not pooled blood. It is better for Von Willebrand patients. The main disadvantage is that there is a variable level of Factor VIII concentrate. It is also not treatment which can be used for home treatment. Each case is treated on its own merits and a record of past responses to blood or blood products is important.

28. I have been referred to the correspondence between Professor Ludlam and me in 1997 (HCDO0000275_132 and HCDO0000275_210). I wrote to Professor Ludlam in my capacity as a member of the Regional Development and Evaluation Committee of South West England to ask Professor Ludlam , then the Chairman of UKHCDO, to write to that influential Committee to ask them to convince the Department of Health that there was a need for self-sufficiency in domestic Factor VIII production. This correspondence illustrates that we knew there was a delay in production but that we could not understand why. No funding was being made available.

29. Professor Ludlam did write to the Committee which would in turn have relayed the concerns to the Department of Health.

30. I was not a member of UKHCDO. I did not attend meetings other than the occasional annual meeting. I note that amongst the papers there is a letter to me from Professor Lindsey Davies presumably at the end of 2003 (DHSC00041329_002) which discloses that there was an ongoing problem with blood supply and a shortage of consultant haematologists at that time. That was nothing new.

31. In relation to the Plymouth Haematology Department's policy and approach in relation to cryoprecipitate I used cryoprecipitate for moderate and mild Haemophilia A and for Von Willebrand's Disease. I tried to stick to that as much as I could. None of us wanted to use pooled products if we could avoid them. Cryoprecipitate is a single donor product.

32. I do recall as a trainee getting cryoprecipitate in single glass bottles. It came freeze dried and was infused in saline. I remember using that product in the 1970s. It was an extremely time-consuming process in the care of patients with severe Haemophilia A.

33. I do not recall anything about home treatment being introduced. I do recall some patients wanted home treatment although I cannot remember who or whether we agreed it with them. We had no haemophilia nurse to train patients.

34. I do not recall when and to what extent prophylactic treatment was introduced. I have no recollection of this.

35. I cannot comment on the use of Factor concentrates for children as the paediatricians were in charge of that treatment. I am afraid I do not remember any discussions about it.

36. Our approach to patients would be informed by advice from the UKHCDO if we agreed with that advice. I do not recall us discussing with any other external parties.

37. The Regional Transfusion Centre (the regional HQ of the National Blood Service was in Bristol) did supply us with cryoprecipitate and NHS Factor. There were shortages of the national product so we had to buy international product on occasion. I do not think the Regional Transfusion Centre supplied commercial products, we sourced our own. I do not recall being involved in a buying consortium at all. Due to our long supply chain we always encountered difficulties in obtaining the product from the Regional Transfusion

Centre. We sometimes got deliveries under blue light from the Regional Transfusion Centre in Bristol. This included blood platelets and cryoprecipitate.

38. A local centre was set up in Plymouth to supply Truro, Torbay and Barnstaple with single donor products. This was to avoid the necessity of blue lighting product from as far away as Bristol. My recollection is that the Regional Transfusion Centre decided to stop the production of fresh frozen plasma and platelets in Plymouth in the late 1990s. I have no recollection of treating patients with mild or moderate bleeding disorders with Factor concentrates unless the moderate patient was suffering a severe bleed.

39. My recollection is that Dr Copplestone reported in a letter at one point that a patient with acute leukaemia had HTLV1, an exceedingly rare virus. That is the only other infection I can recall being transmitted. He reported on that infection in a letter to the British Medical Journal in 1994 (see page 12 of MHRA0007582_008).

Section 3: Knowledge of, and response to, risk

40. The risk of infection associated with use of blood and/or blood products is something I would have discussed with colleagues although I do not recall much discussion. We did have regular meetings as a group of haematologists and we would have discussed it then. I can see from the Cutter letter (BAYP0000009_030) that we did discuss supply although I have no recollection of it. There was not a formal structure within which to have these discussions, it was more at informal meetings. There were all sorts of meetings within the Health Service which had no statutory standing. They are simply set up by colleagues to discuss local difficulties and there are national professional bodies as described in the next paragraph

41. In 2004 – 2005 I was Chairman of the British Committee for Standards in Haematology, a creation of the British Society for Haematology. That Committee started as a way of spreading standard practice and began with standards in the laboratory. It became more interested in the clinical side as time went on. When I was the Chair, I spent some time discussing guidelines with UKHCDO and trying to have them adopted. The British Committee for Standards in Haematology was a very influential Committee and the guidelines were published in the British Journal of Haematology. If one did not follow the guidelines then there would really need to be a very good reason not to do so.

42. All I can recall about the relative risks of infection from commercially supplied Factor concentrates and NHS Factor concentrates is that there was a difference in risk. I

believe that UK donors were regular, unpaid, UK, NBS blood donors. In terms of the commercial products we often did not know the source of that blood supply. Commercial companies were reticent with information. I do recall that in 1968 when travelling in America, I gave blood as a paid donor to fund part of my travel. From the other donors around me at that time it was clear to me even then that the supply chain could have been contaminated. I often thought about that when people were talking about commercial blood supplies.

43. I definitely asked where commercial blood products were coming from and there was a general concern amongst colleagues about it. My way of keeping up to date with scientific and medical developments and knowledge was to read the British Medical Journal, The Lancet, The New England Journal of Medicine and the British Journal of Haematology. Publication of the American Society of Haematology, "Blood", was another publication I regularly read.

Hepatitis

44. I knew the risk of Hepatitis B as I was exposed to it as a Senior Registrar. A contaminated bag of platelets from a Hep B positive donor had burst and sprayed me whilst I worked at the Royal Hospital for Sick Children, Glasgow, in the late 1970s. These products were supplied in advance of the donor being tested because of the urgent need to treat patients. I had to be tested and was fortunately negative so I knew about the risk of Hepatitis B from early in my career. We all knew that Hepatitis B could be fatal. I am not sure when the risks of Hepatitis C became known to me although I am fairly sure that the severity of non-A and non-B hepatitis (which was later renamed Hepatitis C) was not clear until later in the 1980s when it did become clear that it could as bad a Hepatitis B.

45. Part of my training was to be aware of Hepatitis B and my knowledge of it developed over time by reading and discussing it with colleagues.

46. I have already referred to my attempt to reduce the use of blood by the surgeons during operative procedures. I also stopped the wholesale use of fresh frozen plasma unless the treating doctors could demonstrate a real difficulty with a patient's clotting. It was being routinely used for hypo-volaemic or shocked patients. This caused some difficulties with some colleagues from time to time but I eventually persuaded them to use saline instead of blood products for volume replacement. For me, reduction in use of blood and blood products was a key factor in reducing risk to patients. Other ways to

reduce risk included the use of appropriate products. For severe Haemophilia A we would use Factor VIII, for moderate Haemophilia A we would use cryoprecipitate (unless it was a severe bleed) and for mild Haemophilia A we used DDAVP or cryoprecipitate. My recollection is that I always managed to get Factor VIII for severe bleeds in patients who would have died without it.

HIV and Aids

47. My knowledge and understanding of HIV (HTLV III) and Aids developed over time, as it was written up. I would read about it and discuss it with colleagues. It was an established process of developing knowledge. All of this knowledge was acquired through reading paper journals (there were no online journals) and discussions with colleagues at meetings. I have no specific detail of when I first became that there might be an association between Aids and the use of blood products.

48. I cannot recall any specific enquiries carried out by me or within the Plymouth Haematology Department in relation to the risks of transmission of HIV or Aids. Patients were seen frequently to discuss all aspects of their care and it is likely that these discussions would have included the risks of viral transmission through the use of blood products but I cannot recall any such specific discussions.

Response to Risk

49. I did explain and inform my patients that there was a risk in using blood products. I do not remember having any information sheets to provide but that might have changed with the arrival of Dr Noakes. I do not recall. We may well have had literature from sources such as the Haemophilia Society and if we had then we would distribute it. I cannot recall that. All information received for patients would be passed to patients.

50. The general approach to information for patients was to give as much as you can even when that information is painful. People must be told about the risks before being able to give informed consent. In the past I was known to be frank with patients with all information relevant to their care.

51. I do not recall whether or how I responded to the letter from Professor Bloom and Dr Rizza (HCDO0000270_004) as I do not actually remember getting the letter. At that point I was still trying to get home grown product and I suspect I was sceptical about the

content of the letter. They were quite right in their comments on Factor IX. I do not ever recall running out of NHS Factor IX concentrate.

52. I was sceptical about their comments on Hepatitis. One of my colleagues had been sprayed by plasma from a Hepatitis B positive patient and became very sick with Hepatitis B. He survived it and fortunately cleared the virus.

53. I do not recall that their letter changed my policy and use of blood products as evidence was evolving at that time (June 1983) and to change policy in the face of uncertainty would have been unwise.

54. In relation to reduction of risk of infection of HIV from Factor concentrates we tried to use home grown product wherever we could and to limit the concentrate to severe Haemophilia A patients or patients with moderate Haemophilia A suffering from severe bleeds. In those patients to not treat would be unacceptable, and potentially fatal.

55. We did at the Plymouth Haematology Department continue to use Factor concentrates to treat patients after we became aware of the possible risks of infection but only where absolutely necessary.

56. I am afraid I do not recall when Plymouth Haematology Department began to use heat treated Factor products and I cannot recall where we started in terms of the categories of patients. We did use it as soon as it was available.

57. We did use cryoprecipitate where needed to control bleeding. It was not a question of there being a risk of infection but a question of it being treatment that the patient required and that treatment working. We probably discussed the use of cryoprecipitate in severe cases of Haemophilia A or in severe bleeds, but I cannot recall that.

58. The inquiry has provided me with the letter from Professor Davies, Regional Director of Public Health, Director of Health & Social Care East Midlands, in relation to issues around funding (DHSC0041329_002). I was asking her for a clear commitment to provide more funds for both blood and blood products and consultants. That letter does not particularly assist me in considering what could or should have been done differently by other clinicians or other organisations. I do not know what was going on elsewhere but I am very clear that the Department of Health should have followed Lord Owen's request for self-sufficiency in blood and blood products.

Section 4: Treatment of patients at PHC

Provision of Information for Patients

59. I do not recall what information was provided to patients about alternatives to treatment with Factors concentrates. When we knew of the risks in relation to those treatments, we did tell the patients. These risks included Hepatitis B, Hepatitis C and HIV.

60. I do not recall home treatment or home therapy being a trigger to give extra information to patients. They needed information about the risk wherever the treatment was being given.

HIV

61. I told patients face to face in person if they had been infected with HIV. I cannot remember how many I had. I would see them all individually and discuss it with them. It had to be a consultant who spoke to the infected. These were patients I was seeing regularly, and it would not be appropriate to delegate that.

62. Patients were tested for HIV after they had given their consent to that testing. We gave pre-test counselling which covered the consequences of a positive test. I do not recall any patients refusing to be tested.

63. When patients were tested positive I am fairly sure they were told how significant it was and that they had to inform their spouse or partner. They were told that they should not have unprotected sex and if they had had unprotected sex then that partner needed to be told about the diagnosis. They were certainly not told to keep the information secret.

64. The possibility of transmission of HIV to partners/family members would be discussed face to face. Testing and counselling would have been offered.

65. I cannot recall specifically what partners or family members were told about risk. They would certainly have been told about the risk of unprotected sex if they were in a relationship with the patient.

66. Post-test counselling was carried out by me if required. Again, as consultant it was important that I saw the patients. Patients would be told of the effects of the diagnosis. I do recall the patient mentioned in the letter between me and Professor Bloom

(WITN2406014) and there was some uncertainty about his knowledge of his diagnosis before I saw him.

67. Generally, patients would be seen by a consultant post-positive test on several occasions and certainly as often as they wanted to be.

68. Patients did raise concerns about commercial Factor VIII concentrate because of the potentiality of Aids. Some may have wanted commercial concentrate as they did not trust the National Blood Service products. They also wanted whatever was available when they had a bad bleed. Patients wanted the bleeds stopped, and they knew how serious it might be in terms of outcome if the bleeds were not stopped.

69. I cannot recall how many patients at the Plymouth Haematology Department were infected with HIV in consequence of the treatment with blood products. As far as can be established from a letter I have been provided with between me and the Product Services Manager at the Blood Products Laboratory (BPLL0010533) we had no children infected with HIV.

Hepatitis B

70. I do not recall patients infected with Hepatitis B in consequence of their treatment with blood products being informed of their infection and how.

71. I am afraid I do not recall how many patients at Plymouth Haematology Department were infected with Hepatitis B or NANB/Hepatitis C. If patients were infected with a Hepatitis virus then they would be informed. It would be the consultant who met with them and informed them.

72. I do not recall when Plymouth Haematology Department began testing patients for Hepatitis C or over what period of time tests were first carried out. If they were found to be Hepatitis C positive then they would be spoken to face to face, individually by the consultant specifically to discuss a positive result.

73. I do not recall what information was provided to patients infected with Hepatitis C.

74. I am afraid I do not recall the steps taken by the Plymouth Haematology Department or me to trace patients treated with blood products and to invite them to be tested.

75. I do not recall how many patients at the Plymouth Haematology Department were infected with Hepatitis C in consequence of their treatment with blood products.

76. The results of testing for HIV and Hepatitis would have been notified to patients immediately. There were no delays in us informing patients of their test results.

77. I was very clear that HIV, Aids, Hepatitis B and Hepatitis C were all transmissible viruses. As soon as we knew about the risk and indeed infection by those viruses we would talk about risks to families. The sooner we did that the better.

78. I do not recall what information was provided to patients about the risks of other infections.

79. Patients would have been told that all of these viruses were extremely transmissible viruses and there were risks of infecting others.

Consent

80. I do not recall now how often blood samples were taken from patients attending Plymouth Haematology Department. Any blood samples were taken to check viral status or Factor levels. Patients were always asked for consent before they gave blood. I do not recall Plymouth Haematology Department having a bank of stored samples.

81. On one occasion I recall treating a patient with blood products without gaining their consent. The patient was in the Accident & Emergency Department on a Saturday afternoon when I got a call to go to see him. He had severe Haemophilia. I was only told because A&E were asking for plasma. The patient had chest injuries and had probably ruptured his spleen. I had to give that patient Factor VIII without permission because he was unconscious, his next of kin could not be contacted and he was at risk of death without it. I cannot remember when that was although I think it was after Dr Copplestone and Dr Hamon had arrived, most likely after 1993.

82. On another occasion I was called to A&E to treat a child with Von Willebrand Disease who had been circumcised without prior discussion with the Haematology department. A&E could not stop the bleed. My recollection is that child was given cryoprecipitate, and although the child would not have consented I expect I would have obtained parental consent.

83. It is highly unlikely that any patients under my care were tested for HIV or Hepatitis without express and informed consent. I do not know where that consent would be recorded other than in patients' individual notes and the records of the microbiology department.

84. I do not recall any PUPS being treated by me.

85. So far as I recall I have not been involved in any research studies at Plymouth Haematology Department in so far as relevant to the Inquiries terms of reference.

86. Patients were never involved in research studies without their express consent and patient data was not used for the purposes of research or any other purposes without their express consent. Patient data was sent to the Blood Products Laboratory by way of the Oxford returns. I cannot remember if the patients knew about that or not.

87. I have not published any articles or studies relevant to the Inquiries terms of reference apart from being named in the submission of one letter to the British Medical Journal in 1994. That is referenced in Dr Copplestone's CV (MHRA0007582_008) at page 12.

Treatment of Patients who have been infected with HIV and/or Hepatitis

88. Patients with HIV and Aids were treated by two Respiratory physicians at Plymouth District General Hospital. They tended to get chest infections and those with chest infections would be referred on. I do not recall sending patients to other specialists except for specific problems. I do no recall treatment options offered over the years or what information was provided to patients about risks and benefits. I do not recall the follow up of patients infected with HIV.

89. Patients with Hepatitis B would be dealt with by a Gastroenterologist with an interest in liver disease, certainly latterly. I do not remember any other treatment options.

90. Similarly, patients with Hepatitis C would also be managed by a Gastroenterologist with an interest in liver disease. I do not recall when he was appointed and I do not recall any other treatment options.

91. I did not treat or care for children infected with HIV or Hepatitis. I do not recall there being any but in any event they would be under the care of a Paediatrician.

92. When available, patients infected through blood products would be referred to Counsellors, Psychologists or Social Workers. They did become available in later years in my time at Plymouth Haematology Department and they were used.

93. I do not recall any funding from the Department of Health & Social Security to assist with counselling of patients.

94. I have no recollection of whether we asked for or got funding for the treatment of people infected with HIV or Hepatitis C and I do not recall being involved in any clinical trials for treatments of those viruses.

Records

95. If we had any deaths we would discuss those with the Coroner so that the Death Certificate would meet with his satisfaction but I do not recall any deaths of patients infected with HIV or Hepatitis. The retention policies for the medical records at Plymouth Haematology Department were the policies of Plymouth Health Authority. I never retained separate files for any of my patients and I never took notes home.

Section 5: UKHCDO

96. I went to one or two annual meetings of UKHCDO. I was never involved in their work other than the one time I tried to persuade the UKHCDO to allow the British Committee for Standards in Haematology to adopt their guidelines referred to above. My recollection is that UKHCDO would send out minutes of their various meetings and published guidelines that they wrote in a clotting journal. The guidelines had no statutory standing and the UKHCDO body was set up and run by the profession.

Section 6: Pharmaceutical companies/medical research/clinical trials

97. I do not recall any involvement at all with any pharmaceutical company in relation to research into the development or use of blood products. I cannot recall giving any pharmaceutical company any patient's data and I do not recall any financial incentives of payments for any services from pharmaceutical companies involved in the manufacture or sale of blood products. I did not undertake research for or on behalf of a pharmaceutical company.

98. I recall giving information about patients to a pharmaceutical company in the lengthy investigation of the pharmacokinetics and clinical effectiveness of itraconazole, an antifungal agent, during treatment for acute leukaemia. This has no relevance to the remit of the enquiry. The company was Janssen Pharmaceuticals. Any financial support for the study was declared to PHC through its trust funds and any fees paid directly to me were declared to HMRC.

99. Similarly I recall submitting information about patients receiving depsipeptide, an anti-T cell agent against T cell lymphomas, to Gloucester Pharmaceuticals with the same financial arrangements.

100. The majority of my clinical research work was in MRC trials of the treatment of leukaemia. Any laboratory research was funded either by competitive grants or by a local charitable fund and was mostly in the investigation of cellular interactions in chronic lymphocytic leukaemia. Neither of these areas of research involved transfer of data to pharmaceutical companies. I do not keep any documents about these studies.

101. I have no recollection or records of any other studies in which details of patients may have been given to pharmaceutical companies.

102. The regulations or guidelines for involvement with a pharmaceutical company would have been followed, and those guidelines would have been whatever was required by the Plymouth Health Authority.

103. Any funding from any company would have been declared to my employer and personal remuneration to HMRC in the normal way.

Section 7: vCJD

104. I became aware of the risks of transmission of vCJD by way of my ongoing reading and discussions with colleagues. I am afraid I do not remember exact dates. I do not recall any patients having vCJD in Plymouth Haematology Department.

105. I do not recall any involvement in decisions and steps taken in relation to potential vCJD exposure, including offering counselling, support and/or advice to all those potentially exposed.

106. I do not recall consideration of the public health perspective of the risks of receiving transfused blood or blood products, at Plymouth. There may have been consultations or discussions with the then local Director of Public Health but I cannot recall that.

Section 8: The financial support schemes

107. I do not think we had any involvement in the financial support schemes. We may have helped the patients but I do not recall. Letters would be written if requested of course and we would provide the appropriate clinical detail with the patient's permission.

108. My recollection is that patients were very well aware of these sources of funding so there was not a policy of guidance for staff to mention them to the patients.

109. Any information we provided to the Trusts and Funds about or on behalf of patients seeking assistance would have been whatever the patients permitted us to give to them, and at their request.

Section 9: Look-back and tracing exercises

110. I cannot recall the look back and tracing exercises carried out although it appears we did them.

Section 10: Other Issues

111. I do not recall any specific complaints relevant to the Inquiries terms of reference.

112. I hope the Inquiry will establish what happened to papers retained for some time by the Department of Health. I have a recollection that I was visited in Plymouth by three Civil Servants or Lawyers representing the Department of Health & Social Security in the 1980s. They went through all of my papers and expressed surprise that our concerns in relation to blood supplies were kept well documented in the correspondence I had retained and the copies of papers from medical journals. I understood this was happening across England and Wales. My recollection is that they removed some papers which were never returned but I am not clear at this great remove. I do not recall receiving any written report from the Department of Health about that visit. The fact that the department responsible for the overarching care of patients destroyed papers, when the Scottish Office did not do that in Scotland, is of great concern to me.

113. It is clear that colleagues in my position had some difficult choices and decisions to make on risk in treating these unfortunate patients. It is however difficult to accept that they are culpable for harm to these patients in the face of the Department of Health's failure to give them what was needed to treat patients with haemophilia. I am concerned that deceased and retired clinicians may be blamed for their actions where they were not given the tools to carry out the job in any other way.

Statement of Truth

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

Signed GRO-C

Dated 25.4.21

Table of exhibits:

Date	Notes/ Description	Exhibit number