Witness Name: GRO-B
Statement No.: WITN0136004
Exhibits: None
Dated: 21 November 2022

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF GRO-B

I provide this supplementary statement following my first written statement which was provided in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20th November 2018, to provide further information which may be relevant to the Inquiry.

1. Since providing my first statement, I have been provided with Professor Ludlam's response and would like to make some further comments in light of this.

2. In particular, I wish to provide further information on Professor Ludlam's treatment of GRO-B: H his duty to inform my family and I about H infection, or suspected infection and the overall impact on my family.

Professor Ludlam's treatment of GRO-B

3. H received monthly transfusions from Spring 1981 until his diagnosis of acute myeloid leukaemia and his admission to hospital in August 1982, at which point he received very regular transfusions of blood, plasma, platelets and numerous other medications. He was a multi-transfused patient and he used to go to the haemophiliac's room for his transfusions prior to going into hospital.

4. I would criticise Professor Ludlam for his failure to consider the possibility that H illness and rapid decline may have been exacerbated by blood-borne infection in the form of HIV. The fact that he did not consider this indicates a lack of attention on his part to the risk of HIV being in the Scottish donor population in 1983/ 1984 and the possibility that this could have created risks to myself, my daughters and to others who could have been exposed to H blood.

5. It is my view that the risk of HIV and hepatitis B and C from blood and blood products ought to have been discussed with H and myself. This was definitely not discussed with us. In light of the availability of blood and platelets from low-risk family members, had the risk been discussed I believe that H would have insisted that the blood and platelets used for him would have come from them and not other donors. Had it been the case that the blood and platelets only came from family members H infection and the subsequent distress which it has caused to myself and my family would have been avoided.

6. I believe that Professor Ludlam provided me with misleading information about the irradiation of blood in April 1983, given my concerns about AIDS in the press.

7. There remains good reason to believe in light of my family's experience of the unfortunate death of my nephew GRO-B from acute myeloid leukaemia, the speed and severity of H decline after a short remission in the spring of 1984 and the apparent care taken by the nurses at the time of his death that (i) H death was contributed to by his HIV infection as well as acute myeloid leukaemia and (ii) that this was known or suspected at the time of his death. With regard to my nephew, his skin was pale, his eyes were clear, he did not have the same strange tan, he never suffered from oral thrush and he died a very peaceful death. GRO-B was thin but H was emaciated! H also had a horrendous cough, which wracked him with pain - this was particularly difficult to watch GRO-B did not have a cough. I would add that GRO-B was not related to H by blood.

8. I must emphasise that I was told that H had AIDS as opposed to HIV by Professor Ludlam in 1994. Even if this was not known at the time, it should have been suspected in light of available information as a reason for the particular decline which H suffered and in light of the fact that he was multiply exposed to what I now know to be SNBTS sourced blood and platelets.

9. The risk of hepatitis, which Professor Ludlam now appears to acknowledge existed fo H , was also not mentioned by him at the time.

Duty to tell my family and I about H infection

10. I maintain my criticism of Professor Ludlam for not telling me about H infection with AIDS between him finding out in 1986 and me being told in 1994 which shows that he assumed (i) that there were no sexual relations between GRO-B and I (ii) that the disease could not have been spread to me or my children by other means and (iii) that I did not have another partner/means of exposing others to risk of my possible infection. Professor Ludlam did not mention in 1994 that he had known since 1986, the testing he had undertaken or the details of when H was infected (December 1983). In doing so, he denied me a right to know about my husband's infection and about the risk to both myself and my children, he behaved in an unnecessarily paternalistic way, which created a risk that I could have infected others, including my children, for a period of eight years.

11. Professor Ludlam seems to have focused on the possibility of sexual transmission to me when he knew that I also had risks of transmission from the fact that I nursed H at home and I was made responsible for administering his chemotherapy via the Hickman Line, as set out in my first written statement. In addition, we were a close family and we were always kissing each other. The girls were always kissing their daddy.

12. I met Professor Ludlam in June 1992, the day GRO-B was admitted to hospital and we had a chat. This was around the time my daughter, GRO-B moved into

her new flat. It was an ideal time for Professor Ludlam to inform me of H infection.

13. Furthermore, there was an opportunity for Professor Ludlam to tell me about the infection in 1993 when I spoke to him about my nephew's diagnosis of acute myeloid leukaemia. This conversation included reference to the safety and efficacy of the treatment that my nephew would receive which would have created a golden opportunity to discuss the safety of the treatment that H had received.

14. I am unaware of why Professor Ludlam would have been writing to the SNBTS about the circumstances of H infection in September 1993 and I was never told of what that correspondence said at that time or shortly thereafter.

15. In light of what Professor Ludlam has said about the testing of blood and the storage of blood, I was not told precisely what the blood would be tested for while H was alive. I was not told that the blood would be stored, and I do not believe that H was told about this either. I was not told about the blood being tested post-mortem in 1986 and I did not sign anything to give permission for that to be done when he passed away.

16. I was not told that stored blood was being tested at any time until I was told of H infection in 1994 (when it had been tested without my knowledge). The fact that they tested without consent or even had his blood stored made me feel physically sick.

17. Professor Ludlam's response raises further questions due to the fact that he does not state how many samples the hospital had, if they are still there, whether the likely positive test from March 1984 was the earliest test and whether there are or were other samples available from before that date. I want to identify what samples were stored to establish whether H was also infected with hepatitis C as a result of his treatment. My solicitors have made further enquiries and have been told that Lothian Health Board do not hold any

stored samples in respect of H and therefore I still have unanswered questions about whether H had hepatitis C.

18. I do not accept the assertion that my being told of the infection in 1994 was due to sums being available for payments being made to the relatives of those who had HIV from blood transfusions in 1994. It is my position that but for my chance meeting with Professor Ludlam that year when I was attending the hospital for another matter, I would never have been told of the infection as there had been two earlier opportunities to tell me. The claim that it had anything to do with the support then available was a retrospective justification on the part of Professor Ludlam - he was just using it as an excuse. I would add that being told of the infection in 1994 does not fit with his argument about the new scheme for payment being made to the relatives of HIV-infected patients who died. This would have justified Professor Ludlam telling me in 1992 or 1993, which he did not.

19. I never saw a copy of the Trust application form that Professor Ludlam submitted on my behalf. I have not been able to trace a copy of this so far and I would like to see this.

20. With regard to the meeting in 1994, Professor Ludlam took no notes, he had insisted on meeting with me, and he did not suggest that I come with my daughter or any other supporter. Quite frankly, he could not get me out of the room quick enough.

21. Professor Ludlam did not ask me about the date of my sexual relations with H at the 1994 meeting, upon which he appears to place some significance now, despite the fact he knew that H had been in remission at home in the spring of 1984.

22. At the meeting, my blood was taken and tested for infection without prior consent or any pre-test counselling being given. There were no notes, even in my GP records, and the suggestion was that this was helping me is incorrect as I would have to declare it for the purposes of life insurance if I had been

asked.. It is my impression that he did not want to create a record in my medical notes. No post-test counselling was offered.

23. Professor Ludlam appears to confirm that our GP had known of the positive test result since 1986. It makes me so angry that the GP knew but me and my family were not told.

24. With regard to Professor Ludlam's comment that it was "unfortunate" that I did not return to seek a further explanation of the matter after the 1994 meeting, I would say that it was his responsibility to check on me. There was no basis to ask more questions as I have not been told the truth and I had been given hush money by a Trust. I received a letter with a cheque, and I had to sign a waiver and send it back.

25. In terms of the blood and platelets provided by family members, as mentioned above, I would argue that my husband ought not to have received any blood platelets from anyone other than these defined sources from his admission to hospital in August 1982 following his leukaemia diagnosis. He would not have been infected and the failure to inform my family that this had not happened has given rise to a reasonable belief that he must have been infected before that time as he only received "safe" products derived from family members from that point. Family members were required to urgently attend the hospital to donate blood which gave rise to the honest belief that H received only blood and platelets from the family. I remember my brother GRO-B only had a couple of pints whilst attending the football on a Saturday in case he got a phone call from the Hospital to go up to donate blood urgently. My two brothers and my sister in law donated blood and platelets for H and I have recently learned that my sister in law's sister's godson also donated.

26. I do not think it would have mattered who contacted me about the infection, whether it be Professor Ludlam or the SNBTS, as it was still a horrible shock. I would say, however, that being contacted by a blood transfusion agency, presumably in a letter, would have been difficult. I would have been shocked if it was not Professor Ludlam. I would have expected Professor Ludlam to get in

touch. I suppose the SNBTS would know of positive donations with hindsight, but they would not know the patient that received it. That would be entirely within Professor Ludlam's remit.

27. I believe that my family were potentially being followed by Professor Ludlam via my friend after 1986 when she, as a patient of Professor Ludlam, would often ask after me and my family on Professor Ludlam's behalf. I now believe that this was a way of him checking to see if any of us were showing any symptoms of AIDS. I cannot see any other reason for this. My daughter GRO-B had an unfortunate cancer scare in July 1993 which resulted in her attending the Western General Hospital for a lymphadenopathy. At her appointment, a consultant came into the room and declared that she was H daughter, despite H never having been a patient at that hospital, to our knowledge, and he had passed away nearly a decade prior to this. This adds to my suspicion that my family were being watched.

Recent Actions/Impact

28. The lack of apology from Professor Ludlam and the realisation that the full truth about H infection was not given has caused enormous harm to my family. There was the awful situation of the original infection and death, then not being told until 1994. Given what Professor Ludlam knew in 1986 and even in 1994, not being told the full picture means the harm is ongoing. My family and I do not have closure and we have not been able to move on. It has had and continues to have a tremendous impact on me and my daughters. We have all suffered from ill health and I believe that the ongoing harm has contributed to this.

29. To add to this, there is an ongoing lack of explanation about why H brain haemorrhage was not included on the death certificate and whether this was linked to his acute myeloid leukaemia. I would like an explanation for this.

Statement of Truth

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

Signed GRO-B

Dated Nov 22, 2022