SMALLER HAEMOPHILIA CENTRES PRESENTATION
LANCASTER HAEMOPHILIA CENTRE

Directors, status, relationship with other haemophilia centres and with Regional Transfusion Centre

1. Dr Douglas Lee was director of the Lancaster Haemophilia Centre ("Lancaster" or "the Centre") from 1977, when it was formally designated as a haemophilia centre, to 1989. Dr David Gorst took over as director in 1989 [HCDO0002288 and HCDO0002379].

2. In a statement prepared for the HIV litigation, Dr Lee addressed a number of issues relevant to the Inquiry, including the following [NHBT0096558_009]:

    a. In January 1976, Dr Lee was appointed to Lancaster Transfusion Centre "*as Consultant in Charge which was the equivalent of sub-director*". His appointment included sessions at the Royal Lancaster Infirmary ("RLI") as a consultant haematologist. He became regional director of the North Western Regional BTS in April 1989 (having been acting director since October 1988). As for his early career, he was not directly involved in treating haemophiliacs in the early 1970s and was "*mainly a transfusionist*" until he joined Lancaster.
    b. When Dr Lee was appointed he was asked to organise the treatment of haemophiliacs, which was at that time divided between three physicians with no unifying consultant. There were then five or six severely affected patients in the District requiring regular treatment. Dr Lee arranged for haemophiliac patients to attend the Transfusion Centre if they needed treatment as there was always a doctor on call there. He organised a roster for the treatment of patients and saw them periodically for a review in an outpatients appointment. Dr Lee was director of both the Lancaster Transfusion Centre and the Lancaster Haemophilia Centre.

c. In 1980 a new haematologist at RLI – Dr Gorst – joined in the roster for emergency treatment, though Dr Lee retained his earlier role and "*remained in frequent and direct touch with the haemophiliacs in the District.*" Dr Lee stated that he would have discussed arrangements with but not advised Dr Gorst.

d. As for the practical arrangements for treating patients: "*Although the patients would normally ring the Transfusion Centre when needing treatment, and the Centre would then divert the call to whoever was on duty that night or weekend, some patients did in fact have my home telephone number and they knew that I was available to advise and care for them.*" Treatment was also provided for visiting haemophilia patients, and Dr Lee received advance information about haemophiliacs staying in a static caravan belonging to the North West Haemophilia Society at a site close to Lancaster.

e. Dr Lee described Lancaster as an associate centre which dealt "*primarily with treating haemophilia at a basic level.*" Otherwise patients were referred to the reference centre at Manchester Royal Infirmary ("MRI").

f. Dr Lee's main link was with MRI. He attended periodic meetings organised by Dr Wensley (MRI's director or co-director), perhaps annually, which provided an update. In the second half of the 1980s, Dr Gunson held meetings concerning the purchase of heat-treated factor VIII through the RTC budget.

3. A small number of additional documents supplement Dr Lee's account. For example, a September 1981 letter records that Lancaster was designated an associate haemophilia centre in 1977 and that, as at the time of the letter, out-patient treatment of haemophilia patients was almost always undertaken at the Transfusion Centre [NHBT0059252_032]. A March 1979 letter, which would appear to be from Lancaster, stated that the "*usual practise* [was] *for Manchester to see all new haemophilia patients in any case*" [NHBT0059260_018].

4. Lancaster was part of a regional haemophilia service in North Western England, and was sometimes described as a sub-centre to MRI, though both operated as distinct haemophilia centres [NHBT0096549]. The North West regional haemophilia service, including the arrangements for purchasing and distributing concentrates to Lancaster, was described in detail in the written note accompanying the presentation on MRI (relying in part on a statement prepared by Dr Gunson for the HIV litigation [NHBT0020196_001]).

Facilities and staffing in 1970s and 1980s

5. A Dr Barrett worked at RLI in the early 1970s [DHSC0100020_078]. Staff in the early 1980s included Ms Fall, who worked in the medical social work department [HSOC0002821]. A September 1986 letter refers to a Dr Kozlowski in the haematology department [BAYP0000008_365].

6. In late 1987/early 1988, out-patient treatment changed for Lancaster patients [NHBT0059255_017]. Because some haemophiliacs were HIV positive and others carried the hepatitis B virus, it was decided it would be "*inappropriate to bring patients who might shed virus*" into the blood donor suite of the Lancaster Transfusion Centre. In order to preserve confidentiality, the policy had to apply to all patients. As there was no other accommodation at the Transfusion Centre available for clinical use, all treatment was moved to the haematology ward at RLI. The January 1989 letter outlining these changes explained that the same doctors would continue to treat patients: Dr Gorst, Dr Makar and Dr Lee. Patients who needed treatment were advised to continue telephoning the Transfusion Centre, which would contact one of the doctors and arrange attendance at RLI.

7. Dr Gorst continued to work at the Lancaster Centre until at least 1992 [UHMB0000006_014].

Numbers of patients registered and treated

8. In his HIV litigation statement, Dr Lee stated that the "*total number of patients between 1977 and 1989 would be approximately 10*" [NHBT0096558_009].

9. The Centre's annual returns for 1977-1986 provide the following figures for patients treated and registered:

    a. 1977: 5 patients with haemophilia A (plus 8 visitors with the same condition) were treated [HCDO0001173].
    b. 1978: Lancaster treated 10 haemophilia A patients (of whom 5 were visitors) [HCDO0001270].
    c. 1979: 5 patients with haemophilia A, two with Christmas disease and one with von Willebrand's were treated [HCDO0001339].
    d. 1980: 11 patients with haemophilia A, two with haemophilia B and one with von Willebrand's were treated [HCDO0001434]. The number of registered patients (including visitors) appears to have been: 24 with haemophilia A; 3 with haemophilia B; and two with haemophilia B.
    e. 1981: Lancaster treated 15 patients with haemophilia A [HCDO0001535]. The number of registered patients (including visitors) appears to have been: 32 with haemophilia A; 3 with haemophilia B; and 3 with von Willebrand's.
    f. 1982: 9 patients with haemophilia A, an unclear number of haemophilia A patients with antibodies and two with haemophilia B were treated [HCDO0001634]. The number of registered patients (including visitors) appears to have been: 34 with haemophilia A; 4 with haemophilia B; and 3 with von Willebrand's.
    g. 1983: Lancaster treated 15 patients with haemophilia A (including one haemophilia A patient with antibodies), one carrier of haemophilia A, and one haemophilia B patient [HCDO0001733]. The list of registered patients (including visitors) is partly illegible but appears to include: 37 with haemophilia A; 4 with haemophilia B; and 3 with von Willebrand's.

h. 1984: 10 patients with haemophilia A (including one haemophilia A patients with antibodies), two with haemophilia B and one with von Willebrand's were treated [HCDO0001825]. The number of registered patients (including visitors) appears to have been: 36 with haemophilia A; 4 with haemophilia B; one haemophilia A carrier; and 3 with von Willebrdand's.

i. 1985: 8 patients with haemophilia A, one with haemophilia B and two with von Willebrand's were treated [HCDO0001919]. The number of registered patients (including visitors) appears to have been: 35 with haemophilia A; 4 with haemophilia B; one haemophilia A carrier; and 4 with von Willebrand's (plus one acquired haemophilia A patient).

j. 1986: Lancaster treated 7 patients with haemophilia A, two patients with von Willebrand's and one haemophilia B patient [HCDO0000368_004]. The number of registered patients appears to have been: 32 with haemophilia A; 4 with haemophilia B; one haemophilia A carrier; 5 with von Willebrand's (plus one acquired haemophilia A patient) [HCDO0002016].

Treatment policies and blood product usage

Annual returns 1977-1986

10. In 1977 Lancaster mainly treated its haemophilia A patients with cryo (96,560 units), as well as some NHS factor VIII (15,125 units) and a very small amount of commercial product (954 units of Kryobulin) [HCDO0001173].

11. In 1978 Lancaster treated its haemophilia A patients with approximately 120,800 units of cryo and 70,310 units of NHS concentrate [HCDO0001270].

12. In 1979 Lancaster treated its haemophilia A patients with 837 bottles of cryo (which would amount to 58,590 units, assuming 70 units per bottle) and 39,640 units of NHS factor VIII [HCDO0001339]. Its Christmas disease patients were

treated with 6,195 units of NHS factor IX. A patient with von Willebrand's received 8 bottles of cryo (which would amount to 560 units).

13. In 1980 Lancaster treated its 11 haemophilia A patients with more cryo than concentrate [HCDO0001434]. It used:

    a. 73,080 units of cryo, all of which was in hospital.
    b. 48,205 units of NHS factor VIII (of which 28,575 units were in hospital and 19,630 were at home).
    c. 6,744 units of commercial factor VIII, divided between Factorate (6,140 units in hospital) and Hemofil (604 units in hospital).

14. The Centre treated its von Willebrand's patient with 560 units of NHS factor VIII in hospital, and its haemophilia B patient 6,710 units of NHS factor IX in hospital.

15. In 1981 Lancaster treated its haemophilia A patients with more concentrate than cryo for the first time [HCDO0001535]. It used:

    a. 49,600 units of cryo, all of which was in hospital.
    b. 126,125 units of NHS factor VIII (of which 78,110 units were in hospital and 48,035 units were at home).
    c. 14,800 units of Hemofil in hospital.

16. In 1982 Lancaster mainly treated its haemophilia A patients with concentrate [HCDO0001634]. It used:

    a. 3,520 units of cryo in hospital.
    b. 117,659 units of NHS factor VIII (of which 62,222 units were in hospital and 55,437 were at home).
    c. 13,912 units of commercial VIII, all of which was Hemofil (11,840 units and 2,072 units at home).

17. It used 3,200 units of cryo at hospital for haemophilia A patients with antibodies, and 6,600 units of NHS factor IX in hospital for its haemophilia B patients.

18. In 1983 Lancaster treated its haemophilia A patients with significantly more concentrate than cryo [HCDO0001733]. It used:

    a. 11,360 units of cryo, all of which were used in hospital.
    b. 339,440 units of NHS factor VIII (of which 198,810 units were used in hospital and 140,630 units at home).
    c. 7,400 units of Hemofil, all of which were used for home treatment.

19. The Centre's only haemophilia A patient with antibodies was treated with 2,880 units of cryo at hospital, and its haemophilia B patient received 3,400 units of NHS factor IX at hospital.

20. In 1984 Lancaster mainly treated its haemophilia A patients with concentrate [HCDO0001825]. It used:

    a. 24,880 units of cryo in hospital.
    b. 149,830 units of NHS factor VIII (58,730 units in hospital and 91,100 units at home).

21. The Centre's haemophilia A patient with antibodies received NHS factor VIII in hospital (3,680 units). Its haemophilia patients were treated NHS factor IX (8,170 units).

22. In 1985 Lancaster treated its haemophilia A patients almost exclusively with concentrate [HCDO0001919]. It used:

    a. 3,280 units of cryo in hospital.
    b. 32,475 units of NHS concentrate (7,170 units in hospital and 25,305 at home).
    c. 9,000 units of Profilate in hospital.

23. The Centre's von Willebrand's patients were treated only with NHS concentrate (17,040 units in hospital). A haemophilia B patient received 5,040 units of NHS factor IX in hospital.

24. In 1986 Lancaster used only a nominal amount of cryo on its haemophilia A patients; treatment was nearly all with concentrate [HCDO0000368_004]. The Centre used:

    a. 960 units of cryo, all of which were in hospital.
    b. 196,110 units of NHS concentrate (of which 193,820 units were used for home treatment and the remainder in hospital)
    c. 55,300 units of Koate for home treatment.
    d. 9,800 units of Hemofil for home treatment.

25. 560 units of NHS concentrate were used for a haemophilia A carrier patient. The Centre's von Willebrand's patients were only treated with cryo in hospital (17,840 units), and its one haemophilia B patient was treated with 3,300 units of NHS factor IX at hospital.

Other

26. Dr Lee addressed a number of matters relevant to Lancaster's treatment policies in his HIV litigation statement [NHBT0096558_009]. These include:

    a. At the time of Dr Lee's appointment to the Lancaster Centre, initially "*almost all the treatment was based on cryoprecipitate. As Factor VIII Concentrate became available, the patients were trained in home treatment.*" He saw home treatment patients in outpatients approximately once a year, when they came in to pick up their factor VIII or when they came in for treatment (such as for a bad bleed).
    b. Lancaster received as much factor VIII as was required for treatment on demand and later for home treatment. The supply of NHS factor VIII and the purchase of commercial product took place through Manchester. As for Lancaster's treatment policies, Dr Lee stated: "*Most of the*

material used in Lancaster was from NHS sources. We believed that this NHS product was less likely to be contaminated than imported products. One positive step which I took was to try to make sure that individual patients were exposed to as few batches as possible."

c. Dr Lee used NHS factor VIII for all of his patients "*except one or two. That reflects the privileged position that Lancaster was in in being able to get almost all our supplies as BPL Factor VIII.*" He described Lancaster as having "*had occasion to treat two patients with commercial concentrates who in the past who had* [sic] *received large quantities of Factor VIII. For example, one patient broke his leg and he was on daily doses of Factor VIII. So when commercial concentrates had to be used again it was offered to those two patients if we needed to give it to anyone.*" He used imported concentrate "*(only occasionally when necessary) when supplies of NHS Factor VIII were not available in sufficient quantity, for example a particularly severe bleeding episode in a particular patient.*"

d. Dr Lee referred to a "*swing back to cryoprecipitate being administered to children and mildly affected adults in the early 1980's because of the risk of hepatitis.*" He explained that Dr Wensley had "*always been a powerful advocate of cryoprecipitate. It is a harder product to make and to administer than Factor VIII, but his thoughts were that yields of cryoprecipitate over those of concentrate were roughly 70% compared to 20%, and the risk of transfused viruses are* [sic] *certainly less. He would advise this constantly at haemophilia director's* [sic] *meetings, and I remember that he was very much alone on this point at one time.*"

e. Dr Lee wrote that Lancaster "*only used imported non-heat treated Factor VIII as a second line of treatment – it was never the treatment of choice. It was not used for children and mildly affected patients.*" Cryo was "*used for children and mildly affected haemophiliacs*". Dr Lee did not use desmopressin (i.e. DDAVP).

f. As for the information given to patients about the risks of unheated concentrate and cryo: "*I can remember advising patients who received either of these products that whatever the risk of the treatment was, it was less than the risk of non-treatment.*" He stated that patients "*were*

advised of the risk of HIV infection when it was agreed by the Haemophilia Directors [sic] *that this was appropriate.*"[1]

g. Dr Lee described himself as being "*in the hands of Dr Wensley for the consideration given to the use of heat treated Factor VIII and IX*", but stated that he used them as soon as they were available to him. He believed that he began using small amounts of imported heat treated factor VIII from late 1984. The supply came from Dr Wensley and could be verified "*from the relevant stock inventory records*", as well as "*[a]nother book entitled "The Cryo Pooling Book*" which recorded "*the batch number of Factor VIII concentrate (originally recorded the serial number of the cryoprecipitate) used for each treatment episode.*" Dr Lee believed that he used exclusively heat-treated product from April 1985.

h. Dr Lee never prescribed factor VIII prophylactically.

27. This account can be considered alongside a small number of other documents.

a. It would appear that Lancaster's home treatment programme had become established by late 1977 [NHBT0059259_047 and NHBT0059259_046].

b. On 28 January 1985, Dr Lee wrote to BPL to request heat-treated factor VIII for three patients on a named patient basis [BPLL0002377_006].

c. Pharmaceutical companies promoted their products to Lancaster: see, for example, a September 1986 letter to Dr Kozlowski RLI promoting Koate HT [BAYP0000008_365].

28. The presentation on MRI addressed shortages of concentrate in the North West region. Lancaster's input into these issues in the late 1980s/early 1990s can be gleaned from letters written by Dr Lee to Dr Gunson in November 1989 and the Regional Health Authority in April 1990 [NHBT0033661 and NHBT0018288].

[1] Assuming that Dr Lee was referring to the Haemophilia Centre Directors Organisation, there is no evidence from the reference centre directors meetings or the annual directors meetings in 1982, 1983 or 1984 to suggest that it was agreed that patients should be advised of the risk of HIV infection; a discussion about what patients should (or should not) be told appears to have taken place (in the context of testing) at the 10 December 1984 special meeting at Elstree.

Knowledge of risk of hepatitis and response to risk

29. In June 1972, Dr Barrett – who was a member of an advisory group on testing for the presence of Australia antigen – wrote to the Manchester RTC, seeking guidance on whether a dentist who was Australia antigen positive should become a blood donor [DHSC0100020_078].[2]

30. In the mid-1970s RLI was involved in investigating infections with Australia antigen following blood transfusion [NHBT0054324_004].

31. In his HIV litigation statement, Dr Lee described himself as having "*been aware that haemophiliacs were at risk of acute hepatitis since 1966*" when he first became involved with them [NHBT0096558_009]. He did not know when he became aware "*that commercial factor VIII had a higher risk*", and described it as "*a risk faced by anyone who received blood or a blood product.*" He believed that he "*first appreciated the risk of chronic hepatitis to haemophiliacs from Factor VIII and IX in the mid 70's because a colleague in Sheffield was interested in liver damage to haemophiliacs.*" He added that "*[a]ny treatment with blood products carried the risk of hepatitis. It could have been obtained from the cryoprecipitate and was indeed passed on in this way.*"

32. In the late 1970s Dr Lee sent reports of post transfusion hepatitis to Dr Maycock at the Lister Institute, including following treatment with cryo [CBLA0003735].

33. Dr Lee attended was a fairly regular attender at UKHCDO meetings from 1977 to the end of the 1980s, though he did not attend the 1979 or 1982-1984 meetings. It is unclear if he attended the 1980 meeting as the minutes only include a list of apologies [PRSE0003946]. He can be taken to have been aware of the information on hepatitis risks (both hepatitis B and NANB) discussed and shared during the meetings he attended. He may also have read the minutes of meetings that he missed when they were subsequently circulated to directors.

34. In September 1985, Dr Lee wrote to the North Western Regional Health Authority legal adviser regarding a compensation claim from a patient who had

[2] For Dr Stratton's response, see [DHSC0100020_074].

acquired NANB hepatitis following a blood transfusion [NHBT0085206_004]. He wrote as follows with respect to risks to patients: "*There is no definitive test which will identify donors who carry the virus and may pass it to recipients of their blood and in these circumstances the risk to the patient of acquiring non-A non-B hepatitis must be balanced, along with the other possible complications of blood transfusion, by the clinician managing the patient.*"

35. Having stated that he did not think there had been any negligence in the case, Dr Lee made the following comments on risks and patient consent: "*The only possible claim which could be considered would relate to the question of whether the transfusion was necessary and if the benefit outweighed its attendant risks as perceived at the time when blood was prescribed. I have no information on this point and as you pointed out, such a consideration is clouded by the question of informed consent. One can surmise, however, that in a patient ill enough to need four units of blood, that the balance of risks speaks for itself.*"

36. The Inquiry has received a statement from a patient who was infected with HCV following a blood transfusion at RLI in May 1991, having been admitted as an emergency following a miscarriage [WITN1923001].

Knowledge of risk of AIDS and response to risk

37. Dr Lee did not attend the 1982-1984 UKHCDO meetings, at which AIDS risks were first discussed, though it may be that he read the meeting minutes subsequently circulated to centre directors. He would also have received the information and other documents relating to AIDS sent by UKHCDO to all centre directors from 1983.

38. In his HIV litigation statement, Dr Lee stated as follows with respect to the development of his knowledge of AIDS [NHBT0096558_009]: "*I became aware of the emergence of HIV/AIDS when the virus was identified as HLTV III when those papers were published concerning strange illnesses amongst*

homosexuals." He could not remember exactly what the papers were called or when he became aware of AIDS; his recollection was of *"an evolving story from 1981 onwards*". He commented that he relied on the meetings of haemophilia directors and "*contact with Dr Wensley for new information*" as his "*role was to treat Haemophilia patients rather than to make policy.*" He also tried to read the leading articles in The Lancet each week.

39. In November 1985 Dr Lee corresponded with Dr Craske of PHLS regarding blood donors from Lancaster who were involved in a post-transfusion AIDS case [NHBT0100028_018 and NHBT0077702_004].

40. Clinicians including Drs Lee and Gorst were closely involved in the introduction of HTLV-III testing of blood donations and related steps at the Lancaster Transfusion Centre in the mid-1980s [see, for example, NHBT0099297, NHBT0099296, NHBT0099289, NHBT0113679_001, NHBT0113679_002, NHBT0113679_003, NHBT0099287]. In a January 1986 letter, Dr Lee explained that all donations collected after 14 October 1985 had been tested for HTLV III, as had the majority of donations during the previous three weeks while the test was being established [BPLL0010776].

Arrangements for testing patients for HTLV III and informing them of their diagnosis

41. In his HIV litigation statement, Dr Lee wrote that all of his haemophilic patients "*were tested for HIV infection after appropriate counselling, and that included a full discussion culminating the patient deciding whether or not they wished to know the results*" [NHBT0096558_009]. Two patients tested positive, one of whom did not wish to know the results. Dr Lee "*saw the other personally and explained the full implications.*" He described the counselling as being "*in the form of a full and frank discussion.*" As for testing of partners, one of the two HIV positive patients was unmarried and celibate; Dr Lee tested the wife of the patient who was married, preceded by joint counselling with her husband.

42. Dr Lee added that none of the children he treated tested positive. Only one severely affected patient was a child and he "*counselled the father fully.*" He also described "*talking to the headmaster in order to provide the appropriate reassurance when public understanding of the virus was causing worry in the school.*"

43. In March 1988 Dr Rizza wrote to Dr Lee regarding a patient who did not wish to know his test result, noting that the Oxford Centre had respected this wish, though Dr Rizza had a "*strong suspicion* [...] *that he knows his position*" [NHBT0059259_003].

Numbers infected with HIV

44. Provisional UKHCDO data available to the Inquiry suggests that one patient was infected with HIV at the Centre, and that they tested positive in 1985 [INQY0000250].

Testing for hepatitis C

45. It appears that, in 1989, patients who had received blood transfusions in Lancaster were being tested for hepatitis C through PHLS. In a December 1989 letter to Dr Craske, Dr Makar of the Lancaster Transfusion Centre provided a sample from a patient who had been diagnosed with NANB hepatitis in November 1989, as well as from one of the implicated donors [NHBT0054310_026]. Dr Makar asked if Dr Craske could "*do a Hepatitis C marker on them.*"

46. In 1990-1991 Dr Lee and others were closely involved in the introduction of testing of blood donations for hepatitis C at the Lancaster Transfusion Centre [see, for example, NHBT0000189_189, NHBT0000073_042 and NHBT0090778_002]. It appears that testing of all donations began in September 1991.

47. In a 16 August 1991 letter to the local ethical committee, Dr Lee proposed joining a hepatitis C study designed by Professor Allain of the Cambridge RTC [NHBT0113653_001]. He wrote: "*Patients transfused before September will receive blood untested for HCV and some will receive blood with HCV markers; after September this will not be the case. There is therefore now an opportunity – a last opportunity – to evaluate the significance of HCV markers in relation to infectivity in recipients.*" Dr Lee had already asked haematologists in the North West to retain pre-transfusion samples, which would provide the baseline from which seroconversion for hepatitis C would be established. He added: "*Let me say at once that this is in no way intended to preempt ethical approval and these samples will take place until the matter has been considered by the Ethical Committees concerned. If, for any reason, approval is not given, the samples will be discarded.*"

48. Dr Lee applied for ethical approval for the study shortly thereafter, on 19 August 1991 [NHBT0113623. See also NHBT0113621]. The application described the proposed methodology, highlighted some of the ethical issues that arose and provided draft information and consent documents. Dr Love had expressed strong reservations about the potential study in July 1991 [NHBT0113622_002].[3] It did, however, gain ethical approval and go ahead. Dr Lee summarised its background and purpose in an October 1992 letter to a patient's GP, in which he asked for the GP's advice on whether it would be appropriate to approach the patient about testing a blood sample which had been retained in July/August 1991 [NHBT0112569_001].

49. In a December 1991 letter to Dr Gunson on behalf of Dr Lee, Dr Love wrote to highlight a lack of funding for the counselling and follow-up of hepatitis C positive donors [NHBT0000075_081].

50. The Lancaster Transfusion Centre's approach to hepatitis C testing continued to evolve in the early 1990s as the tests developed: see, for example, an April 1992 memo regarding screening tests not confirmed by PHLS [NHBT0033884].

[3] See also the manuscript amendments to the draft study documents.

51. The Inquiry witness was who was infected with HCV following a May 1991 transfusion at RLI found out she had been infected through a look back programme in 1996 [WITN1923001]. She was contacted by the South Thames Blood Transfusion Service and asked to attend for a test [WITN1923002].

Treatment arrangements for HIV and HCV patients

52. In an October 1991 letter regarding hepatitis C positive donors, Dr Adamson – a consultant physician at RLI – wrote that they would be happy to see any hepatitis C positive patient who was referred by their GP, before commenting on liver biopsies: "*I think my policy would be that a liver biopsy would only be indicated if the standard liver function tests were abnormal but I suspect that the patients would need to be kept on follow-up for a time*" [NHBT0058163_003].

Other issues

53. In a May 1985 memo, Dr Lee referred to a "*present policy of not bleeding at Prisons*" [NHBT0054619_009].

54. In July 1991, correspondence took place between the Lancaster Transfusion Centre and Dr Gunson about storing samples from blood donors [NHBT0010438].

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