Witness Name: Dr Gary Benson
Statement No.: WITN3082044
Exhibits: **WITN3082045- WITN3082053**
Dated: 29th March, 2024

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR GARY BENSON**

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I provide this statement in response to the request under Rule 9 of the Inquiry Rules 2006 dated 15 August 2023.

I, Dr Gary Benson, will say as follows: -

## Section 1: Introduction

1. My name is Dr Gary Benson. My professional address is NI Haemophilia Centre, Belfast City Hospital, Lisburn Road, BT9 7AB. My date of birth is known to the Inquiry. My professional qualifications are as follows; MB, BCh, BAO, FRCP, FRCPath.

2. I have held the following positions:-
    - JHO Aug 1999-July 2000: Altnagelvin Hospital, Western Health and Social Care Trust.
    - SHO Aug 2000-July 2001: General Medicine, Altnagelvin Hospital, Western Health and Social Care Trust.
    - SHO Aug 2001-Jan 2002: General Medicine, Causeway Hospital, Northern Health and Social Care Trust.
    - SHO Feb 2002-July 2002: Clinical Oncology, Belvoir Park Hospital, Belfast Health and Social Care Trust.
    - SHO Aug 2002-Jan 2003: Clinical Haematology, Belfast City Hospital, Belfast health and Social Care Trust.

- Specialist registrar Feb 2003-Jan 2007: Haematology, Belfast City Hospital, Belfast Health and Social Care Trust.
- Specialist registrar Feb 2007-Jan 2008: Haematology, East Of Scotland Haemophilia Comprehensive Care Centre, Royal Infirmary Edinburgh.
- Consultant Haematologist with a specialist interest in disorders of haemostasis: Feb 2008 – present, Belfast City Hospital, Belfast Health and Social Care Trust. This post includes the role of Director for the NI Haemophilia Comprehensive Care Centre in leading and delivering the care to patients in NI with congenital and acquired bleeding disorders. The majority of work revolves around those who attend the adult centre but also undertaken a clinic alongside the paediatric haematologist.
- I am the laboratory lead for specialty coagulation and run the regional specialty coagulation laboratory for NI.
- I am the Clinical Director for Blood Sciences within the Trust.

## Section 2: Responses to criticism by Witness W2778

***Preliminary remarks***

3. I have received a statement from the Infected Blood Inquiry made by Witness W2778 dated 26 June 2023. I initially received a copy of the statement unredacted, and subsequently the Inquiry provided a version to which redactions have been applied in respect of matters which fall outside the Inquiry's Terms of Reference.

4. Further to my oral evidence to the Inquiry on the 1st April 2021 and my written statement, I wish to address the professional criticisms made in W2778's witness statement pertaining to the treatment of her two brothers when under my care at the Belfast Haemophilia Clinic.

5. At the outset, I wish to state in the clearest terms that the allegations made in these statements, regarding my personal integrity and professional competence are totally unfounded. Witness 2778 has alleged that I have set out to mislead the Inquiry both in my written statement and in my oral evidence. She also alleges that I falsified medical records and knowingly engaged in deception with the intention of causing harm to an individual or group of individuals. These are grave allegations. I absolutely and categorically refute them.

***Witness 2778's complaint to GMC***

6. Shortly before I gave my oral evidence to the Inquiry in late March 2021, I received notification of a referral having been made to the General Medical Council by Witness 2778 in relation to my conduct and professional care of her brothers and that a preliminary investigation was being opened. I subsequently received notification by email on 18th June 2021 from Helen Tebbey, GMC Investigation Officer, advising me that the investigation had concluded and that no further action was being undertaken.

***Witness 2778's allegations of incorrect dosages of clotting factor***

7. The witness has also raised issues throughout her statement in relation to my management of haemophilia and specifically in relation to the dosing of clotting factors as per my prescriptions. This had previously been raised during a face-to-face meeting with Witness 2778 and two other parents of young men attending the centre. At this meeting, Witness 2778 stated that during a phone call with Liz Carroll, Chief Executive of the UK Haemophilia Society, she had been informed that the dosing to her son was 50% of what it should have been and that this was very unusual. Witness 2778 shared this information with the other two parents in attendance who were very distressed. She also shared it on the social media pages of the UK Haemophilia Society.

8. I paid close attention to what Witness 2778 had said and discussed it with the service manager for Cancer and Specialist Medicines. A meeting was then arranged with Liz Carroll and a trustee of the Haemophilia Society to discuss the issues Witness 2778 had raised. Following this meeting I received an apology letter from Liz Carroll. The letter contained clarification of the conversation Liz Carroll had with Witness 2778 and confirmed that at no time had she (Liz Carroll) criticised or advised that dosing of clotting factor concentrate was too low. The letter also stated that the use of the Society's social media was inappropriate and confirmed that the post had been deleted albeit it had already been commented on and widely seen by local patients. I refer to correspondence from Liz Carroll, UK Haemophilia Society dated 20th February 2019 **(WITN3082045)**

***Criticisms contained in Witness 2778's redacted written statement***

9. I have fully supported the Inquiry from its inception and continue to do so. I therefore welcome the opportunity to provide a further statement in response to the criticisms

made by Witness 2778. My attention has been drawn specifically to criticisms found in the following paragraphs of Witness 2778's redacted written statement:

- Paragraph 62, page 14.
- Paragraph 85, page 19.
- Paragraphs 99-100, page 21
- Paragraph 113, page 24
- Paragraphs 134-135, page 28
- Paragraphs 143-160, pages 30-34
- Paragraphs 186-187, pages 39-40

I will deal with each of them in turn. For ease of reference and for avoidance of doubt as to the nature of the allegations I am refuting, I have reproduced the relevant sections of Witness 2778's statement verbatim.

***Paragraphs 62, page 14***

***62 In Dr Benson's oral evidence to the IBI, he said that they had access and used 'HaemTract' in Northern Ireland which as far as I'm aware is not true. The 'HaemTract' only came into use in March 2021.***

10. This statement is incorrect. An external quality review of the Adult Service in Northern Ireland by the West Midlands Group in October 2019, highlighted the lack of Haemtrak usage. Northern Ireland worked alongside CMU to address the lack of Haemtrak and by September 2020 we had joined the national home delivery contract with the first patients being recruited from that time.

***Paragraph 85, page 19***

***85. On 1 April 2021 Gary Benson misled the inquiry during his oral evidence, when he was asked if a patient wished to leave his clinic to attend a different one somewhere else, and the question was posed "how does this work?" He stated "it was easy and you can just leave". This is not true. He knew at that time that he, Caroline Leonard, Cathy Jack and the HSCB were and are currently blocking and refusing Luke, Carla and myself to leave the Belfast Clinic.***

11. This statement is incorrect. I have never blocked any individual or individuals in seeking their care at an alternative provider. Witness 2778 and her two family members were referred, as per their request, to the Haemophilia Centre in St James Hospital Dublin and following the withdrawal of their care from that service, onwards again to the Royal Free Hospital, London.

***Paragraphs 99-100, page 21***

***99. During the year of 2018 my brother Seamus and cousin Michael died from contaminated blood liver cancer. Because of their deaths, we tried to get Eddie the liver scan referral from Gary Benson at his haemophilia clinic; but he wouldn't refer him. Benson continued to state that "his bloods were normal".***

***100. Despite repeated requests and Dr Gary Benson refusing to refer Eddie to the liver unit for nearly all of 2018, Eddie eventuality got an appointment with Dr Cash, Hepatology RVH, on the morning of 28th November 2018. Eddie was given an ultrasound scan, then a consultation with Dr Cash, where Dr Cash told Eddie and myself that the ultrasound looked good and he was happy with it. We were pleased at this especially after Seamus and Michael's deaths, from liver cancer. I asked Dr Cash for a copy, but it was at this point the pleasantries ended and he became irritated, asking "why did we want it?" I explained "for the Infected blood Inquiry, we wanted to get a copy".***

**12.** This statement is incorrect. At no time have I, nor would I, ever knowingly withhold any investigation from a patient. Over the preceding years to 2018, the team had made strenuous efforts to have Mr E Conway attend the regional hepatology service for review of his hepatitis C infection including offering multiple appointments and providing solutions to stated transportation issues with the assistance of our colleague from social services and Mr Conway's aunt. I refer to the outpatient letter dated 9 June 2017 in that regard. **(WITN3082046)**

13. From a review of the relevant medical records, I note referral letters dated 26th February 2016 and 13th April 2018 respectively in respect of Mr E Conway as well as

several updated emails in the interim. These include a referral on 5th May 2017 of all remaining hepatitis C positive patients (which would have included Mr Conway) to the hepatology service for their considered review. **(WITN3082047)**

Mr E. Conway's hepatology outpatient attendance records, prior to 2018, show:

| Appointment date at **hepatology** service | Outcome |
|---|---|
| 01.04.2016 | Did Not Attend |
| 01.09.2017 | Cancelled (Hospital) |
| 06.10.2017 | Cancelled (Patient) |
| 03.11.2017 | Did Not Attend |

Mr E Conway also did not attend an appointment at the hepatology service on 22nd May 2018 as per the correspondence from Dr Cadden to Dr Courtney dated 4 July 2018. **(WITN3082048)**

Consequently, there was no clinical or investigative basis for me to have known that Mr S Conway had advanced liver disease at the material time. I was not able to inform him as there had been no update physical examination, blood results or imaging.

All patients who remained hepatitis C PCR positive were automatically referred to the hepatology team as previously discussed, regardless of anything other than the hepatitis C status.

***Paragraph 113, page 24***

***113. These liver function blood tests that Gary Benson reports at his clinics and states to patients that everything can be seen in the bloods, gives patients a false confidence that their livers are healthy and safe. In my view it is either, clearly not fit for purpose, or deliberately being falsified, in order to 'gaslight' these hepatitis infected patients to a certain death from liver cancer. This has been the fate of Seamus and Michael to date and had we not stepped in would most certainly have been the fate for Eddie.***

14. This statement is incorrect. At no time have I ever stated to any patient that 'everything can be seen in the bloods'. Blood tests undertaken at the time of a patient's outpatient review serve as a marker to note trends and changes over time. These results are interpreted alongside the clinical pattern of the patient on the day and are one aspect of an overall clinical assessment.

***Paragraphs 134-135, page 28***

***134. Dr McDougall had added him to the list in 2017, for 'surveillance'. But this was after his GP at Foyleside family practice, sent him for an emergency scan at hospital. They are trying to show that Dr Benson referred him to be looked at, but this is absolutely not true, as Gary Benson has said Seamus didn't turn up for the 3 appointments a full year and a half before his terminal diagnoses, so I wonder when did he refer Seamus, and if so what prompted this referral?***

***135. Dr Benson never told Seamus (his patient) that he thought he had ALD, the fact that Seamus had no idea he had any liver disease is just disgusting. Furthermore, how did Gary Benson know Seamus had liver disease when Seamus never had a liver scan? The only way he could have known is through the liver function blood test taken at his clinic that he always reported as being normal? I believe that Gary Benson was setting the stage that any liver disease that Seamus would develop by his own doing and not because of the HCV infected blood, which was injected into him as a 6 year old child by his predecessors.***

15. This statement is incorrect. As already stated in paragraph 12 above, I can confirm an email was sent by myself to the hepatology service on 5th May 2017 (**WITN3082047**) detailing all patients who were currently hepatitis C positive, requesting an appointment and follow up.

***Paragraphs 143-160, pages 30-34***

***143. In 2004 he states Seamus didn't attend 7 appointments. But why was he expected or needed to attend 7 appointments in a year? When they usually only offer 2 appointments per year? Nevertheless, Seamus did end up going to 2 appointments in 2004 (WITN2778008; 02/02/04, 11/05/04).***

16. I came into post in 2008 and am unable to answer regarding the practice in 2004.

***144. Dr Benson was sent a letter to Mr Mullally regarding a clinical appointment on 16th June 2008 (WITN2778011; annotations are mine). However, in Dr Benson's statement (WITN3082001), it says that Seamus did not attend on 16th June 2008, even though Dr Benson wrote a letter demonstrating that he did. For instance, if you look at 16/06/2008 (WITN2778011), it states DNA (we believe this means 'did not attend'). Therefore, there could be no trust of what Dr Benson has said in his statement.***

17. This statement is incorrect. As per hospital systems and my previous written statement to the Inquiry dated 13.01.2020, this clinic attendance relating to Mr S Conway has been annotated as Did Not Attend (DNA). There is no corresponding letter detailing the attendance, as there was no attendance. While the referral made to the regional dental service reflected issues raised at the 'recent review' as per the letter, it is important to point out that this does not relate to the day that the clinic DNA occurred because, as just stated, the patient was not in attendance. It is likely that I had utilised the clinic list on the day (which would have included the names of all patients scheduled to attend) to prompt the referral to Mr Mullaney at the regional dental service. Referral did not depend on the patient having attended the clinic on the day.

***145. He definitely did not miss these appointments. I refute Gary Benson notes. The notes state for example, on 18th January 2008 (WITN2778008) it reads DNA for Seamus. However, appointments Seamus did attend were 21/11/08, 02/05/08, 01/07/08, 16/06/08, 15/08/08, 07/08/09, and 02/04/09. But I note that the 06/01/09 date is not included on Gary Benson's list.***

18. I refer back to my initial written statement to the Inquiry dated 13.01.2020 which included the relevant information taken from the hospital records and which set out individually the outpatients' appointments offered to Mr S. Conway and their outcome.

146. ***In 2011, (WITN2778034; WITN2778033) Gary Benson said Seamus did not attend the clinic on 04/10/11 and wrote to Seamus's GP, Dr J.C. Stone, criticising that he failed to attend his appointment. But when I looked at this letter (WITN2778034) I noticed the Hospital number looked different, when I checked it against Seamus's Altnegalvin hospital number they were different. I then noticed at the bottom of this letter a different man's name, H+C no and BCH number.***

The current system used by secretarial staff is different from this historical system. I do not understand as to how the footer is different from the correct patient details used in the text box as well as the body of the text. I can confirm the letter pertains fully to Mr S. Conway. As to why the footer is of a different patient, this query may be best directed through the relevant service within the Trust.

147. ***This was the paper copy of Seamus's medical records we had, so I thought I would check for the same letter on the Infected Blood Inquiry's, Egress copy, the letter was there, however someone redacted the Altnagelvin hospital number with a black marker, and handwritten Seamus's Altnagelvin number below.***

148. ***So not only has Dr Gary Benson manipulated another patient's hospital letter to make it look like it belonged to Seamus, he has in doing this, breached this patient's confidentiality.***

149. ***In Seamus's medical notes titled 'Patient Summary' (WITN2778016 – the handwritten notes are mine), which is dated 16th March 2011, there are numerous references to asterisks on his results. An asterisk demonstrates abnormalities outside of a normal range. From 2011 - 2014 there were signs of abnormalities. So, if it was known then, how was this missed?***

150. ***For example, in a letter from Dr Benson regarding a clinic appointment on 17 February 2011, Benson notes that Seamus had 'severe Haemophilia A complicated Hepatitis C'. Any of Seamus's clinical bloods that we have copies of and all have asterisks against them from as far back as 1980. There are abnormalities shown but nothing was ever done or said, Dr***

***Julia Anderson, on leaving 2006/07 on hand over, said 'Seamus would need his liver kept an eye on due to its condition'.***

***151. There are numerous references to Seamus missing his appointments WITN2778015; WITN2778008; WITN2778009 (handwriting is my own notes). All the blood tests were done in the clinic. If you look at WITN3082008 (Patient attendance summary for Seamus) at entry number 9, on the 12th February 2016 it shows that he apparently didn't attend for over a year? As it shows 'DNA' (presumably 'Did Not Attend'), and only attended in August 2016 for that whole year.***

19. The various allegations contained within the paragraphs set out above are incorrect. To be absolutely clear: I did not alter or "manipulate" another patient 's letter; I did not breach patient confidentiality; and I did not disregard abnormal signs in blood tests. The printed copy of the blood results, as provided to the witness is taken from the Electronic Care Record, which takes a running trend of the liver function tests from ALL sources who have undertaken tests. Blood tests are visible from all clinics, primary care, and Emergency Department attendances during that time and are not unique to the haemophilia clinic attendances. All health care professionals who send blood tests, also interpret the results in line with the clinical issues at the time the testing was required. I have set out below details of blood tests undertaken in respect of Mr S Conway between March 2011 and May 2018. On 3 out of the 18 occasions referenced by Witness 2778 the tests were undertaken as part of the routine haemophilia blood panels. On each of these occasions, the results were within the historical trend.

Furthermore, it will be noted that entry 9 below dated 12.02.16 is coded to Dr Leeson from Foyleside Family practice – a general practitioner.

| | DATE | TIME | SOURCE |
|---|---|---|---|
| 1 | 16.03.2011 | 0140 | ALT A&E |
| 2 | 22.07.2013 | 1734 | ALT A&E |
| 3 | 28.08.2013 | 2225 | ALT A&E |
| 4 | 17.01.2014 | 1509 | ALT HAEMOPHILIA CLINIC |
| 5 | 04.04.2014 | 0930 | ALT TRAUMA/ ORTHO |
| 6 | 15.09.2014 | 0553 | ALT A&E |

| | | | |
|---|---|---|---|
| 7 | 11.11.2014 | 0956 | ALT A&E |
| 8 | 21.11.2014 | 1432 | ALT HAEMOPHILIA CLINIC |
| 9 | 12.02.2016 | 1155 | GP FOYLESIDE |
| 10 | 12.08.2016 | 1458 | ALT HAEMOPHILIA CLINIC |
| 11 | 16.10.2016 | 0800 | ALT A&E |
| 12 | 17.10.2016 | 1015 | ALT ACUTE MED |
| 13 | 12.02.2018 | 1151 | GP FOYLESIDE |
| 14 | 25.04.2018 | 1916 | ALT A&E |
| 15 | 27.04.2018 | 1231 | ALT WARD 1 |
| 16 | 02.05.2018 | 1403 | ALT WARD 1 |
| 17 | 18.05.2018 | 1635 | GP FOYLESIDE |
| 18 | 24.05.2018 | 1419 | GP FOYLESIDE |

***152. This does not explain how they then got his bloods. He is shown that he did not attend from 21st November 2014 - 12th August 2016. It also shows CND (presumably means 'cannot attend'). There are no copies of the appointment letters sent to Seamus to attend these clinics or the reminders and calls, supposedly sent to him.***

20. Appointment letters are generated through the appointments office and paper copies are not entered onto the Electronic Care system – the appointments are recorded on the ECR and coded as to whether they were attended or not. "CND" denotes cancelled on the day

***153. In January 2016, Dr Benson had conversations and wrote notes to Seamus's GP (cc'ing Dr McDougall), saying "again he hasn't turned up and I wanted to speak to him about the conditions of his liver. Hopefully if he turns up next time, I will send him for scans to Dr McDougall." His appointment was in April 2016, he pre-empted and dated the letter for July, and I think he was back tracking on his paperwork. Less than 6 months later, when Seamus did attend his appointment nothing was said by Gary Benson, about sending him for a liver scan or treatment etc. My heart breaks knowing that my lovely brother was terminally ill and obviously suffering and the people he trusted were taking care of him, were in fact working on escalating his death.***

21. This is a particularly egregious allegation and is incorrect. I can locate a DID NOT ATTEND letter for clinic date 26.02.2016, dictated same day and typed on 29.02.2016. In the same year, there is a haemophilia travel letter provided on 12.08.2016 and a further outpatient clinic letter dated 12.08.2016, dictated 15.08.2016 and typed on 16.08.16.

***154. From Dr Benson's exhibit (WITN2778008; WITN2778009; handwriting is my own), it shows 'DNA' regarding not turning up, and some were regarding Dr Judith Anderson, but this was for dentistry not his clinic. I don't know what this has got to do with HCV and Dr Benson's notes. Seamus was signed off from the dental hospital. He has not had access to dentistry. A lot of people were like this. I don't know why Dr Benson was trying to use this against my brother.***

22. This statement is incorrect. Patients living in the North West of Northern Ireland, for their own convenience, had their specialty dental care provided through the dental unit at the Waterside Hospital in Derry/Londonderry. It was and remains routine practice for the Haemophilia Clinic to discuss with the dental unit the specialist dental needs of patients with bleeding disorders and for this to be included in patient notes.

***155. In 2014, Seamus broke two bones in his leg, he was transferred to the Belfast Royal Victoria Hospital, as an inpatient, he was on a ward for 3 weeks, which is managed by Belfast City Hospital Haemophilia Centre, Gary Benson. I know that Dr Benson attended rounds daily as the haematologist, and saw Seamus. This would have been an ideal opportunity to scan Seamus's liver.***

***156. Yet again deliberately missing any and all opportunity to identify and treat his liver cancer, which was liver cancer he developed from decades of untreated hepatitis, even when our local doctors had tried to draw his attention to their concerns of gastric cancer.***

23. Mr S. Conway was admitted under the care of the orthopaedic surgeons at that time to undertake the surgery required in line with the fractures sustained. The haemophilia service, as is standard practice, advised the surgical team as to how to manage the factor replacement therapy required for the surgery to be undertaken safely and with no greater a bleeding risk when compared to a person without haemophilia.

24. I can confirm that I did see Mr S. Conway during his hospital admission – I recollect on at least one occasion during which a sister was present throughout.

25. As stated in my previous written statement dated 13.01.2020-and re-stated in this one – I have never deliberately withheld tests, treatment or investigations from a patient. I have maximised all opportunities in light of the pattern of non-attendance by Mr Conway at the haemophilia outpatient clinic to ensure all health professionals have been aware his non-attendance and to encourage him to engage with the haemophilia service. As all treatment had required a commitment from the individual being treated to attend for regular assessments throughout the treatment phase, it would have been unsafe to provide toxic medication with significant side effects in the absence of a commitment to attend. When Mr Conway was in hospital for management of his complex fractures, it was not the time for treatment of his liver condition to be discussed and started.

26. All hepatitis C positive patients were referred to the hepatology service in May 2017 when non-interferon and non-ribavirin therapy became standard.

***157. In 2014, there were many X-rays on his hips and there was no explanation as to why, I think this was related to bone cancer. This still wasn't properly investigated and should have been sent to see a bone specialist, as a bone lesion was first seen on an X-ray of Seamus's in as far back as 2010, a destructive Iliac lesion was found, it was still there when he was dying in 2018. Gary Benson was always saying he can't be managed outside of the haemophilia clinic and stopping any doctor looking into Seamus. But nothing was done for him. Again, letting him die, and stopping any other clinician interfering.***

27. In 2014, Mr S. Conway was brought to Altnagelvin Hospital by ambulance having fallen and fractured his right neck of femur. Multiple scans were performed – x ray and CT, confirming the fracture with no other abnormality. He was managed by the Western Trust Orthopaedic team on Ward 2 with discussion with the emergency haematology team at the Belfast Trust. This was fully in accordance with the emergency protocol within their unit which applied to dynamic hip screw placement. All x rays were undertaken and interpreted by the requester – the specialist bone team. The suggestion that I stopped any doctor "looking into Seamus" or stopped any other clinician undertaking investigations or treatment is, frankly, ridiculous.

28. In 2018, the CT scan of abdomen as requested by the acute take physician within Altnagelvin Hospital confirmed a destructive soft tissue lesion in the right hilum above the acetabulum in keeping with metastatic spread. An earlier CT scan performed by the hepatology service in January 2018 was reported as confirming the previous right dynamic hip screw but no separate bone abnormality seen. Furthermore, as stated in paragraph 29 below, none of the three x rays undertaken in 2010 (and specifically the abdominal x ray) refers to a destructive lesion in the right iliac bone. The suggestion that a bone lesion was first seen on x ray in 2010 and not followed up is simply wrong. Exhibits 5-7.

***158. WITN2778012 (handwriting is my own) is a Radiology Report dated 30 April 2018 which refers back to a previous imaging abdominal x-ray done on 23 October 2010, which reads, 'a destructive lesion seen in the right iliac bone'. He was dying and they were talking about a scan in 2010. They found the same thing that they found 8 years before. Why were we not told about this in 2010? Why was this all coming out only when he was dying?***

29. This statement is incorrect. An abdominal x ray was undertaken and reported on 25.04.2018 and makes reference to the CT abdomen & pelvis with contrast performed on 30.04.2018 (**WITN3082052**). As stated at paragraph 28 above, three x rays were performed on 23.10.2010 – chest, abdomen and facial bones. [Exhibits 5-7]. There are no references on any of these x rays in relation to a destructive lesion in the right iliac bone.

***159. An undated medical note (WITN2778014) says 'severe Haemophilia A, known to Dr Benson', 'early ALD – as per Dr Benson's knowledge'. It even said 'Hepatitis C' and Seamus didn't know how serious Hepatitis C know or even that he had active Hepatitis C, he was not concerned as he was confident that he was being taken care of, as his bloods were being monitored at his haemophilia clinic, little did he know he was never going to be told about cancer, terminal cancer or any cancer. I believe they hoped he would just die.***

***160. WITN2778015 medical notes from Belfast to Altnagelvin Hospital (30 April 2018) reads, "I note from the ECR that the patient has cirrhosis secondary to***

***HCV and alcohol, portal hypertension, multiple liver lesions, portal vein thrombosis. This information was not provided in the referral form." This demonstrates that even when he was referred to a doctor in Altnagelvin Hospital; Belfast City Hospital wasn't giving vital medical information about Seamus's health to other medical professionals in the same country. Altnagelvin Hospital states that "information was not provided in the referral form." I do not feel this appropriate care.***

30. This statement in the medical records is not in reference to any poor communication between the haemophilia centre and the Altnagelvin Hospital. The sentence, as referenced in the medical notes, is a direct quotation from the outcome of the Upper GI MDT conclusion dated 09.02.2018. and available through the ECR. The letter was addressed to Dr Leeson.

***Paragraphs 186-187, pages 39-40***

***186. In September 2018, Eddie was going to clinic and said, "oh I better take my Factor, I always take it". I said "do they not tell you to abstain if you don't have a bleed?" Factor levels are taken to identify their peak and troughs, but the result would calculate high Factor levels, if they had taken Factor 8 before an appointment.***

31. It is routine practice for adults, to take their factor as and when they are scheduled to do so as per their prescription. There is neither need to withhold nor bring forward a dose specifically. At the time of blood being taken from the patient, we confirm when they last took their injection so as to ensure we can interpret it accordingly.

***187. I was aware that all the men had their Factor units reduced by half, like Luke, Seamus and Eddie in particular were reduced from 3000 units to 1500 units Factor. Eddie said he was never on 3000ui of factor he believes the highest regular dosage was only ever on was 2000ui until he was reduced to 1500ui three days a week, by Gary Benson stating he is not as active and doesn't need as much factor, this is unbelievable Eddie should be on at least 4000ui every other day.***

32. This statement appears to be based on a misunderstanding of how appropriate dosage of clotting factor is determined. It asserts that prescribed dosages were too low. This is incorrect. Dosing of clotting factor takes into account the reported bleeds from the patient – provoked and spontaneous as well as the frequency of their administration, physical activities and their body weight. The primary goal is to ensure the annual bleed rate is as low as is possible – ideally zero spontaneous bleeds. Factor levels are interpreted alongside the bleed reported and the trough should always be measurable ie greater than the basal level of zero per cent for patients with severe haemophilia. The longer patients' levels are below zero per cent, the greater the likelihood of them bleeding spontaneously. Mr Conway reports zero annual bleeds at the outpatient clinic reviews on his current prescribed dosing of factor replacement.

33. Since providing her statement to the Inquiry, WITN2778 has made a number of posts on social media pages giving an account of some of the same matters which she raises in that statement including posts on the Facebook page of the Haemophilia Society UK. I was made aware of the posts when the Haemophilia Society UK contacted me on 15 December 2023 to advise the posts made been made the night before and had been removed by the Society at the earliest opportunity **(WITN3082053).** This use (or misuse) of social media appears to be part of an ongoing campaign of highly personal attacks by W2778 designed to undermine my professional competence and personal integrity. It is, therefore, all the more important that I avail of the opportunity that this statement to the Inquiry has given me to respond.

***Concluding remarks***

34. In the opening paragraphs of this statement, I noted the gravity of the allegations contained in the written statement of Witness 2778 and I stated that I refuted them in the strongest terms. I went on to address those allegations in greater detail, many of which were directed at my personal integrity and professional competence. I endeavoured to set out why they were unfounded or, put more bluntly, were simply "wrong". I recognise that in doing so there is often a fine line between effective rebuttal and appearing to engage in a purely self-serving exercise. With that in mind,

I will conclude this statement by recalling remarks made by Sir Brian Langstaff, at the conclusion of my oral evidence to the Inquiry:

> *"I don't think anyone would have failed to be moved by your reaction to some of the patients and be assured by that, as I see it, your care for your patients is deeply genuine. Nobody has questioned it, nobody could here after your evidence, and thank you very much for telling us what it is like now in Belfast and -- through Belfast, Northern Ireland".*

In my view, Sir Brian's assessment of my commitment to patient care makes further comment unnecessary.

**Statement of Truth**

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

Signed GRO-C

Dated 29-03-24

**Table of exhibits:**

| Date | Notes/ Description | Exhibit number |
|---|---|---|
| 20.02.2019 | Correspondence from Liz Carroll, UK Haemophilia Society to Dr Gary Benson | **WITN3082045** |
| 09.06.2017 | Outpatient clinic letter – Dr Gary Benson to Dr Courtney, | **WITN3082046** |
| 05.05.2017 | Email from Dr Gary Benson to Dr Johnny Cash | **WITN3082047** |
| 04.07.2018 | Letter from Dr Ian Cadden to Dr Courtney | **WITN3082048** |
| 23.10.2010 | XR Facial bones | **WITN3082049** |
| 23.10.2010 | XR Chest | **WITN30820450** |

| | | |
|---|---|---|
| 23.10.2010 | XR Abdomen | **WITN30820451** |
| 30.04.2018 | CT Scan Abdomen and pelvis | **WITN3082052** |
| 15.12.2023 | Email from The Haemophilia Society UK to Dr Gary Benson | **WITN3082053** |