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29 JUL 1974

National Blood Transfusion Service

SOUTH LONDON TRANSFUSION CENTRE

75 CRANMER TERRACE LONDON SW17 ORB Telephone 01-672 8501/7 ext

Director Dr. K. Ll. Rogers *Deputy Director* Dr. J. V. Barry

Redacted under FOI Exemption Section 40 Closed Until 2075

Your Ref:
Our Ref: KL1R/ES

25th July, 1974.

Dr. W. d'A. Maycock,
Dept. of Health and Social Security,
Hannibal House,
Elephant and Castle,
London, SE1 6TE

Dear Dr. Maycock,

Re: [redacted]

We had this notified to us in September of last year. All donors had been tested by I.E.O.P. and found to be negative and we elected not to take further samples from the donors. Within a month or two we had a couple of cases of post-transfusion jaundice where David Dane had found one of the donors to be a carrier of Australia antigen below the level detectable by I.E.O.P. As a result of this I thought we should re-test our donors involved with [redacted] and, since they were all due to be called to a session shortly, I made arrangements for extra samples from these donations to be sent to David Dane. In the event two of them did not turn up and we discovered this in one of our periodic reviews a month or so back and wrote to the two non-attending donors asking for samples. These arrived fairly shortly and the report was sent off.

It really is a problem sometimes to know precisely what to do. It is obviously not feasible to get fresh samples from a case which involves say, 160 donations, but where should one draw the line? Also one finds that the more donors you try to chase up the greater likelihood that some of them will be untraceable or will just not respond to your letters. At what stage do you give up trying to contact them and send in an incomplete report?

Yours sincerely,

GRO-C

K. Ll. Rogers
Director.