Witness Name: Dr David Goff
Statement No.: WITN5423001
Exhibits: None
Dated:
27th Feb. 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR DAVID GOFF

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 January 2021.

I, David Kenston Goff, will say as follows: -

Section 1: Introduction

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

1.1. David Kenston Goff (address known to Inquiry) D.O.B. GRO-C 1939. M.B. B.S. A.I.M.L.S. F.R.C.Path

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. In addition, please explain the capacity in which you attended the meeting of Haemophilia Centre Directors held on 13 November 1978 [HSOC0010549].**

2.1. P.R.H.O posts Newcastle, Perth (Scotland)	1969 -1970
S.H.O. Paediatrics, Ayr (Scotland)	1970 -1971
R.A.F. Medical Branch	1971 -1978
Hon. Senior Registrar in Haematology R.I. Sheffield	1977 - 1978
Consultant Haematologist, Sunderland Hospitals	1978 - 2004
Part time Consultant Haematologist Sunderland Hospitals	2004 -2009

I attended the meeting of the 13th of November 1978 as a learning experience to try and keep abreast of current theories and practice.

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.**

3.1. Member of the Royal College of Pathology

Member of British Society for Haematology

Member of Association of Clinical Pathologists

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 not provided any evidence to, nor have I been involved in any inquiries, investigations, criminal or civil litigation in relation to any of the matters referred to.

5. **The questions below focus on your time as consultant at Sunderland Royal Infirmary. If you have information relevant to the decisions, policies and practices at other institution(s) where you previously/ subsequently worked and which are relevant to the Inquiry Terms of Reference, please set them out.**

5.1. I have no information relevant to the decisions, policies and practices of other institutions.

Section 2: Decisions and actions of the Haemophilia Centre at Sunderland Royal Infirmary

6. **Please:**

   a. **Describe the roles, functions and responsibilities of the Centre during the time that you worked there.**

   b. **Outline the facilities and staffing arrangements for the care of patients with bleed 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.**

6.1. Upon appointment in1978 I joined Dr. A. McKenzie (who did non clinical work). The first Clinical Haematology Unit was then set up in Sunderland. It started as a 6 bedded unit with 2 out patient rooms gradually expanding to 14 beds, 3 outpatient

rooms and a day care centre for chemotherapy, venesection, plasmapheresis etc. Staff included 1 S.H.O. (Medical Rotation), 1 Registrar or Senior Registrar (Regional Haematology rotation). All this was shared with a Consultant colleague Dr. Peter Carey who joined me about 1985.

7. **Please describe:**

   a. **Your role and responsibilities at the Centre and how, if applicable, these changed over time.**

7.1(a) The management role of the Unit was rotated between my colleague and me biannually from 1985.

   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(b) There was no Haemophilia Unit in Sunderland. Any patient presenting or newly diagnosed was immediately referred to Newcastle Haemophilia Centre for further care. Acquired bleeding disorders were a regular presentation or complication of treatment. Appropriate treatment was administered as necessary.

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. There was no clinical unit before my appointment and no patient with an hereditary bleeding disorder was treated at Sunderland.

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, 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. The only blood products ever used in Sunderland were provided by the Regional Blood Transfusion Service. These included whole blood, concentrated red cells, platelets, fresh frozen plasma, cryoprecipitate. Factor concentrates were not held in Sunderland. All decisions about the use of blood and its products were made by my colleague Dr. Carey and I. Always supplied by Regional Blood Services.

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. There was no contact between blood supplying companies and Sunderland.

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 Regional Blood Transfusion Service was our sole supplier.

12. **Please describe your relationship/the Centre's relationship with the local Regional Transfusion Centre. Please explain whether the Regional Transfusion Centre supplied the Centre with cryoprecipitate and with NHS factor concentrates and whether (and if so to what extent and with what frequency) there were shortages or other difficulties in obtaining sufficient supplies. Please confirm whether the Regional Transfusion Centre had any involvement in supplying commercial factor concentrates or whether those were obtained from the pharmaceutical companies directly.**

12.1 There was a good and close relationship with the Regional Blood Transfusion Service. They supplied us with Cryoprecipitate as necessary but no factor concentrates.

13. **How were decisions taken as to which products to use for individual patients? What involvement did you have in such decisions? To what extent, if at all, were patients offered a choice as to which products to use?**

13.1. See answer to question 9.

14. **To your knowledge, 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?**

14.1. I had a background knowledge of the use of alternatives. At the time I was not aware of any that would be relevant to our clinical practice.

15. **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?**

15.1. Cryoprecipitate was more readily available than fibrinogen concentrate but was only prescribable with Consultant Haematologist approval. Home and prophylactic treatments were not prescribed in Sunderland.

16. **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?**

16.1. Not given.

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

17.1. No patients were ever seen as far as I can recall.

18. **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?**

18.1. I was not aware of any patient becoming infected. Regular liver function tests would be carried out as part of treatment and follow up for our patients.

Section 3: Knowledge of, and response to, risk

General

19. **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?**

19.1. There was no specific structure set up to consider risks of infection. A general awareness was promoted amongst the medical community such that an auto transfusion technique was offered to cold surgical cases.

20. **What was your understanding of the relative risks of infection from (i) the use of commercially supplied blood products, and (ii) the use of NHS blood products?**

20.1. I was aware that commercial products were more dangerous than NHS blood.

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

21.1. Weekly Regional Haematology meetings.

21.2. Attendance at national and international symposia.

21.3. Read relevant articles in: a) 21.3.1. B.M.J. b) N.E.J.M c) B.J.H. d) Blood e) Clinics in Haematology f) Lancet g) J.C Path h) Vox Sanguinis.

Hepatitis

22. **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?**

22.1. There was awareness of the risks of hepatitis and I knew that blood was screened for Hepatitis B. My year at Sheffield exposed me to the problem of non A and non B Hepatitis.

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

23.1. The knowledge would have been gained through discussion with colleagues, sometimes from varying specialities in the Medical community and reading medical journals.

24. **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)?**

24.1. There was always a strict central control over the use of blood and blood products and this was maintained.

HIV and AIDS

25. **What was your knowledge and understanding of HIV (HTLV-III) and AIDS and in particular 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. I learned of the possibility of HIV infection by transfusion by journal reading and attendance at symposia specifically related to A.I.D.S.

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

26.1. I cannot recall the exact date when I first became aware of the possibility of H.I.V. transmission.

27. **What, if any, enquiries and/or investigations did you and/or the Centre carry out or cause to be carried out in respect of the risks of transmission of HIV or AIDS? What information was obtained as a result?**

27.1. Because only N.H.S. products were used and no factor concentrates were given, no investigations were undertaken.

Response to risk

28. **Did you 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?**

28.1 No specific steps were taken to inform patients about the risks in our unit. Any transfusion of blood and its products was considered essential to the treatment of acute cases. As mentioned in question 19, the offer of auto transfusion was given to cold surgical cases.

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. No specific steps were taken and treatment remained unchanged.

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 No factor concentrates were ever given in Sunderland.

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. See Question 30 above.

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

32.1. This was not a question that I had to consider seriously but in general terms sooner would be better rather than later.

33. **Please consider the minutes from the fourteenth meeting of the UKHCDO held on 17 October 1983 which you attended [PRSE0004440]. The increasing issue of patients refusing to use commercial factor VIII concentrates was raised and attendees discussed whether to revert to using cryoprecipitate, which in some areas was in greater supply than commercial concentrates. After discussion it was agreed that patients should not be encouraged to return to cryoprecipitate for home therapy but should continue with NHS or commercial concentrates [page 10 of PRSE0004440]. Did you agree with the consensus of the meeting on this issue? Regardless of what was discussed at the meeting, 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, how was it determined which patients would be offered a return to cryoprecipitate and which would not? If not, why not?**

33.1. I cannot recall precisely my sentiments at that meeting. Decisions made did not impinge upon my clinical practice.

34. **Do you consider that your decisions and actions, and those of the Centre in response to any known or suspected risks of infection were adequate and appropriate? If so, why? If not, please explain what you accept could or should have been done differently.**

34.1. Our practice remained unchanged.

35. **Looking back now, what decisions or actions by you and/or by the Centre could and/or should have avoided, or brought to an end earlier, the use of infected blood products?**

35.1. I don't think we could have made significant changes.

36. **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?**

36.1. It seemed to me at the time that England should have been self-sufficient in the production of blood concentrates just as Scotland allegedly was. The Haematology community should perhaps have pressed harder.

37. **Do you consider that greater efforts could and/or should have been made to inactivate viruses in blood or blood products prior to 1980? If so, who should have made or coordinated those efforts and what steps should have been taken and when? If not, why?**

37.1. I have insufficient knowledge to be able to answer this question.

Recombinant clotting factor

38. **Please consider the enclosed documents regarding funding from the Department of Health for recombinant clotting factors in England [HCDO0000109_038 and HCDO0000254_880]. Please explain any involvement you had with efforts to obtain recombinant blood products for patients with haemophilia. What, if any, difficulties were encountered and why?**

38.1. I had no involvement.

39. **In your view, should recombinants have been made available to all haemophiliacs earlier than they were? if so, when?**

39.1. Insufficient knowledge.

40. **In relation to the Centre, when were recombinant products made available to patients?**

40.1. There were no patients with hereditary bleeding disorders.

Section 4: Treatment of patients at the Centre

Provision of information to patients

41. **What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients at the Centre with a bleeding disorder about the risks of infection in consequence of treatment with blood products (in particular, factor concentrates) prior to such treatment commencing? Please detail whether, and if so, how this changed over time.**

41.1. I was not aware if any specific information about infection risks was given to patients in Sunderland.

42. **What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients about alternatives to**

treatment with factor concentrates? Please detail whether, and if so, how this changed over time.

42.1. There were no patients with hereditary bleeding disorders.

43. **What information did you provide or cause to be provided (or was, to your knowledge, provided by others) to patients before they began home treatment/home therapy?**

43.1. See Question 42.

HIV

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

44.1. I cannot recall having done this.

45. **Please describe how and when you learned that patients under your care/the care of the Centre had been infected with HIV.**

45.1. I was not aware of any patient having been infected with HIV.

46. **Please describe the arrangements that were made for the testing of the patients. Were they tested without their knowledge? What if any arrangements were made at the Centre for pre-test counselling?**

46.1. No patients in my care were specifically tested for Hep B, Hep C or HIV.

47. **How and when and by whom were patients told that they had been, or might have been, infected with HIV? Were they told in person, by letter or by phone? Were they seen individually or in groups? What if any involvement did you have in this process?**

47.1. Not applicable.

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

48.1. Not applicable.

49. **What was the Centre's/your 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?**

49.1. Not applicable.

50. **What, if any, information or advice was provided by you or colleagues at the Centre to partners or family members of people who were at risk of infection with HIV or were infected with HIV?**

50.1. None.

51. **What if any arrangements were made at the Centre for post-test counselling?**

51.1. None.

52. **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?**

52.1. a,b,c,d,e and f. None.

53. **Was work undertaken at the Centre to establish the time period during which patients seroconverted? If so, please describe what work was done and what if any conclusions were reached.**

53.1. No.

Hepatitis B

54. **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?**

54.1. None to my knowledge.

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

55.1. None to my knowledge.

NANB Hepatitis/Hepatitis C

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

56.1. Not applicable.

57. **When did the Centre begin testing patients for hepatitis C and over what period of time were such tests first carried out? How, when and by whom were patients informed of their diagnosis of hepatitis C? Were they told in person, by letter or by phone? What if any involvement did you have in this process?**

57.1. None undertaken.

58. **What information was provided to patients infected with hepatitis C about their infection, its significance, prognosis, treatment options and management?**

58.1. None.

59. **When the test for HCV became available, what if any steps were taken by the Centre and/or by you to ensure that all patients who had received blood products were traced and invited to be tested?**

59.1. None.

60. **How many patients at the Centre were infected with hepatitis C in consequence of their treatment with blood products?**

60.1. None to my knowledge.

Delay/public health/other information

61. **Were the results of testing for HIV and hepatitis (of all kinds) notified to patients promptly, or were there delays in informing patients of their diagnosis? If there were delays in informing patients, explain why.**

61.1. Not aware of any tests being taken.

62. **To what extent, if at all, did you/your colleagues take into account the public health implications of HIV, AIDS, hepatitis B, NANB hepatitis and hepatitis C, when taking decisions as to what information or advice to provide to patients or what treatment to offer patients?**

62.1. Not applicable.

63. **What information was provided to patients about the risks of other infections?**

63.1. None.

64. **What information was provided to patients about the risks of infecting others?**

64.1. None.

Consent

65. **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?**

65.1. Blood samples were taken from every patient in every clinic in order to monitor disease status. Verbal consent always requested.

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

No blood was stored long term.

67. **Were patients under your care or under the care of your colleagues at the Centre 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?**

67.1. No factor concentrates were given. Blood products transfused would come under the heading of verbal treatment consent.

68. **Were patients under your care ever tested for HIV or hepatitis or for any other purpose without their express and informed consent? If so, how and why did this occur? What was your approach to obtaining consent for testing? Was their consent recorded and if so how and where?**

68.1. No.

PUPS

69. **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).**

69.1. Not applicable to PUPS.

Look back

70. **Please consider the enclosed letter from Christine Lee addressed to all Haemophilia Centre Directors, regarding HCV testing of exposed patients [GGCL0000074_001]. Were you aware of this letter? If so, what actions were taken by you/the Centre in response?**

70.1. I never received the letter.

71. **Please describe, as far as you are able, any look back exercises that were undertaken to trace recipients of blood products from donors that were later known to be infected with HIV, HBV, HCV or any other blood borne infection. Please describe what this involved and your views of the efficacy of it.**

71.1. None were undertaken.

72. **Did you counsel those of your patients who had been infected, yourself? If so, please provide details.**

72.1. No counselling was undertaken.

73. **Were you involved in any other look back exercises? How successful have they been? What could have been done to improve their efficacy?**

73.1. No.

Research

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

a. **A proposed clinical trial on 8Y Factor VIII, where you are listed as one of the Haemophilia Centre Directors who may take part in the trial [OXUH0000608_002];**

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

c. **An article published in 1996: "Importance of age at infection with HIV-1 for survival and development of AIDS in UK haemophilia population" [HSOC0002661];**

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

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

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

g. **A report titled 'HIV and Mortality in the UK Haemophilia Population: Demonstration of a Casual Relationship' by UK**

Haemophilia Doctors' Organisation [Marked Confidential Draft - Not for citation], 31 July 2002 [HCDO0000572]

Please set out what, if any, involvement you had in them.

74.1. I was not involved in any clinical trial or in any research involving haemophiliac patients.

75. **Please list all other research studies that you were involved with during your time as a Consultant at the the Centre 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 ethical 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.**

75.1. None.

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

76. **How was the care and treatment of patients with 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 to those infected with HIV?**

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?**

76.1. There were no known patients infected with HIV caused by blood Transfusion treated in Sunderland.

77. **What follow-up and/or ongoing monitoring was arranged in respect of patients who were infected with HIV?**

77.1. See question 76.

78. **How was the care and treatment of patients with hepatitis B 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?**

78.1. There were no known patients infected with Hep B caused by blood transfusions.

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

79.1. See question 78.

80. **How was the care and treatment of patients with NANB hepatitis 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?**

80.1. There were no known patients infected with non A or non B caused by blood transfusion.

81. **How was the care and treatment of patients with 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?**

81.1. There were no known patients infected with Hep C caused by blood transfusion.

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

82.1. See question 81.

83. **What arrangements were made for the care and treatment of children infected with HIV or hepatitis? How did those arrangements differ (if at all) from the arrangements made for adults?**

83.1. None.

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

84.1. None.

85. **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?**

85.1. No.

86. **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?**

86.1. See Question 85.

87. **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.**

87.1. None.

Records

88. **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.**

88.1. There was no policy. There were no inquests held about any patient under my care.

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

89.1. All case notes were permanently stored as far as I was aware.

90. **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?**

90.1. No in both cases.

91. **Do you still hold records or information about any of your patients? If so, explain why and identify the records or information that you still hold.**

91.1. No.

Section 5: Self-sufficiency

92. **In January 1975 the Health Minister announced to Parliament special finance to boost UK production of blood products, with the objective of becoming self-sufficient in the next few years [DHSC0000274].**

    a. **Were you aware of this announcement at the time?**

    b. **What role, if any, did you play in any arrangements made in any organisation, in response to that announcement?**

92.1. I was not in this country at the time.

93. **What did you understand the term "self-sufficiency" to mean in 1974/1975? In particular, did you understand it to mean self-sufficiency in providing Factor VIII blood products prophylactically, or solely in response to bleeding incidents?**

93.1. I cannot recall contemplating this topic but would have thought it was self-evident.

94. **Did your understanding of what was meant by "self-sufficiency" change at any time? If so, when and why?**

94.1. No.

95. **At the ninth meeting of the UK Haemophilia Centre Directors on 13 November 1978, which you attended, the view was expressed that it was dangerous to rely on commercial concentrates and the UK should be self-sufficient, without relying on foreign materials [page 15 of HSOC0010549]. Did you share this view? If so, what in your opinion were the specific dangers of relying on commercial concentrates? Were you party to any further discussion on this issue?**

95.1. I did agree with this view because of the dangers with paid donors. I had no further involvement.

96. **To what extent do you consider that England and Wales were effectively self-sufficient in blood products for the period with which the Inquiry is concerned, in the sense that clinicians had sufficient NHS products to meet the demand for such products? Why (if this is your view) was self-sufficiency not achieved? Do you consider that more could have been done to achieve self-sufficiency? If so, what?**

96.1. I was not party to any consideration of this question. I was always able to give appropriate blood products provided by the R.B.T.S. but was aware anecdotally that factor concentrates were in short supply. I am unable to answer questions about self sufficiency.

Section 6: UKHCDO

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

97.1. I believe I only ever attended 2 U.K.H.C.D.O. annual meetings 1978 and 1983. I was not involved in any other way.

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

a. **The purpose, functions and responsibilities of UKHCDO, as you understood them.**

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.**

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

98.1. I was never a member of the U.K.H.C.D.O.

Section 7: Pharmaceutical companies/medical research/clinical trials

99. **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?**

If so, please provide details.

99.1. I have had no contact whatsoever with blood product pharmaceutical companies.

100. **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?**

100.1. See question 99.

101. **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?**

101.1. See question 99.

Section 8: vCJD

102. **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?**

102.1. I believe it was in the mid 1990's that vCJD raised its ugly head in connection with possible blood transmission. I cannot recall how this came to be known to me.

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

    a. **What steps were taken to inform patients about possible exposure to vCJD and to provide information to them about vCJD?**

    b. **What steps were taken to arrange for counselling, support and/or advice to be offered to patients who were being informed that they might have been exposed to vCJD?**

103.1. I had input into the provision of patient information but was not aware of any patient counselling.

104. **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?)**

104.1. I had no input into Public Health affairs.

Section 9: The financial support schemes

105. **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?**

105.1. I had no involvement with any trusts connected with support for patients who had become infected.

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

106.1. I am unable to answer this question.

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

107.1. Not that I was aware of.

108. **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?**

108.1. None.

109. **Based on your own dealings with any of the trusts or funds and/or based on your knowledge of the experiences of your patients in relation to the trusts or funds, do you consider that the trusts and funds were well run? Do you consider that they achieved their purposes? Were there difficulties or shortcomings in the way in which they operated or in their dealings with beneficiaries and applicants for assistance?**

109.1. Not applicable; please see 105 answer.

Section 10: Other Issues

110. **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.**

110.1. I was not aware of any complaints made about me.

111. **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.**

111.1. I have no further comments or information to give.

Statement of Truth

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

Signed..... GRO-C .....

Dated .....27 Feb. 2021.....