Witness Name: Charles Hamilton Massey
Statement No.: WITN3365011
Exhibits: WITN3365012-WITN3365031
Dated: 30 August 2019

INFECTED BLOOD INQUIRY

EXHIBIT WITN3365015 OF MR CHARLES HAMILTON MASSEY

WITN3365015 – Exhibit: Complaint by Mr GRO-A against Dr Peter Mercer Jones (GMC Ref: 0407030) and Dr Peter John Hamilton (GMC Ref: 1235072). GMC Case Reference: 2003/0728

General
Medical
Council

Case Examiner Decision Form

Investigation Officer: Jon Abel

File Reference No 2003/0728 Date 10/10/2005

Dr's Name Peter JONES Reg No 0407030

Part 1.

Nature of Allegations

Date complaint first received by the GMC: 16/03/2003

Year alleged events took place: 1992 onwards

The following are the allegations raised by the complainant and/or employer: (TO BE NUMBERED)

The allegations have been amalgamated from the CERF for clarity

1. Sub-standard clinical care in relation to Mr GRO-A

Nature of Allegations: presumption of impaired FTP

1.1 Do the allegations fall within one of the categories where there is a presumption, if proven, of impaired fitness to practise to a degree justifying action on registration?

Sexual Assault or indecency	**Yes**	**No**
a. Indecent behaviour	☐	☒
b. Indecent assault	☐	☒
c. Rape/attempted rape	☐	☒
d. Female circumcision	☐	☒
e. Child pornography	☐	☒
Violence		
f. Assault	☐	☒
g. Attempted murder	☐	☒
h. Firearms offence	☐	☒
i. Murder/manslaughter	☐	☒
j. Robbery	☐	☒
Improper sexual/emotional relationship	☐	☒
Dishonesty		
k. False claims to qualifications/experience	☐	☒
l. Financial fraud/deception	☐	☒
m. Forgery/improper alteration of documents	☐	☒
n. Research misconduct	☐	☒
o. False certification, false reporting	☐	☒

p. False claims about effectiveness of treatment	☐	☒
q. Other serious incidence(s) of dishonesty not covered above	☐	☒

Part 2.

Nature of allegations: Good Medical Practice

2.1 Do the allegations relate to one or more of the principles of Good Medical Practice set out below? If yes, please tick and cite the relevant paragraph in the right hand column then go to Part 3.
If no, please tick ' None of the above' then go to Part 3.

(For more detail on the principles of GMP, refer to the GMP booklet and the guidance provided.)

		Para(s) in GMP
a. Good Clinical Care	☒	2,3
b. Maintaining Good Medical Practice	☐	
c. Teaching and Training	☐	
d. Relationships with patients	☐	
e. Working with colleagues	☐	
f. Probity	☒	50
g. Health	☐	
i. None of the above GMP allegations	☐	

Part 3

Criteria for assessing the seriousness of allegations

Questions 3a to 3g will help to identify whether the allegations are sufficiently serious to meet the Investigation stage test: 'Is there a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration?'

Please tick yes or no in each section

Do the allegations indicate that:

	Yes	No
a. the doctor's performance has harmed patients or put patients at risk of harm?	☒	☐
b. the doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients?	☐	☒
c. the doctor has abused a patient's right or violated a patient's autonomy or other fundamental rights?	☐	☒
d. the doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others?	☒	☐
e. the doctor's behaviour is such that public confidence in doctors generally might be undermined if the GMC did not take action?	☐	☒
g. the doctor's health is compromising patient safety?	☐	☒

Part 4

Realistic prospect test

4.1 Is there a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration

Yes ☐

No ☒

4.2 Please give reasons for your decision

1. Sub-standard clinical care in relation to Mr GRO-A

If a doctor's care or omission represented a significant breach of Good Medical Practice and contributed to patient harm then this would be a serious matter. This case is one of a series, brought by patients with complications relating to transfusion with blood replacement products. The allegations are difficult to attribute to an individual clinician as care of such patients was universally delivered via a multi-professional team approach. The GMC is concerned with an individual doctor's fitness to practise and this is the context in which the specific allegations must be considered.

The allegations will be considered in turn against the two stage GMC test

1. Testing patient for Hepatitis C without consent and withholding the test result for a number of years, preventing the patient making appropriate informed lifestyle choices: The testing for Hepatitis C evolved over a number of years in the early 1990s. In addition the implications of a positive result became better understood after this period. Drug treatment for hepatitis C became available in 1995. The Newcastle Centre had a patient-centred ethos that included the active involvement of patients in their own care, the publication of several informative leaflets and books, including "*Living with haemophilia*".All of these were widely available to patients and include up to date information on complications associated with the condition and its treatment, specifically hepatitis and HIV. It is noted that the presence of hepatitis C antibodies does not necessarily indicate infection. The Centre used an HCV testing sheet, which records whether verbal consent was obtained. Specific record is made in a letter of 22/05/1991 of a discussion with Mr GRO-A about his HCV status, which undermines his claim that he was not told until 1994.

2. Failure to refer to a specialist: The team at the Newcastle Centre had expertise in many areas of patient care relating to haemophilia and its complications. It is appropriate that hepatology referral be considered in complicated cases out-with their skills and experience. There is no evidence that this was the case with Mr GRO-A who had regular review of his symptoms and liver function.

3. Failed to advise patient of risks: It is accepted that treatment with blood replacement products must be considered in the context of consideration of both the benefits and risks. The evidence is that the Newcastle centre had drawn up appropriate protocols, developed useful and comprehensive patient guidance, delivered multi-professional and patient-orientated care within the available NHS resources and appeared to act in

deliberately withheld any information, manipulated knowledge available to him or acted *inappropriately in respect of his duties as Medical Director of the Newcastle Haemophilia* Centre.

The allegations that have been made are serious, but no breach of Good Medical Practice has been identified; realistic prospect test not met.

Conclusion

The Case Examiners considered the allegations made in the context of an individual doctor's responsibility, conduct and performance. Care is delivered to patients with haemophilia and other related chronic medical conditions using a multi-disciplinary team approach. This is the situation in which this doctor's registration has been considered. Having read the documentation carefully it is clear that the Newcastle Centre delivered care that involved patients in their own management. The Centre produced regularly updated booklets designed to facilitate this active involvement including "*Living with haemophilia.*" This booklet, in addition to the clinic guidelines, specifically covered issues such as the risks and benefits of blood replacement products. The ethos of the centre was to have easy access for patients, who gave informed consent, sometimes verbally, for their treatment. In the early 1990s knowledge about Hepatitis C and other blood borne infections was evolving. This evolution included testing, treatment and prognosis. The evidence provided indicates that the doctors appeared to act reasonably and in their patients' best interests. No corroborative evidence has been supplied to support the allegation that the doctors wilfully withheld information or acted unprofessionally in the management of centre patients, nor that they were inappropriately influenced by external influences when providing patient care within the available NHS resources. The allegations made against the doctor do not demonstrate impairment of his individual fitness to practise. The GMC will not be taking action on Dr Jones' registration as a result of this complaint.

General
Medical
Council

Case Examiner Decision Form

Investigation Officer: Jon Abel

File Reference No 2003/0728 Date 10/10/05

Dr's Name Peter HAMILTON Reg No 1235072

Part 1.

Nature of Allegations

Date complaint first received by the GMC: 5/03/2003

Year alleged events took place: 1992 onwards

The following are the allegations raised by the complainant and/or employer: (TO BE NUMBERED)

The allegations have been amalgamated from the CERF for clarity

1. Sub-standard clinical care in relation to Mr GRO-A

Nature of Allegations: presumption of impaired FTP

1.1 Do the allegations fall within one of the categories where there is a presumption, if proven, of impaired fitness to practise to a degree justifying action on registration?

Sexual Assault or indecency	**Yes**	**No**
a. Indecent behaviour	☐	☒
b. Indecent assault	☐	☒
c. Rape/attempted rape	☐	☒
d. Female circumcision	☐	☒
e. Child pornography	☐	☒
Violence		
f. Assault	☐	☒
g. Attempted murder	☐	☒
h. Firearms offence	☐	☒
i. Murder/manslaughter	☐	☒
j. Robbery	☐	☒
Improper sexual/emotional relationship	☐	☒
Dishonesty		
k. False claims to qualifications/experience	☐	☒
l. Financial fraud/deception	☐	☒
m. Forgery/improper alteration of documents	☐	☒
n. Research misconduct	☐	☒
o. False certification, false reporting	☐	☒

p.	False claims about effectiveness of treatment	☐	☒
q.	Other serious incidence(s) of dishonesty not covered above	☐	☒

Part 2.

Nature of allegations: Good Medical Practice

2.1 Do the allegations relate to one or more of the principles of Good Medical Practice set out below? If yes, please tick and cite the relevant paragraph in the right hand column then go to Part 3.
If no, please tick ' None of the above' then go to Part 3.

(For more detail on the principles of GMP, refer to the GMP booklet and the guidance provided.)

			Para(s) in GMP
a.	Good Clinical Care	☒	2,3
b.	Maintaining Good Medical Practice	☐	
c.	Teaching and Training	☐	
d.	Relationships with patients	☐	
e.	Working with colleagues	☐	
f.	Probity	☒	50
g.	Health	☐	
i.	None of the above GMP allegations	☐	

Part 3

Criteria for assessing the seriousness of allegations

Questions 3a to 3g will help to identify whether the allegations are sufficiently serious to meet the investigation stage test: 'Is there a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration?'

Please tick yes or no in each section

Do the allegations indicate that:

	Yes	No
a. the doctor's performance has harmed patients or put patients at risk of harm?	☒	☐
b. the doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients?	☐	☒
c. the doctor has abused a patient's right or violated a patient's autonomy or other fundamental rights?	☐	☒
d. the doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others?	☒	☐
e. the doctor's behaviour is such that public confidence in doctors generally might be undermined if the GMC did not take action?	☐	☒
g. the doctor's health is compromising patient safety?	☐	☒

Part 4

Realistic prospect test

4.1 Is there a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration

Yes ☐

No ☒

4.2 Please give reasons for your decision

1. Sub-standard clinical care in relation to Mr GRO-A

If a doctor's care or omission represented a significant breach of Good Medical Practice and contributed to patient harm then this would be a serious matter. This case is one of a series, brought by patients with complications relating to transfusion with blood replacement products. *The allegations are difficult to attribute to an individual clinician as care of such* patients was universally delivered via a multi-professional team approach. The GMC is concerned with an individual doctor's fitness to practise and this is the context in which the specific allegations must be considered.

The allegations will be considered in turn against the two stage GMC test

1. Testing patient for Hepatitis C without consent and withholding the test result for a number *of years, preventing the patient making appropriate informed lifestyle choices: The testing for* Hepatitis C evolved over a number of years in the early 1990s. In addition the implications of a positive result became better understood after this period. Drug treatment for hepatitis C became available in 1995. The Newcastle Centre had a patient-centred ethos that included the active involvement of patients in their own care, the publication of several informative leaflets and books, including "*Living with haemophilia*".All of these were widely available to patients and include up to date information on complications associated with the condition and its treatment, specifically hepatitis and HIV. It is noted that the presence of hepatitis C *antibodies does not necessarily indicate infection. The Centre used an HCV testing sheet,* which records whether verbal consent was obtained. Specific record is made in a letter of 22/05/1991 of a discussion with Mr GRO-A about his HCV status, which undermines his claim that he was not told until 1994.

2. Failure to refer to a specialist: The team at the Newcastle Centre had expertise in many areas of patient care relating to haemophilia and its complications. It is appropriate that hepatology referral be considered in complicated cases out-with their skills and experience. There is no evidence that this was the case with Mr GRO-A who had regular review of his symptoms and liver function.

3. Failed to advise patient of risks: It is accepted that treatment with blood replacement products must be considered in the context of consideration of both the benefits and risks. The evidence is that the Newcastle centre had drawn up appropriate protocols, developed useful and comprehensive patient guidance, delivered multi-professional and patient-orientated care within the available NHS resources and appeared to act in

patients' best interests. There is no corroborative evidence to show that Dr Hamilton deliberately withheld any information, manipulated knowledge available to him or acted inappropriately in respect of his duties as a consultant at the Newcastle Haemophilia Centre.

The allegations that have been made are serious, but no breach of Good Medical Practice has been identified; realistic prospect test not met.

Conclusion

The Case Examiners considered the allegations made in the context of an individual doctor's responsibility, conduct and performance. Care is delivered to patients with haemophilia and other related chronic medical conditions using a multi-disciplinary team approach. This is the situation in which this doctor's registration has been considered. Having read the documentation carefully it is clear that the Newcastle Centre delivered care that involved patients in their own management. The Centre produced regularly updated booklets designed to facilitate this active involvement including "*Living with haemophilia.*" This booklet, in addition to the clinic guidelines, specifically covered issues such as the risks and benefits of blood replacement products. The ethos of the centre was to have easy access for patients, who gave informed consent, sometimes verbally, for their treatment. In the early 1990s knowledge about Hepatitis C and other blood borne infections was evolving. This evolution included testing, treatment and prognosis. The evidence provided indicates that the doctors appeared to act reasonably and in their patients' best interests. No corroborative evidence has been supplied to support the allegation that the doctors, as individuals or as a group, wilfully withheld information or acted unprofessionally in the management of centre patients, nor that they were inappropriately influenced by external organisations or factors when providing patient care within the available NHS resources. The allegations made against Dr Hamilton do not demonstrate impairment of his individual fitness to practise. The GMC will not be taking action on this doctor's registration as a result of this complaint.

Part 4

Realistic prospect test

4.1 Is there a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration

Yes ☐

No ☒

4.2 Please give reasons for your decision

1. Sub-standard clinical care in relation to Mr GRO-A

If a doctor's care or omission represented a significant breach of Good Medical Practice and contributed to patient harm then this would be a serious matter. This case is one of a series, brought by patients with complications relating to transfusion with blood replacement products. *The allegations are difficult to attribute to an individual clinician as care of such* patients was universally delivered via a multi-professional team approach. The GMC is concerned with an individual doctor's fitness to practise and this is the context in which the specific allegations must be considered.

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2. Failure to refer to a specialist: The team at the Newcastle Centre had expertise in many areas of patient care relating to haemophilia and its complications. It is appropriate that hepatology referral be considered in complicated cases out-with their skills and experience. There is no evidence that this was the case with Mr GRO-A who had regular review of his symptoms and liver function.

3. Failed to advise patient of risks: It is accepted that treatment with blood replacement products must be considered in the context of consideration of both the benefits and risks. The evidence is that the Newcastle centre had drawn up appropriate protocols, developed useful and comprehensive patient guidance, delivered multi-professional and patient-orientated care within the available NHS resources and appeared to act in

patients' best interests. There is no corroborative evidence to show that Dr Hamilton deliberately withheld any information, manipulated knowledge available to him or acted inappropriately in respect of his duties as a consultant at the Newcastle Haemophilia Centre.

The allegations that have been made are serious, but no breach of Good Medical Practice has been identified; realistic prospect test not met.

Conclusion

The Case Examiners considered the allegations made in the context of an individual doctor's responsibility, conduct and performance. Care is delivered to patients with haemophilia and other related chronic medical conditions using a multi-disciplinary team approach. This is the situation in which this doctor's registration has been considered. Having read the documentation carefully it is clear that the Newcastle Centre delivered care that involved patients in their own management. The Centre produced regularly updated booklets designed to facilitate this active involvement including "*Living with haemophilia.*" This booklet, in addition to the clinic guidelines, specifically covered issues such as the risks and benefits of blood replacement products. The ethos of the centre was to have easy access for patients, who gave informed consent, sometimes verbally, for their treatment. In the early 1990s knowledge about Hepatitis C and other blood borne infections was evolving. This evolution included testing, treatment and prognosis. The evidence provided indicates that the doctors appeared to act reasonably and in their patients' best interests. No corroborative evidence has been supplied to support the allegation that the doctors, as individuals or as a group, wilfully withheld information or acted unprofessionally in the management of centre patients, nor that they were inappropriately influenced by external organisations or factors when providing patient care within the available NHS resources. The allegations made against Dr Hamilton do not demonstrate impairment of his individual fitness to practise. The GMC will not be taking action on this doctor's registration as a result of this complaint.

Case Examiner Referral Form

Section 1: Case Details

See Notes on Completion at end of form

FPD reference **2003/0728**

Doctor's name **HAMILTON, Peter**

Registration no. **1235072**

Date **3 October 2005**

Investigation Officer Jon Abel

File location: E:\.... Not Relevant

Section 2: Previous History

See Note 1

Previous history? Yes

FPD Reference	Nature of complaint	Outcome/current status
2003/0315	Similar to this one	Open
2003/2098	Similar to this one	Open
2003/0621	Similar to this one	Open

Section 3: Index complaint – background and summary

This is one of a series of complaints about the issue of haemophiliacs contracting hepatitis C through contaminated plasma.

The complainant was one of the original litigants in a class action against the Department of Health, which concluded in 1991. That case was concerned with the contracting of HIV. The case was settled out of court, and part of the settlement was signing a 'hepatitis waiver', which meant that the complainant could undertake no legal action in the UK in relation to the hepatitis virus. The complainant is currently seeking legal redress through the American Legal System.

The letter highlighting the complaints against Dr Hamilton is at flag 6. Dr Hamilton was a former Consultant Haematologist at the Royal Victoria Infirmary (RVI). The allegations are similar to those in the other cases concerning similar issues.

Namely that Dr Hamilton tested Mr GRO-A without his knowledge and express permission and that no pre/post-test counselling was offered. Dr Hamilton also acted unethically in that he played down the seriousness of the Hepatitis C Virus, calling those infected the 'worried well'. Further, Dr Hamilton had knowledge of results of tests carried out in 1990, but yet withheld these results for 4 years.

The complainant also alleges that Dr Hamilton was remiss in his reluctance to offer referrals to liver specialists.

On page 3 of the letter, the complainant also alludes to the fact that Dr Hamilton knew about the risks associated with the plasma concentrates, but never passed this knowledge on to the patients. Mr GRO-A refers to a High Court ruling which states that patients must be informed of medium-high risks associated with their treatment in order to make an 'informed choice'. Page 5 of his letter talks about more evidence to back this claim up, contained in the *Grayson & Longstaff* File (2003/0621).

There are no comments on file from Dr Hamilton.

Section 4: Additional information

Mr GRO-A medical records are with this file.

Section 5: Performance Assessments/Health Examinations

None

Section 6: Summary of Allegations

See Note 5

A	B	C	D
No	**Allegation**	**Presumption of impaired FTP?**	**Breach of GMP?**
1	Dr Hamilton was involved in testing Mr GRO-A for non-A, non-B Hepatitis without his express consent and knowledge.	No	Yes
2	Dr Hamilton hid results of tests from the complainant for four years.	Yes – dishonesty	
3	Dr Hamilton did not offer any pre/post-test counselling and failed to offer any follow-up treatment such as referrals to specialists.	No	Yes
4	Dr Hamilton knew of the risks associated with the plasma concentrate but deliberately did not inform his patients of these risks.	Yes – dishonesty.	

Other relevant guidance? No

See Note 6

Section 7: Charges

Mr GRO-A

Mr GRO-A was a patient at the Newcastle Haemophilia Centre.

In or around 1990 GRO-A was tested for the Hepatitis C virus.

You had full access to the Hepatitis C test results.

You allowed GRO-A to be tested without his consent.

You did not:

a) tell GRO-A that he had been tested for Hepatitis C until 1994;

b) tell GRO-A that he had tested positive for Hepatitis C;

c) offer pre or post test counselling;

d) give GRO-A an opportunity to make lifestyle choices to protect is liver from further damage;

e) advise GRO-A that his wife might be at risk of infection.

You administered US blood replacement products to GRO-A even though you knew they were high risk products.

You did not tell GRO-A of the risks associated with the products to enable him whether to decide whether to take the treatments.

Section 8: Conclusion/Suggested Action

At first glance it may seem difficult to get evidence that Dr Hamilton knew about these facts as there was no direct involvement. However, it would be fairly easy to prove that Dr Hamilton had *constructive knowledge* of the events, as he was a co-director – he therefore would and should have sought out the requisite knowledge.

As stated on other CERFs:

The question is whether an individual doctor can bear responsibility, such that his fitness to practise is impaired.

This case must be considered with reference to 2003/0621. 2003/0621 (Peter Longstaff and Drs Jones and Hamilton) contains the bulk of the evidence. As stated on the CERF in that case, the solicitors acting for the doctor do offer a very credible defence. Ultimately, however, their version of events does differ from that of the complainants. I do think that there certainly is a realistic prospect of establishing impaired fitness to practise based on the evidence.

Turning to allegations 1 and 2, the complainants say that they were not told of the dangers of the blood product and were not told of the positive test result, the doctor says that the complainants were told. I think that these allegations should be tested before a Panel, based on the fact that the complainants' version of events is corroborated by four other sets of complainants.

I recommend referral to a Panel.

Case Examiner Referral Form

Section 1: Case Details

See Notes on Completion at end of form

FPD reference **2003/0728**

Doctor's name **JONES, Peter**

Registration no. **0407030**

Date **3 October 2005**

Investigation Officer Jon Abel

File location: E:\.... NR

Section 2: Previous History

See Note 1

Previous history? Yes

FPD Reference	Nature of complaint	Outcome/current status
2003/0315	Similar to this one	Open
2003/2098	Similar to this one	Open
2003/1298	Similar to this one	Open
2003/0776	Similar to this one	Open
2003/0621	Similar to this one	Open

Section 3: Index complaint – background and summary

This is one of a series of complaints about the issue of haemophiliacs contracting hepatitis C through contaminated plasma.

The complainant was one of the original litigants in a class action against the Department of Health, which concluded in 1991. That case was concerned with the contracting of HIV. The case was settled out of court, and part of the settlement was signing a 'hepatitis waiver', which meant that the complainant could undertake no legal action in the UK in relation to the hepatitis virus. The complainant is currently seeking legal redress through the American Legal System.

Whilst looking through his medical records, Mr GRO-A found that there was a letter from 1991 which referred to his being diagnosed as having the hepatitis C virus a year earlier. This meant that a) he had been tested for the virus without his knowledge and express consent and b) he had not been informed that he was carrying the virus for about four years.

As a result of this, he could have put his wife at risk and also, he was denied the opportunity to make the requisite lifestyle changes needed to protect his liver from further damage. This would have undoubtedly influenced his decision to sign the aforementioned waiver.

Records from the period surrounding the 1990 test have gone missing. It is clear that there *was* a test in 1992, and Dr Jones' initials are on the test result paper, and there is an unexplained gap of two years before Mr GRO-A was informed. There was also no pre/post-test counselling offered. Further, the consequences of this virus were not explained in 1994 (which his wife can attest to), and no treatment options for cirrhosis were discussed.

Also, the 1991 letter makes clear the need for a biopsy and a liver scan – neither of which he has had to date. Dr Jones made no effort to refer Mr GRO-A to the appropriate specialist. Mr GRO-A says that he has no knowledge of attending a liver clinic, yet that is contained within his records.

There is a further letter at flag 2. He states his wish that this case not be considered in isolation, but along with other haemophiliac cases. He refers to evidence contained within Ms Grayson's file (2003/0621) and lots of other evidence, much of which is in his medical records or attached to the letter (flag 2). The letter also contains many additional points, such as the lack of care and lack of information given to patients despite evidence that they knew about the virus. He also states that claims of inaccuracies in the tests which may be made by the doctors does not hold true, as Mr GRO-A (2003/1298) was told that he had the virus in 1990.

Dr Jones has not made any comments at this time.

Section 4: Additional information

The Medical Records are attached to this file.

Section 5: Performance Assessments/Health Examinations

None

Section 6: Summary of Allegations

See Note 5

A No	B Allegation	C Presumption of impaired FTP?	D Breach of GMP?
1	Dr Jones authorised the testing of the complainant without his consent.	No	Yes
2	Dr Jones offered no pre/post test counselling/advice, including not referring the complainant to liver specialists.	No	Yes
3	Dr Jones withheld the results of the test for a number of years.	Yes – dishonesty	
4	The plasma company's funding of Dr Jones may have influenced his decision to use their product.	Yes – dishonesty	

Other relevant guidance? No

See Note 6

Section 7: Charges

GRO-A

37. Mr GRO-A was a patient at the Newcastle Haemophilia Centre.

38. In or around 1990 you arranged for GRO-A to be tested for the Hepatitis C virus.

39. You did not:

a. tell GRO-A that you had requested that he be tested for the virus;

b. obtain GRO-A consent to be tested for the virus;

c. offer GRO-A counselling to see if he wanted to be tested for the virus.

40. Following the test for Hepatitis C you did not:

a. reveal the results of the test to GRO-A

b. refer GRO-A to a Liver Specialist;

c. give GRO-A an opportunity to make lifestyle choices to protect his liver from further damage;

d. advise GRO-A that his wife might be at risk of infection.

41. You did not keep any or any adequate records of the Hepatitis C test having been carried out in or around 1990.

42. In or around 1992 you arranged for GRO-A to have a further test for the Hepatitis C virus.

43. You did not:

a. tell GRO-A that you had requested that he be tested for the virus;

b. obtain GRO-A consent to be tested for the virus;

c. offer GRO-A counselling to see if he wanted to be tested for the

virus.

44. Following the test for Hepatitis C you did not:

a. reveal the results of the test to GRO-A;

b. refer GRO-A to a Liver Specialist;

c. give GRO-A an opportunity to make lifestyle choices to protect his liver from further damage;

d. advise GRO-A that his wife might be at risk of infection.

45. You have provided assistance to the lawyers claiming compensation for Haemophiliacs who had contracted HIV.

46. You were aware that GRO-A would have been asked to sign a Hepatitis C waiver as part of his claim for compensation against the government.

47. You administered US blood replacement products to GRO-A even though you knew that they were high risk products.

48. You did not tell GRO-A of the risks associated with the products to enable him to decide whether to take the treatment.

49. In 1994 you told GRO-A that he had tested positive for Hepatitis C.

50. You told GRO-A and his wife not to worry and to get on with life.

51. You did not:

a. explain to GRO-A that he had been infected with a dangerous virus;

b. explain to GRO-A the possible consequences of that infection;

c. discuss any treatment options with GRO-A;

d. arrange a liver scan;

e. arrange a liver biopsy;

f. arrange appropriate treatment.

52. GRO-A medical records contain reference to him attending a liver clinic.

53. You did not tell GRO-A that what he was attending was a liver clinic.

Section 8: Conclusion/Suggested Action

The question is whether an individual doctor can bear responsibility, such that his fitness to practise is impaired.

This case must be considered with reference to 2003/0621. 2003/0621 (Peter Longstaff and Drs Jones and Hamilton) contains the bulk of the evidence. As stated on the CERF in that case, the solicitors acting for the doctor do offer a very credible defence. Ultimately, however, their version of events does differ from that of the complainants. I do think that there certainly is a realistic prospect of establishing impaired fitness to practise based on the evidence.

Turning to allegations 1-3, the complainants say that they were not told of the dangers of the blood product and were not told of the positive test result; the doctor says that the complainants were told. In addition, the doctor has said that pre-/post- test counselling was offered; the complainants again say that no such counselling was offered. I think that these allegations should be tested before a Panel, given the seriousness of the issues and the weight of evidence the complainants have supplied.

Screening decision
GRO-A v Drs Jones & Hamilton (2003/0728)

Background
This case is part of a larger one involving Haemophiliac patients who have contracted Hepatitis C via infected blood products. A number of patients and doctors are implicated. This case concerns Dr Peter Mercer Jones and Dr Peter John Hamilton, haematologists involved in the treatment of Mr GRO-A, a patient with haemophilia who has HIV and Hepatitis C.

Allegations
- Essentially claims are that there was knowledge of Hepatitis C and its potentially fatal consequences for a significant time before patients at risk were involved in a discussion of the pros and cons of their treatment with blood replacement products
- In addition complaints are that testing was carried out without any pre-test counselling
- Patients were not made aware of positive results and were therefore unable to make appropriate decisions about lifestyle and future treatment
- Doctors continued to administer blood replacement products in the knowledge that they were high risk products without involving patients in the decision making process
- Patients who had haemophilia signed a waiver preventing future claims for Hepatitis C infection when they sought HIV compensation. Most patients at this time allege that they were unaware that they were infected and not made aware of the potentially serious implications of Hepatitis C infection.
- Consent issues surround the fact that other professionals (e.g. GP) were aware of the patients hepatitis C status, when the patient was not
- Mr GRO-A alleges that funding from a US company may have affected Dr Jones' choice of blood replacement products, thereby not putting his patient's best interests first

Decision
The facts are well outlined in Tim Cox-Brown's screening memo and the case is complex. However the allegations, if proven would represent SPM and therefore I think that the case should go forward to PPC for both doctors. The complexity arises from the difficulty in identifying specific individual responsibility, because of the large number of people involved in the treatment of patients with haemophilia

The wider public interest facets of this case mean that I believe the 5 year rule should be waived in this instance

Dr Peter Mercer-Jones: Refer to PPC
Dr Peter John Hamilton: refer to PPC

GRO-C

Memorandum

Ref: **2003/0728**
To: 1. Medical Screener
2. Lay Screener

Out	Back

From: Tim Cox-Brown
GRO-C

Date: 11 May 2004

Complaint by: Mr. GRO-A

Against Dr(s): **1. Dr. Peter Mercer Jones**
MB BS 1962 Durh SR (Paediatrics & Haematology)
2. Dr. Peter John Hamilton
BM BCh 1968 Oxfd SR (Haematology)

Registration No: 1. 0407030
2. 1235072

Identification & History

1. Drs. Jones and Hamilton have been identified. There have not been any previous complaints about either doctor, although there are five other current complaints about Dr. Jones (2003/0315, 2003/0621, 2003/0776, 2003/1298 and 2003/2098), and three other current complaints about Dr. Hamilton (2003/0315, 2003/0621, and 2003/2098) which are attached and which are from other haemophiliacs.

2. Mr. GRO-A complaints about Drs. Jones and Hamilton have already been considered by Medical Screeners (on two separate occasions). The Screeners was asked to decide whether the public interest required that we consider Mr. GRO-A complaints, despite the events leading to them having taken place over five years ago. The Medical Screeners confirmed that we should consider the complaints (see memos below at Flags A and B), and we have therefore dealt with this complaint in the usual manner, including disclosure to Drs. Jones and Hamilton who have both declined to comment at this stage (see Flag 3 for response from Dr. Jones; Dr. Hamilton has not responded at all).

3. At Flag C below is a copy of our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s.

4. Mr. GRO-A initial complaint about Dr. Jones is at Flag 1. Further information from Mr. GRO-A is at Flags 2 and 5. Mr. GRO-A complaint about Dr. Hamilton is at Flag 4. We have obtained copies of Mr. GRO-A medical records from his GP (volume 2), and from Victoria Royal Infirmary (which are voluminous, and are

available should you require them). In his correspondence Mr. GRO-A refers to the "collective evidence of Carol Grayson", which is contained within case file 2003/0621.

Background

5. Mr. GRO-A made his complaints about Drs. Jones and Hamilton on separate occasions, but it seems to be the case that the allegations he has made apply equally to both doctors. These allegations are as follows:

a) Mr. GRO-A was infected with HIV and hepatitis C from contaminated plasma concentrates used in the treatment of his haemophilia.
b) He was tested for hepatitis C without his knowledge or consent as early as 1990, and he was not informed of the positive result of this test until 1994. Dr. Jones requested a hepatitis C test in 1990, but Mr. GRO-A also claims that Dr. Hamilton would have known of the results and failed to inform him of his hepatitis C positive status.
c) Mr. GRO-A says that it is clear from his medical records that he had been exhibiting symptoms of liver disease "for several years" by 1991, and that Dr. Hamilton was monitoring him as long ago as 1985 because of "an interest in liver disease in haemophiliacs". Mr. GRO-A claims that he was not informed of this monitoring, or that abnormal liver function test results had been recorded.
d) Mr. GRO-A says that he has put his wife at risk of infection with hepatitis C unknowingly, given that four years elapsed between his first positive hepatitis C test result and the date on which he was informed of his positive status (1994). He also says that by failing to inform him that he had tested positive for hepatitis C immediately the doctors denied him the opportunity to make immediate lifestyle changes to protect his liver from any further damage.
e) Mr. GRO-A signed a waiver regarding potential future litigation on hepatitis C infection in 1991 as part of the HIV litigation brought against the department of health. He says that he would not have signed this waiver had he known at the time that he had tested positive for hepatitis C. He appears to be suggesting that Drs. Jones and Hamilton deliberately withheld his test results from him for this purpose.
f) Mr. GRO-A says that when he was informed that he had been infected with hepatitis C he was told that it was nothing to worry about. He claims that the seriousness of the disease was played down and he received no information about the possible consequences of the infection. Mr. GRO-A says that this was the case despite it being well known by doctors that haemophiliacs had become seriously ill because of the virus, and that others had died as a result of hepatitis C infection. Mr. GRO-A says that Dr. Hamilton referred to haemophiliacs infected with hepatitis C as the "worried well" until recently.
g) Mr GRO-A says that his doctors did not discuss possible treatment options, and that it is only in the last two years that he has begun to receive treatment for hepatitis C.

h) Mr. GRO-A says that he did not receive any pre- or post-test counselling regarding hepatitis C.

i) Mr. GRO-A says that correspondence in his medical records which dates from 1991 suggests that he needed to have a liver biopsy, but that this has never been carried out. He also says that he has never been referred to a liver specialist, or assessed for a liver transplant, even though his medical records say that he has attended "liver clinics" at the haemophilia centre at the Royal Victoria Hospital. Mr. GRO-A says that he was never told that he was attending such clinics, and that hepatitis C was never discussed.

j) Mr. GRO-A claims that his doctors were reluctant to provide treatment for hepatitis C, or even to discuss it with haemophiliacs with hepatitis C and HIV, as they were embarrassed that those infections had been caused by NHS treatment.

k) Mr. GRO-A claims that Dr. Jones failed to develop a policy for testing for hepatitis C when the experiences with HIV should have shown that such a policy was necessary.

l) Mr. GRO-A says that he was not informed of the risks of treatment with factor concentrates made from human plasma, despite those risks having been well known by medical practitioners for some considerable time. Mr GRO-A says that he was therefore denied his right to make an informed choice about his treatment. He also says that even when it became clear that patients were being infected with hepatitis C from contaminated factor concentrates, often on first use, doctors continued to use those products, thus exposing patients to repeated risk of infection.

m) Mr. GRO-A has suggested that Dr. Jones may have received funding from US plasma companies, either for himself or for the Haemophilia Centre, and that this may have influenced him to continue to use risky products at the same time as failing to inform patients of the risks.

Conclusion & Recommendation

6. Mr. GRO-A has made serious allegations about Drs. Jones and Hamilton, which clearly reach the threshold of SPM, and which are properly arguable. I feel, therefore, that this complaint should be referred to PPC for further consideration, but I should be grateful, however, for your advice on this case.

7. I should also be grateful if you would confirm that the public interest requires that Mr. GRO-A complaint should be referred to PPC despite the events giving rise to it occurring over five years ago.

8. I look forward to receiving your advice.

[redacted]

GRO-A

TEL N°:- GRO-A

16 MARCH 2003

PRIVATE AND CONFIDENTIAL

TESTING PATIENTS FOR HEPATITIS C WITHOUT THEIR PERMISSION

Dear Sir,

I wish to make an official complaint in relation to the conduct of my former consultant Dr. Peter Jones, who worked for many years at the Haemophilia Centre, Royal Victoria

Infirmary, Newcastle upon Tyne.

I am a haemophiliac who became infected with HIV and hepatitis C through contaminated plasma given to me as an NHS patient. I was one of the original litigants in a class action against the Department of Health which ended in an out of court HIV ex-gratia payment in 1991. As part of this settlement I had to sign a hepatitis 'waiver' which meant that I could not take further legal action for hepatitis C infection.

I have recently obtained the services of an American lawyer and I am now pursuing a legal case against four major plasma companies through the American courts.

I was required to obtain copies of my medical records to send to my U.S. lawyer and it was whilst doing so that I came across information in my medical records which gave me cause for great concern. In my notes was a letter dated 1991 which referred to my being hepatitis C positive 'a year earlier' which would have presumably been sometime in 1990. Also a letter dated 1991 referred to me having symptoms consistent with cirrhosis related to my hepatitis C infection and abnormal liver function tests for a number of years.

I was very upset and angry as I then realised that I had been tested for hepatitis C against General Medical Council guidelines without my knowledge and

permission in 1990 with further tests carried out in 1992, yet I was not told of my infection until 1994. This meant that I could have unknowingly put my wife GRO-A at risk, and also because I was not told the positive result in 1990 I was denied the opportunity to make life-style choices at that time to protect my liver from any further damage. I would certainly not have signed a hepatitis legal waiver had I known of my positive hepatitis C resulted and that hepatitis C was a potentially life threatening disease.

I have recently written to the RVI Trust, as despite reference in a letter in my notes to being hepatitis C positive in 1990 and requesting a copy of this early test

result, so far I have only been sent test results from 1992. They appear to have lost this early 1990 test result, an occurance which is happening only too often nationally with regard to haemophilia records. I believe questions are being raised in Parliament on the subject of missing haemophilia records.

The name on the 1992 test request form is Dr. Peter Jones. I fail to comprehend why he would keep an important test result from me for years. I recall he was assisting in providing information to my Solicitor Mr Tony Mallen with regard to viral infections.

I had always made it clear to my consultant that I would want to be informed of any medical problems with

regard to my health, so why did Dr Jones test me without my knowledge then not tell me the result?

I am aware that patients cannot be tested for infectious diseases without their informed consent. I did not give written or oral consent to these early tests. I also understand that I should have received pre and post test counselling to help deal with a test result positive or negative. This did not happen. When I was eventually told that I had tested positive for hepatitis C in 1994 in the presence of my wife who attends all of my appointments, we were told not to worry and to get on with life. I was not explained at the time that I had been infected with a dangerous virus and the

possible consequences of that infection.

It is frightening to think that despite having been identified as having symptoms consistent with cirrhosis in 1991 that Dr Jones did not think to discuss any possible treatment options with me at the time. It is only during this last year that I have been prescribed interferon/ribavirin along with other patients after we complained over why we had not been offered any type of treatment in the past. It took intervention from other non-haemophilia departments to help haemophiliac's access treatment. Were our haemophilia consultants just going to let us die without treatment, had they written us off because of our HIV status?

The 1991 letter mentions the need for a

biopsy, which I still have not had and the need for a liver scan. The whole issue of hepatitis C was played down. I recall another haemophiliac asking about the possibility of a liver transplant but being refused. I am aware of only one person being referred for assessment for a liver transplant and that is Mr Longstaf Haematologists are not experts in liver disease yet for years they appeared reluctant to refer over to specialist services. My medical notes recorded that I had attended a 'liver clinic' at the Haemophilia Centre for years yet incredibly I was not even made aware that I was attending such a clinic as until recently nothing related to my hepatitis C was discussed with

myself or my wife. What they recorded in the records and what happened in reality often do not match up. It is difficult for patients to speak up as it is usually the doctor's word that is believed over that of a patient.

It is my belief that because haemophiliacs acquired their viruses through their NHS treatment that they were an embarrassment to their consultants. The doctors attitudes to us suggested that they would rather we were not around, particularly as we became more informed. Our consultants did not want to answer our questions on our contamination or support us for a public inquiry. Dr Jones did not even

support us in our fight for the safer treatment recombinant, a synthetic alternative to human plasma.

I would be most grateful if you could investigate my concerns over Dr Jones testing me for hepatitis C without permission and the resulting issues. I believe according to GMC guidelines that doctors can be held to account in a criminal court for such actions.

My wife supports me in my complaint.

Thanking you in anticipation of your reply.

Yours sincerely

GRO-A

GRO-A

GRO-A

Friday 18th April 2003

HEPATITIS C TESTING WITHOUT PERMISSION

Dear Mr Cox-Brown,

Thank you for your letter explaining the procedure for complaining about a doctor. My wife GRO-A and I have gathered together documents from my records, which refer to testing without permission and knowledge of liver problems. We are very concerned to read that some hospital letters and records do not accurately record certain events and we will explain this further. We ask that you consider our complaint against Dr Jones alongside other Newcastle haemophiliacs, not in isolation. Ms Carol Grayson has given permission for her collective evidence to be taken into account with other similar cases in Newcastle. We have realised how similar our cases are when we have met together and shared information. We are concerned that much information has been withheld from patients, and doctors that have done this may try to cover their tracks. There is now an internal investigation into record keeping at the Royal Victoria Infirmary as a result of haemophiliacs' written complaints. It may be too late when confidential information has already been lost. I thought medical records were supposed to be accurate legal documents? It is very difficult for patients to complain about doctors who have treat them for years and it is also very difficult for us to have to go back to the same haemophilia centre as the atmosphere is uncomfortable for those of us that challenge the doctors and dare to question the way they have treat us.

We first noted a reference to liver problems in haemophiliacs in my medical records going back to a letter dated January 1985 from Dr Peter Hamilton, Consultant Haematologist, Royal Victoria Infirmary Newcastle to Dr R Wilkinson, which states, "I keep an eye on him because of an interest in liver disease in haemophiliacs." This was written even before we had been given my HIV result and shows that haemophiliacs were clearly being monitored years back for liver disease. At that time we were not aware of this nor were we told the reason why I was being monitored. If there were problems with the factor VIII treatment surely the doctors had a duty to inform me fully of any risks, see collective evidence from Ms Carol Grayson, (House of Lords Ruling 1985). I believe I would have had the right to refuse treatment if I wished to do so because of the risks of HIV and hepatitis C in the factor VIII. I believe I should have been warned of the high risks as soon as they were known and I refer to collective evidence (letter from Dr J Garrott Allen to William Maycock, 1975, discussing hepatitis risks in treatment.)

I requested my very first hepatitis C test results from the RVI Haemophilia Centre and it is interesting to note that the first test result I was sent by Sister Maureen Fearns was a December 1992 test result. When I examined copies of some medical records that were copied for the American lawyers I came across an earlier test result

dated October 1990, (which Sister Fearns didn't send us,) the initials on the test result refer to Dr Peter Jones who was my Consultant and the person we believe ordered this test. The result states, "HCV detected", (see test photocopy). There is another test form dated November 1990 which reads "previous test (17th October) stated HCV antibody positive" (see test photocopy.) Please could you read the following also, a letter dated 14th March 1991 referring to my being hepatitis C positive and having had "persistent abnormal liver tests for a number of years" and "He now has hepatomegaly consistent with hepatitis C related cirrhosis. He ought to have a liver biopsy and scan and perhaps we could discuss this." Also, a letter written by Doctor Jackson in June 1991, where he refers to my being hepatitis C positive last year which made it 1990. Why didn't someone sit down and explain all this to me, educating my wife and I about hepatitis C? The only thing we knew at that time was that I had problems with my stomach and was seen at a Gastroenterology Clinic, no-one mentioned hepatitis C. We thought our biggest problem then was HIV but it is obvious that I was already starting to show signs of liver problems. There is a further test result dated December 1992 which reads "hepatitis C antibody positive" (see test photocopy) which was the test passed off by Sister Fearns as my first ever positive test result, again this appears to be requested by Dr Jones, my Consultant Haematologist.

It is immaterial that the hospital may claim the first results were not accurate enough; the fact is I was not asked for my permission to test for an infectious disease, hepatitis C. If I was being used to research a test shouldn't someone have asked my permission? My consent for these tests is not documented anywhere in the notes that I could see because I certainly did not give it, I repeat, no-one asked me. Even if the first tests were not so accurate, I am not a guinea pig to try out tests and would have expected to be asked. Any testing of my blood for infectious diseases should have been explained to me, because testing has serious implications. This was all supposed to have been sorted out after the HIV test was introduced in 1985 because of mistakes made at that time. We were told procedures for infectious diseases were in place.

GRO-A and I were not given any pre or post-test counselling for hepatitis C, no-one explained the implications of being tested. I could not make life choices without this knowledge. I could not enquire about health issues or treatment when I did not know I had hepatitis C. If I had known I was being tested even with an inaccurate test or even if I had known a test was available, I would have been suspicious that something might be wrong and I certainly would not have signed the hepatitis legal waiver in the HIV settlement required by the Government in 1991. My right to "informed consent" has been denied me by a doctor or perhaps more than one withholding information on the hepatitis C test. I hope to challenge this legally along with other haemophiliacs.

I don't understand if the test was so inaccurate how Mr GRO-A another haemophiliac could be told his result in 1990 and also that other hospitals could actually write to their patients at that time giving them their results on paper, (see collective evidence letter from Mr GRO-A who has given Ms Grayson permission to use this letter plus the letter from the Royal Free Hospital). When GRO-A and I were eventually told of GRO-A positive test result in 1994, we were told not to worry about it, no-one explained that it could be a life threatening condition and that doctors had known how serious it was for years. (See collective evidence Professor Preston's

legal report for Mr Longstaff.) I want to know why Dr Jones and Dr Hamilton told patients it wasn't a problem for so long when in Ms Grayson's evidence (see GRO-A GRO-A letter 1996) it said that before haemophiliacs signed the waiver in 1991the Government knew that haemophiliacs had died and others were seriously ill from hepatitis C. Why weren't haemophiliacs told this at the time?

In a letter from Dr Jones to Dr Hamilton dated 22nd May 1991 I note the following lines, "I put to him our suggestion that we should sit down with Jane sometime at the end of June to develop a policy which we should obviously explain to the patients first." (see photocopy of letter) I want to know why this didn't happen? I wasn't told until 1994 and then hepatitis C was played down. Doctors should have already had a policy from their experience of testing us for HIV. It was too late after they had already tested patients for hepatitis C.

My wife and I are very angry over the letter dated 22nd May 1991 (see photocopy) the content of which is totally incorrect. GRO-A remembers clearly that her distress was because she was asked to leave the room in which I was being examined. It was suggested to her that I may need to have an invasive procedure carried out (we understood this to be in relation to a possible recurring ulcer/gastroenterology problem not anything connected to the liver), and GRO-A was aware that I had not had any cover (factor VIII) treatment, which I must take before any invasive procedure. She mentioned this to a nurse and later we both went from my out-patient appointment to see Dr Jones together to ask that if we had further appointments in other departments he would ask the staff to ring the Haemophilia Centre to confirm that cover was needed for invasive procedures. That was the reason for her concern and upset, hepatitis C was not even discussed. I don't know where Dr Jones got the idea we were concerned about hepatitis C at that time, it hadn't been discussed with us as an issue for GRO-A We were only told of his positive hepatitis C result in 1994 and then we were told verbally, not in writing. Why would Dr Jones write to Dr Hamilton in May 1991 of the need to introduce a policy if one was already in place before we were first tested?

We were told that HIV was the big problem back then and I might have only a few years to live. I know that it is difficult for people to understand that hepatitis C wasn't discussed with patients until around 1994 and then not in any detail. I feel that this may have something to do with fear of further litigation as the Trust was a defendant in the HIV litigation and I don't suppose they wanted a repeat of that experience. Eventually we all got an ex-gratia payment from the Government but the work of the original solicitors and their evidence, often withheld from patients, is now being examined. The police are also looking into the whole affair. Hepatitis C was certainly not put over as a serious problem by staff at the Haemophilia Centre until the late 1990s. In the early 1990s it would have been easy to pass off any medical problem as HIV- related and patients would have been none the wiser. We recall that haemophiliacs with hepatitis C were called the "worried well" by Dr Hamilton for a long time. The national Haemophilia Society did not acknowledge the serious nature of hepatitis C until it started its campaign in 1995, a year after Ms Grayson began her campaign in 1994.

GRO-A and I believe that the haemophilia centre at the RVI was way behind with its knowledge of this virus. (see recent letter April 2003 from Chief Executive,

Len Fenwick, about testing without permission). This letter is full of contradictions. I have still not been referred over to the liver clinic at the Freeman Hospital, Newcastle, although I have recently had interferon/ribaviron treatment, other patients managed to be seen here only after they got their GP to refer them. The haematologists are not liver specialists but it appeared for a long time that they were not keen for us to be seen outside of the haemophilia centre, it was as if they were ashamed at how many of their patients were infected with HIV and hepatitis C through what was supposed to be a miracle treatment and turned out a disaster for most haemophiliacs. We had to fight to be referred to other hospitals for treatment.

We are also fighting to get a public inquiry into how haemophiliacs came to be contaminated and why so much information was withheld from haemophiliacs. It wasn't just in Newcastle, it happened in other hospitals as well. I know that you can't organise a public inquiry but you can look at individual doctors. We believe that the standard of good practice at the Haemophilia Centre in Newcastle fell far short of what is required. Doctors are supposed to educate their patients about their problems and observe their human rights. We were treated like children, which is insulting to our intelligence. I would also like to know what funding Dr Jones received over the years from the American plasma companies either for the Haemophilia Centre or for himself, travel research etc as I am concerned along with others that this may have influenced what he told patients (or did not tell them) about the dangers of treatment. I know in other countries doctors were sent to prison over contaminated blood issues. We need some answers to our questions not just for us but also for the many relatives who have lost someone and are still in the dark. We hope that you can help us with this.

GRO-A and I would like to ask for a private group meeting for ourselves and other people who have complained about these issues. We know that there are other patients who have the same concerns but dare not complain, they still have to go to the Haemophilia Centre as I do, and they don't have much faith that anything will be done about complaints to the GMC. The Department of Health is supposed to be investigating testing without permission and writing to us. Lord Alf Morris of Manchester is assisting us as he got involved in haemophilia problems through his former constituent. We believe that the Haemophilia Society has also raised this with the Department of Health although they themselves have withheld a lot of information over the years.

If you need any more information please contact us. We would also like to know the names of those individuals who will receive a copy of our letters and evidence? Thank-you for your help.

Yours sincerely

GRO-A

Mr GRO-A and Mrs GRO-A

LETTER + REPORTS

Ref: PJH/MB

7 January 1985

Dr R Wilkinson
Consultant Haematologist
FREEMAN HOSPITAL

Dear Bob

GRO-A dob GRO-A .41
GRO-A

This young man attends your hypertensive out-patient Department. He has been shown to have chronic pyelonephritis in the past by IVP. I keep an eye on him because of an interest in liver disease in haemophiliacs. We do not seem to have had any letters from your clinic since September, 1983.

If he has been followed up by the SHO on a yearly basis it might be better if hypertensive follow up was incorporated into our physical assessment.

With best wishes,

Yours sincerely

PETER HAMILTON MA BH BCH FRCP MRCPath
Co-Director

DEPARTMENT OF VIROLOGY/PUBLIC HEALTH LABORATORY, NEWCASTLE GENERAL HOSPITAL

SURNAME GRO-A

FORENAME(S) GRO-A Sex M

Hospital No. GRO-A

Ward Haem C" Date of birth

Hospital RVI Consultant PJ

Lab No(s) 17 OCT 1990 13799

SPECIMEN V-BLOOD Time Date 17.10.90.

Date of onset of symptoms

CLINICAL DETAILS AND INVESTIGATION REQUIRED Haem A. HIV above

HCV Status Please.

Reported

FOR LABORATORY USE ONLY

24 OCT 1990

nti HCV DETECTED

ENTERED

GRO-C

BIOHAZARD

S/NGH/113
WZV 413

PLEASE USE BALL POINT PEN FIRMLY

NGH/PHL VIROLOGY

S/NGH/113
WZV 413

PLEASE USE BALL POINT PEN FIRMLY

SPECIMEN DATE/TIME

BIOHAZARD

Date Pathologist

27.10.90

LABORATORY, NEWCASTLE GENERAL HOSPITAL

FORENAME(S) GRO-A Sex

15106

13.NOV.1990

Hospital No. GRO-A

Ward Haem Date of birth

Hospital RVI Consultant Jones

SPECIMEN V1B Time Date 13.11.90

Date of onset of symptoms

CLINICAL DETAILS AND INVESTIGATION REQUIRED

Haem A on AZT HCV status, please.

HIV+ve

Date reported FOR LABORATORY USE ONLY

14 NOV 1990

Previous test on 17.10.90 (lab.no. 13799) showed

Hepatitis C antibody POSITIVE

GRO-C

NC VIROLOGY S/NGH/113 WZV 413

S/NGH/113 WZV 413

NGH/PHL VIROLOGY S/NGH/113 WZV 413

PLEASE USE BALL POINT PEN FIRMLY

PLEASE USE BALL POINT PEN FIRMLY

PLEASE USE BALL POINT PEN FIRMLY

SPECIMEN midstream urine

BIOHAZARD

DATE/TIME RECEIVED 27.6.36

SPECIMEN DATE/TIME

Pathologist

NEWCASTLE HEALTH AUTHORITY
THE ROYAL VICTORIA INFIRMARY
QUEEN VICTORIA ROAD, NEWCASTLE UPON TYNE NE1 4LP
Telephone Tyneside (091) 232 5131

DR C O RECORD/DR K MATTHEWSON
GASTROENTEROLOGY AND LIVER CLINIC

Ref COR/JMH/1258858R

14 March 1991

Dr P Hamilton
Consultant Physician
Haematology Department
RVI

cc Dr Graham
Medical Centre
Percy Street
Tynemouth
Tyne and Wear

Dear Peter

re: GRO-A dob GRO-A 41
GRO-A

Thanks for your letter about this HIV positive haemophiliac who has been on the AZT trial since 1990. He had a vagotomy and pyloroplasty for duodenal ulcer in 1974 and was pretty well following this until about five years ago since when he suffered from epigastric and retrosternal burning. He has been on Tagamet and Zantac more or less continuously since then but his symptoms only resolved with a one month's course of Omeprazole. At present he complains of indigestion every day, usually after breakfast and about 7.00 p.m. after his main meal. It is relieved by a biscuit or taking mild and chocolate. His appetite is reasonable and his weight is steady.

On examination he appeared fit enough. Abdominal examination revealed hepatomegaly (one finger breadth) but there was no tenderness.

I think it is important to exclude recurrent ulcer disease in his case and I am therefore arranging endoscopy four weeks after discontinuation of H2 receptor antagonist therapy. In the meantime I have told him to control his symptoms with Maalox. I note that he is hepatitis C positive and has had persistently abnormal liver function tests for a number of years. He now has hepatomegaly consistent with hepatitis C related cirrhosis. He ought to have a liver biopsy and scan and perhaps we could discuss this.

I will let you know the results of the endoscopy in due course.

Yours sincerely

C O Record
Consultant Physician

GRO-C

Dictated but not signed.

CASTLE HEALTH AUTHORITY

LETTERS + REPORTS

MEDICAL IN-PATIENT SHEET No. ..... or OUT-PATIENT SHEET No. .....

R4

..... HOSPITAL

CONSULTANT

.....

REFERRED BY

.....

SURNAME (Block Letters) .....

HOSPITAL NUMBER

FIRST NAME(S) ..

GRO-A

AGE

DATE

GHJ/JJW - 4.6.91

Admitted: 3.6.91
Discharged: 3.6.91

This pleasant young gentleman with Haemophilia A came for investigation of abnormal liver function tests. He has had a raised ALT for sometime and was Hepatitis C +ve last year. He has been noted to have some degree of hepatomegaly over the last few weeks and he was admitted as a routine case for liver scan which was performed on the Ward.

He will be followed up closely in the Haemophilia out-patient clinic.

Yours sincerely,

GRAHAM H. JACKSON
Lecturer in Haematology

Dr. Graham,
Medical Centre,
Percy Street,
TYNEMOUTH.

Directors: Dr. P
Clinical Nurse Sp

Blood Reports

10th

VIROLOGY RVL

Serology Only

ENTERED

Please use ball point pen

Surname	GRO-A	Record Number	GRO-A	CLINICAL DIAGNOSIS AND DURATION OF ILLNESS
Forenames	GRO-A			Haem A - HIV+ve. Hep A IgG } Please. Hep C }
Date of Admission		Age	D.O.B.	Nature of specimen / Time Collected
Consultant Code: Jones	Ward: Haem	Hospital: RVI		M.O. Signature / Date: 15.12.92

FOR LABORATORY USE ONLY

ANTIBODY TITRES	VIRUS	RESULTS FROM OTHER LABORATORIES	
VIRUS	CMV IgG	RUBELLA HI TITRE/IMMUNE	
INFLUENZA A	CMV IgM		
INFLUENZA B		HEPATITIS A Ig[illegible]	POS=IMMUNE
PSITTACOSIS / LGV		HEPATITIS B VIRUS	B_3
Q FEVER	ANTI-EBV CAPSID IgG	HBsAg	B_4
MUMPS V	ANTI-EBV CAPSID IgM	ANTI-HBs Ag	B_5
MUMPS S	ANTI-EBNA IgG	ANTI-HBc Ag	B_6
ADENOVIRUS			
M. PNEUMONIAE			
HERPES SIMPLEX			
[illegible] V.			
RUBELLA BOOTER			
MEASLES			

COMMENTS:- Hepatitis B Antibody Positive by ELISA RIBA: 2nd

Hepatitis C positive. Post Hep A infection.

Maria Peiris 24/12/92

NGH/PHL VIROLOGY

PLEASE USE BALL POINT PEN FIRMLY

NGH/PHL VIROLOGY

PLEASE USE BALL POINT PEN FIRMLY

S/NGH/113 WZV 413

NGH VIROLOGY

S/NGH/113 WZV 413

PLEASE USE BALL POINT PEN FIRMLY

S/NGH/113 WZV 413

PLEASE USE BALL POINT PEN FIRMLY

NGH/PHL VIROLOGY

S/NGH/113 WZV 413

PLEASE USE BALL POINT PEN FIRMLY

SPECIMEN: Midstream urine

DATE/TIME RECEIVED: 21:02:89 1537

SPECIMEN DATE/TIME: 21:02:89

BIOHAZARD

Date: 27.3.93

Pathologist

110

LETTERS 85-99

NORTHERN REGIONAL HAEMOPHILIA SERVICE

THE ROYAL VICTORIA INFIRMARY
QUEEN VICTORIA ROAD, NEWCASTLE UPON TYNE, NE1 4LP

TEL: (091) 232 5131
EXT. 24171
FAX: (091) 230 0651

Ref: PJ/LM

22nd May, 1991

IN CONFIDENCE

Dr. P. Hamilton,
Consultant Haematologist,
RVI.

Dear Peter,

GRO-A dob GRO-A 41
GRO-A

I enclose a copy of a letter I received from Chris Record this week. It came shortly after GRO-A and his wife had descended on me in a great state of alarm after GRO-A outpatient consultation. They had been told, or thought they had been told, that GRO-A had severe liver disease as a result of hepatitis C, that there was need for a liver biopsy (which was not explained to them), and that there was a possibility of some rather dire treatment in the offing. All this came as a complete surprise to them. I explained all the usual things and settled them down but subsequently ran across GRO-A in the ward whilst he was seeing another patient. I put to him our suggestion that we should sit down with Jane some time at the beginning of June to develop a policy which we should obviously explain to the patients first. I have asked Linda to arrange a meeting at a mutually convenient time and hope this is alright.

Kind Regards,

Yours sincerely,

GRO-C

PETER JONES
Director

The Newcastle Upon Tyne Hospitals NHS
NHS Trust

LRF/PA/JPM/272/02

28 March, 2003

CONFIDENTIAL

Headquarters
Freeman Hospital
High Heaton
Newcastle upon Tyne
NE7 7DN

Tel: 0191 284 3111
Fax: 0191 213 1968

GRO-A

Dear Mr & Mrs GRO-A

I am writing further to my letter of 25 March 2003 having completed an investigation into the concerns which arose out of GRO-A treatment for Haemophilia. May I advise of my findings.

At the outset may I apologise for the delay in coming back to you.

I am advised that the use of pooled coagulation concentrates became widespread in the 1970's and this resulted in a dramatic improvement in the quality of life for haemophilia patients. In the early days of using these concentrates it became clear that nearly all patients developed abnormal liver function tests. During the 1970s and 1980s there was considerable debate in the medical literature about the significance of these abnormalities. These abnormalities were not usually due to hepatitis B infection and the term "non-A non-B Hepatitis" (NANB Hepatitis) was used. During the 1980s there was conflicting information as to whether or not NANB Hepatitis resulted in progressive liver disease. At this time there was no known effective treatment and due to the apparent and immediate benefits of the concentrates, the long-term consequences were, and with the benefit of hindsight, very much under-estimated.

In 1989 Hepatitis C virus (HCV) was identified. This was shown to be the agent responsible for the vast majority of cases of NANB Hepatitis. Following the discovery of HCV, a first generation serological (i.e. blood serum) test became available in about 1990. I understand that there were considerable problems with this test as it resulted in both false positives and false negatives. In addition I am advised that at this time the significance of a positive test was not fully understood.

As time passed more reliable serological tests for HCV were generated and also the PCR (Polymerase Chain Reaction) test to detect chronic viraemia (i.e. the presence of a virus in the blood particles) also became available. By the mid 1990s accuracy of tests and the ability to monitor treatment with PCR was widely available. Also by this time, the natural history of chronic HCV infection, both in individuals with Haemophilia and in non-Haemophiliacs had become more apparent. In the early 1990s there was considerable uncertainty surrounding Hepatitis C and it was only by the mid to late 1990s that more information had become available.

When the first generation serological tests were available many Haemophilia Centres in the UK tested batches of stored serum. Dr Hanley, Consultant Haematologist and Haemophilia Centre Director, is of the opinion that it is unlikely that individual patient consent would have been sought at this time. Dr Hanley does not have personal knowledge of the practice in Newcastle at the time, as this occurred a decade before he came to work here. Dr Hanley has advised that no stored serum was available at this time so general testing would have been done on freshly obtained samples. On looking through the medical records, specific consent for HCV testing was very rarely documented but this was not to say that it would not be discussed at the time. At this time Dr Hanley is certain there would have been no reason for any reluctance on the part of the staff at the Haemophilia Centre to discuss Hepatitis C. Also, from 1991, approximately every two years there were educational events organised by the staff of the Haemophilia Centre to discuss a wide range of issues, including HIV and hepatitis. All patients registered at the Centre were invited to attend these meetings, but take-up was variable.

I note that you were seen at the Haemophilia Centre regularly in the 1990's and as Hepatitis C was so typical it would have been unusual for it not to have been discussed at some stage. Sister Fearns, Senior Haemophilia Nurse Specialist, and who would normally have discussed results on numerous occasions and provided counselling as appropriate. It is very difficult with the passage of time and the changes in personnel to provide you with a more comprehensive response. I must apologise again that it has taken so long to investigate this matter and for the paucity of information we are able to provide.

We have taken this grievance very seriously and acted accordingly but should you have any remaining concerns then please do not hesitate to get in touch and in the first instance you may find it helpful to contact Mr P Anderson, our Patient Services Officer, on GRO-C GRO-C

Finally, the Complaints leaflet sent with our acknowledgement of your grievance, explains what further steps can be taken if you should remain dissatisfied with the outcome of my investigation.

Yours sincerely

GRO-C

L R Fenwick CBE
Chief Executive

[redacted]

GMC-m
RECEIVED
23 JUL 2003
cash PO
cheque T.C

GRO-A

TEL:- GRO-A

Dear Mr Cox-Brown,

COMPLAINT RE DOCTOR HAMILTON

I wish to make an official complaint with regard to the conduct of Dr Peter Hamilton, former Consultant Haematologist at the Royal Victoria Infirmary, Newcastle upon Tyne.

As you are aware I have already written to you in relation to another Consultant Haematologist from the same hospital. I believe that Dr Hamilton is also implicated with regard to the same issue.

I have a letter dated January 1985 from Dr Hamilton to Dr R. Wilkinson which states "I keep an eye on him because of an interest in liver disease in haemophiliacs". This was written even before I had been given my HIV results and shows that haemophiliacs were clearly being monitored years back for liver disease.

When the class action against the Department of Health in the late 1980's began I was transferred to Dr Hamilton from

(1 OF 5)

[redacted]

Dr Jones. As a co-director of the RVI Haemophilia Centre he would surely have consulted with his fellow co-director on this issue and would have had full access to hepatitis C test results, yet he failed to communicate to patients that they were being tested without their consent and he failed to communicate test results at the appropriate time.

In copies of my medical records, a letter dated 1991 referred to me being hepatitis C positive 'a year earlier' which would have presumably been sometime in 1990. Also a letter dated 1991 referring to me having symptoms consistent with cirrhosis related to my hepatitis C infection and abnormal liver function tests for a number of years. I realised that I had been tested for hepatitis C in 1990 with further tests carried out in 1992 without my knowledge or permission. I was not told of my hepatitis C infection until 1994.

Dr Hamilton did not offer any pre or post-test counselling to me and like his colleague played down the seriousness of the hepatitis C virus. Dr Hamilton referred to haemophiliacs with hepatitis C as the 'worried well'.

I feel that there was a significant delay by both consultants with regard to patients being offered liver scans, liver biopsies and appropriate treatment for their condition. There appeared to be a reluctance to refer to specialist services outside the Haemophilia Centre.

I myself went to my own G.P. and asked to be

referred to Newcastle General Hospital for treatment for my HIV and Hepatitis C. I have been attending Ward 25 Out Patients Department since October 2000. I was told I had diabetes and [illegible] had it for quite a long time, Dr Hamilton had never told me, [illegible] referred me to a diabetic department. I now attend my G.P.'s Diabetic Clinic and have everything under control with tablets. In May 2001 after attending Newcastle General Hospital only a few months I began treatment for my hepatitis C (Pegilated Interferon/Ribavirin) for 6 months, which has worked well and I have been undetectable for nearly 2 years.

Patients feel that Dr Hamilton alongside his co-director failed to properly convey the contamination risks associated with commercial plasma concentrates. Dr Hamilton and his co-director are intelligent men who had access to a well-stocked medical library at the RVI. Haemophiliacs and their families have since used the library [illegible] old medical journals from the 1970s onwards with regard to [illegible] in plasma. Only [illegible] realise that haematologists including Dr Hamilton and his co-director would or should have been fully aware of the dangers of the treatment, especially that haemophiliacs were at a very high risk of contracting hepatitis viruses (and later HIV). We realise now that UK haematologists often wrote about this risk in journals but failed to impart this knowledge to their patients and instead promoted the treatment as 'safe'.

Patients are aware of a High Court ruling that patients

must be informed of medium to high risks associated with their treatment in order to make an 'informed choice' even if that meant haemophiliacs choosing to decline treatment which is a patient's prerogative. I believe that this is just good medical practise. If a patient is not properly informed of risk surely the doctor is failing in his 'duty of care' and violating a patient's human rights. I beli that Dr Hamilton and his co-director should be investigated with regard to this issue. I allege t they were negligent in their duty of care. They would or should have been aware that patients were being infected with hepatitis non-A, non-B, from their first shot of commercial treatment, yet I believe that they continued to prescribe this treatment to new patients and prescribe a treatment that re-infected existing patients.

Patients have only recently been able to lodge complaints with the GMC as they did not previously have reason to suspect until they applied for their medical records and legal documents from solicitors. I allege that despite a warning in May 1983 from Dr Galbraith at the PHLS warning Dr Field, Department of Health, to meet haematologists urgently advising them to withdraw any plasma treatment manufactured in the U.S. after 1978 because of the risk of AIDS, neither Dr Hamilton nor his co-director withdrew this treatment. Dr Galbraith had clearly done his homework and knew that the consensus of opinion in from the Centre

(4 OF 5)

For Disease Control, Atlanta, in 1982 was that AIDS was blood-borne. I allege that Dr Hamilton and his co-director failed to recall these products off the shelves and continued to prescribe high-risk products without fully informing their patients of the risks they were being subjected to.

Haemophiliacs feel that they have been used as part of a long-term experiment, without their consent. We are aware that the Government funded a 3 year study to be carried out by the UK's haematologists from 1979 to 1982 to look at non-A, non-B hepatitis in haemophiliacs. Dr Hamilton and his co-director were working at the Newcastle Haemophilia Centre at this time. At one meeting of the UK Haemophilia Centre Directors Organisation one doctor, Dr Craske, asked that 'suspect' batch numbers for hepatitis non-A, non-B be recorded. Haematologists even knew which product carried the highest risk (Factor VIII concentrate), yet failed to discuss their findings with the risk of treatment with their haemophilia patients. I allege this was negligent. I can send you copies of these documents to back up the allegations.

Haemophiliacs feel that Dr Hamilton and his co-director were still withholding information from patients until quite recently.

I ask the GMC to look into my complaints.

Yours sincerely,

GRO-A

GRO-A

(5 of 5)

18 October 2005

In reply please quote: JA/FPD/2003/0728

General Medical Council

GRO-A

5th Floor, St. James's Buildings
79 Oxford Street, Manchester M1 6FQ

Telephone: 0845 357 8001
Facsimile: 0845 357 9001
Email: gmc@gmc-uk.org
www.gmc-uk.org

Dear Mr GRO-A

I refer to our previous correspondence regarding your complaint about Drs Jones and Hamilton.

Firstly, may I apologise for the lengthy delays which have occurred with your case.

In accordance with Rule 8 of the General Medical Council (Fitness to Practise) Rules 2004, the Case Examiners have considered your complaint. They have concluded that we do not need to take any further action on the doctors' registration, in respect of this.

When making their decision, the Case Examiners must consider whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. In doing so, they must have in mind the GMC's duty to act in the public interest, which includes the protection of patients and maintaining public confidence in the profession.

They first consider the seriousness of the allegations and then whether the GMC is capable of establishing that the facts demonstrate the practitioner's fitness to practise is impaired to a degree justifying action on registration.

The Case Examiners concluded in this case that, whilst the allegations were serious, there was no realistic prospect of establishing that the doctors' fitness to practise is impaired to a degree justifying action on their registration.

The Case Examiners wrote:

"We considered the allegations made in the context of an individual doctor's responsibility, conduct and performance. Care is delivered to patients with haemophilia and other related chronic medical conditions using a multi-disciplinary team approach. This is the situation in which these doctors' registrations have been considered.

Having read the documentation carefully it is clear that the Newcastle Centre delivered care that involved patients in their own management. The Centre produced regularly updated booklets designed to facilitate this active involvement including "Living with haemophilia." This booklet, in addition to the clinic guidelines, specifically covered issues such as the risks and benefits of blood replacement products. The ethos of the centre was

to have easy access for patients, who gave informed consent, sometimes verbally, for their treatment.

In the early 1990s knowledge about Hepatitis C and other blood borne infections was evolving. This evolution included testing, treatment and prognosis. The evidence provided indicates that the doctors appeared to have acted reasonably and in their patients' best interests. No corroborative evidence has been supplied to support the allegation that the doctors wilfully withheld information or acted unprofessionally in the management of centre patients, nor that they were inappropriately influenced by external influences when providing patient care within the available NHS resources. The allegations made against the doctors do not demonstrate impairment of their individual fitness to practise. The GMC will not be taking action on their registration as a result of this complaint."

I acknowledge that this may be disappointing news for you but hope that given our explanation you understand the reasons for our decision.

Yours sincerely

GRO-C

Jon Abel
Investigation Officer
Fitness to Practise Directorate
Direct Dial: GRO-C
Fax No: GRO-C
Email: jabel@ GRO-C