Witness Name GRO-B
Statement No: WITN 1447001
Exhibits:0
Dated: April 2019

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF GRO-B

I, GRO-B will say as follows:-

Section 1. Introduction

1. My name is GRO-B I was born on the GRO-B . My address is GRO-B . I currently work as a GRO-B

2. I am an affected person in relation to my late partner GRO-B: H who was born on the GRO-B and passed away on the GRO-B GRO- at the age of GRO-B as a result of receiving contaminated blood products.

3. **This witness statement has been prepared without the benefit of access to H full medical records. If and in so far as I have been provided with limited records the relevant entries are set out in the medical chronology at the end of this statement.**

Section 2. How infected

4. H had Haemophilia type A, classed as severe. He was diagnosed as a child. I am not sure how old he was when he was first diagnosed but I know it was before he started primary school.

5. H was born in the GRO-B and at that time diagnostic services were not as good as they are today. It was therefore difficult to manage his haemophilia. He was always in hospital and missed a lot of school in order to treat his condition.

6. H was treated with Factor VIII concentrate in order to manage his haemophilia. As far as I am aware neither H nor his family were ever told that there were any risks associated with these products.

7. H was infected with Hepatitis C (HCV) as a result of receiving contaminated blood products.

8. I do not know the full details as to where H was treated for his haemophilia before I met him. H grew up in London and I know that in his younger years he would have received his treatment there.

9. When I first met H he was being treated at GRO-D Hospital GRO-B GRO-B. I know he wasn't infected at GRO-D and he had been infected a long time before he was a patient there. I am still trying to find out when and where H was infected.

10 H was aware that he had Hepatitis C before we met. I can't be precise in regards to when he was told. I do know that both his treating Consultant and his GP were involved in telling him.

11. I do know that no information was given to H or his parents once he was diagnosed with Hepatitis C. They were never given any advice regarding the implications of the infection. They were just told what the treatment would be.

Essentially he was left to just get on with it. There was no access to the internet in those days so you could only rely on the information provided by the medical professionals and that it was the correct advice.

12 H told me when I met him that he had been infected with Hepatitis C. I was aware of what it meant to have the HCV virus because of my GRO-B training. As his partner I was never offered any information by any of his Consultants and I was never given any documentation or advice in relation to how to protect myself from being infected. The only support we received was from GRO-B.

13 H would have blood transfusions regularly as he suffered from bleeding in his joints on a regular basis. I am not sure when these took place. This required him to attend A&E to receive treatment.

14. At that time prophylactic treatment was not available and H received blood transfusions in hospital. He was in hospital all the time.

15. When home treatment became available in the late 1980's I was trained by GRO-B to inject H with Factor VIII and I would do this every other day. There would be the odd occasion that he would still need to be hospitalised due to the pain caused by the bleeding in his joints. On these occasions H would be treated prophylactically in hospital.

16. Looking back, it seems that there was an enormous failure to protect patients from receiving contaminated blood products. GRO-B GRO-B. There should have been preventative safety measures in place to ensure that the products were fit for purpose. So much pain and suffering could have easily have been avoided and I cannot believe that this has actually happened.

17 H passed away in GRO-B as a result of being infected with these contaminated blood products H cause of death on the death certificate is listed as Hepatocellular Carcinoma, Hepatitis C and Haemophilia A.

Section 3. Other Infections

18. As far as I am aware H did not receive any other infections as a result of receiving contaminated blood.

Section 4. Consent

19. It is impossible to know if H was treated or tested without his knowledge or consent. Patients with haemophilia have blood taken all the time and who knows what blood was taken and when. Patients have absolutely no control over what is being done to them so I wouldn't be shocked if they tested H without telling him.

Section 5. Impact of the Infection

20. I don't believe for one moment that H knew what his infection would mean in regards to his long-term health. His primary concern was dealing with his haemophilia which was hard enough due to its severity. When he was first diagnosed with Hepatitis C I don't think he understood the implications at all.

21. It was clear 6 months before H passed away that his liver was in very poor condition. GRO-B GRO-B GRO-B.

22. It wasn't until he had a CT scan as part of the screening for the transplant that we discovered H had a secondary carcinoma in his lung. I have no idea how this had been missed. H was having regular ultrasounds but the surveillance regime was completely ineffective. He was not given the CT scans that he should have and he lost his life as a result.

23 H condition resulted in his liver ceasing to function correctly. It wasn't until that point that the medical professionals realised something was very wrong. GRO-B

GRO-B

There should have been so much more surveillance and he should have received scans much earlier and on a regular basis. I find it really difficult to talk about this to this day.

24. It wasn't until H was admitted as an impatient that he had several CT scans and by that time it was too late. My argument is that the surveillance of his condition relied on an ultrasound scan which would not have been sufficient to alert them to the issues H was likely to face due to his Hepatitis C. If they had been alerted sooner the medical professionals could have done something and potentially saved his life. GRO-B

GRO-B

GRO-B. In my opinion the intervention at the end was too little too late.

25 H received Interferon treatment for the Hepatitis C. I can't remember exactly when the treatment started but it was some time in the late 1990s to the early 2000s. In my view he was given the treatment far too late.

26. The treatment that was available in the 1990s was very different to what is available now. Interferon is all there was at the time. The impact of the treatment was enormous and the side effects were terrible. The treatment is a bit like chemotherapy in that it is given in cycles H had to have several cycles of treatment.

27. The treatment itself was quite invasive and H was hospitalised when he received it. It affected H general health and well-being. He faced a multitude of dreadful side effects that are known to be associated with Interferon such as an inability to function normally and a loss of appetite. It also affected him psychologically and he suffered with depression.

28. Once the infection was there it was very difficult to get rid of and the damage was already done. His consultants should have known there was a high possibility of H getting liver cancer as a result of his infection. GRO-B

GRO-B

29. The treatment didn't work and the infection wasn't cleared. H had regular consultant appointments where they would conduct ultrasounds and blood tests. When they found the treatment wasn't working there was a discussion with the consultant and nothing was offered after that.

30 H had two children from his previous relationship. When H died they were GRO-B years old. They had to live with the fact their father was unwell from a very young age. They understood that their dad wasn't able to do what other dads could. H children were very young to lose their father H and his previous partner had an amicable separation when the kids were young. The children lived with their mother but we all shared the parenting. The children were practically carers from the moment they were born.

31 H managed to keep working for most of his life. When he died his family not only lost their father but also the economical support he provided. I don't know how you quantify their loss but it is obviously devastating emotionally and financially.

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GRO-B

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GRO-B

. I had to put everything on hold because you have to in that situation. I had to put my

studies on hold in GRO-B for the best part of a year. I then had to re-start my studies the following academic year.

34. Aside from the distress and pain that H illnesses caused all of us it also had a huge financial effect. The household income went from two to just one. GRO-B GRO-B H loved his work and wanted to provide for his family. His intention was to get back to work and that is what kept him alive.

35 H children are now obviously grown up and have independent lives. Both of his children went to University and have done amazingly well considering what they had to suffer, although the scars are still there. GRO-B GRO-B GRO-B The immediate impact on the children was it stopped them being able to study properly for their GRO-B Somehow they got through them and I don't know how they managed it. Both children required counselling and have had to live most of their lives without their father.

Section 6. Treatment/care/support

36. We were never offered any psychological support or help while H was dealing with his infections or after he passed away.

37 H children had bereavement counselling which we had to arrange ourselves. The counselling was provided through a charity.

38. I eventually went to see my occupational health service providers and explained that I was struggling and that I needed help. I ended up receiving counselling after this.

39. I believe the whole family should have been offered psychological support as it was clear that we all needed it. We ended up having to seek help ourselves which is not good enough.

Section 7. Financial Assistance

40. H received an initial payment of around £20000 from the Skipton Fund or its predecessor I cannot quite recall what it was called.

41. Not long after H died he was awarded the Skipton Fund stage 2 payment in the sum of £50000 from the Skipton Fund. This went into H estate and me and H children were the beneficiaries. Since then because I have been working I have not qualified for anything other than the winter fuel payments which results in a sum of around £500 every December. I had been told that I would receive an additional annual payment as well but I was that I didn't qualify because I was working.

Section 8. Other Issues

42. I would like to put on record the amazing support that the Haemophilia Centre at GRO-D Hospital offered us. These people were there to ensure that H had a regular supply of Factor VIII and the help they provided for H was brilliant.

43. GRO-B

44. I want to know why the medical examiners didn't look into the deaths of the victims and why there were not any inquests. GRO-B GRO-B Protocol was not followed properly in this case. I want to know why this did not happen. I would like to know why no serious untoward incident procedure was ever followed.

45. This inquiry needs to set a precedent so that this is never allowed to happen again.

46. Those who have been infected with contaminated blood should have access to the best treatment that is available. The people who have died as a result were obviously failed but we can still help those who are still alive.

47. I am providing this statement because it might help people who are suffering and are still alive. I know it won't help H but it could make other lives easier.

Anonymity

48. I wish to remain anonymous.

49. I do not wish to provide oral evidence at the inquiry.

Statement of Truth

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

Signed..... GRO-B

Dated 20 June 2019