SMALLER HAEMOPHILIA CENTRES PRESENTATION

ABERDEEN

The Centre

1. The Aberdeen Haemophilia Centre ("the Centre") was located at the Aberdeen Royal Infirmary in Foresterhill, alongside the Aberdeen Maternity Hospital, the Royal Aberdeen Children's Hospital, the University of Aberdeen Medical School and the SNBTS Transfusion Centre.

The Directors

2. Dr Audrey Dawson was the Centre's Co-Director from 1967 to 1996.[1] In her statement to the Inquiry she states that she '*shared responsibilities as a team*' with Dr D. J. King, paediatric haematologist, and Dr N. B. Bennett,[2] reader in Medicine and honorary consultant haematologist.[3]

3. Dr Dawson describes Dr Bennett as '*effectively the expert in haemostasis and thrombosis'* who had '*great expertise in bleeding conditions*', whereas Dr Dawson states that she had more involvement with malignant haematology services and spent most of her time '*developing the service for leukaemia, lymphoma and myeloma.*'[4] However from 1990 to 1996 she states that she '*was more visible to the patients and so became identified by them as a treater of their haemophilia and [she] was officially the haemophilia director from 1967 – 1996*'.[5]

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[1] From 1958 she had worked as terminable lecturer, then lecturer in the Department of Medicine at University of Aberdeen and honorary registrar at the Aberdeen Royal Infirmary. She held a number of positions during her career including the President of the Scottish Society of Physicians from 1995 to 1996: WITN3503004

[2] Known as Bruce Bennett.

[3] §3 of WITN3503004

[4] §5 of WITN3503004

[5] §5 of WITN3503004

4. Dr King has also provided a statement to the Inquiry.[6] For the majority of his career he was the only haematology consultant at the Royal Aberdeen Children's Hospital ("RACH").[7] He was a member of the Scottish Haemophilia Directors Organisation from 1986 to 1996.

5. Henry G. Watson took over as the Centre's Director in 1996.

Other staff members

6. Gena Andrew, nurse at the Aberdeen Royal Infirmary ("ARI"), has provided a statement to the Inquiry.[8] She was a relief sister and clinical teaching student on ward 47 from 1985 to 1987. She initially worked under Sister Ethel Sutherland.[9] Upon completion of her nursing diploma, she applied for the ward sister of haematology post and was appointed. She was a joint appointee alongside Maggie Grundy, who was appointed after her. They worked as joint appointees until 1995.

7. Sister Joan Rae was the specialist haemophilia nurse.[10] She generally saw patients in the outpatient area, and then in the ward if the patient had been admitted.[11]

8. In addition to the Centre's directors, Gena Andrew describes working with Mike Greaves, Dominic Culligan, Jane Tighe, Beverley Robertson, Gavin Preston, Al Lawrie, Mohammed Khan and Mark Vickers.

Facilities and staffing at the Centre in 1970s and 1980s

9. Gena Andrew has described to the Inquiry that haematology beds were initially based in ward 41 of the ARI and there were around 9 haematology beds. In around 1987 haematology split off from the general medical patients and moved to ward 16 of the ARI. This was a 22-bed ward with a mixture of multi-bedded and single

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[6] WITN4535001
[7] §7 of WITN4535001
[8] WITN4045001
[9] §5 of WITN4045001
[10] Her precise dates of appointment are unclear.
[11] §7 of WITN4045001

rooms. Haematology then moved to ward 112, which was part of the emergency care centre. This was a 23-bed ward made up entirely of single, en-suite rooms.[12]

10. The Haemophilia Society's Grampian Group fundraised to furnish the Centre in 1989, which included provision of an ice-making machine.[13]

Blood Transfusion Centre

11. The Aberdeen and North-East of Scotland Blood Transfusion Service ("ANESBTS") was based at the ARI. Dr Brodie Lewis was the Regional Director in the 1970s. In the late 1970s Dr Lewis made requests for more space so that the ANESBTS could be extended.[14]

12. Dr Stan Urbaniak became the Regional Director of the ANESBTS in November 1982.[15] Like his predecessor, Dr Urbaniak pressed for the funds to modernise the blood transfusion centre. In November 1983 the ANESBTS advertised for a new consultant[16] and in May 1984 the Scottish Health Service agreed for a new centre to be built on the Foresterhill site with a physical link to the ARI.[17]

13. Dr Dawson's statement to the Inquiry describes the relationship between the Centre and the ANESBTS as follows:

> '*We received concentrates from the Blood Bank in our local BTS. The concentrates were mostly SNBTS concentrates. We used the batches as they arrived in BTS and the Blood Bank staff kept details of the amount of products that were issued to each patient through the year.*'[18]

14. By 1990 Dr Urbaniak noted the '*extreme pressure for space and suitable accommodation for modern transfusion requirements*'.[19] A state-of-the art building,

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[12] §2 of WITN4045001
[13] HSOC0019923_031
[14] SBTS0000221_042
[15] SCGV0000094_005
[16] SBTS0000240_017
[17] SBTS0000197_027
[18] §24 of WITN3503004
[19] SBTS0000653_110

described as the '*most modern in Scotland*' and costing £4.5 million, was built in the early 1990s.[20]

SNBTS

15. Dr Dawson has described the relationship with SNBTS as '*good*'.[21] In her view SNBTS '*provided the best treatment they could and played a key role in maintaining records of its use whenever it was released from the transfusion centre.*'[22]

16. Dr Dawson states that there were '*many discussions*' between SNBTS and ANESBTS about the risk of infection from blood and blood products.[23] Dr Dawson says that '*none of these were formal meetings and in them we tried to make the best decisions that we could based on what was known at the time.*'[24]

Numbers of patients registered and numbers of patients treated

17. In correspondence related to the Penrose Inquiry, Dr Dawson wrote the following about the patients treated at the Centre:

> '*We had several patients, whose exposure to commercial concentrates before arrival was not accurately known to us. Aberdeen and North-East Scotland in the 1970s-80s were experiencing an economic boom related to North Sea oil, and we had many incomers, often transient. One man I remember treating was French, working off-shore on a Total rig, having not admitted to his French employers that he had haemophilia (for which he had been treated in several other places).*
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> *There were also several other haemophiliacs, who were transient in Grampian, either working or on holiday. Also, our 'native' patients, even although treated probably exclusively with NEBTS material in Aberdeen, would have been exposed to commercial products when away from North-east Scotland.*

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[20] SCGV0000045_184
[21] §24 of WITN3503004
[22] §24 of WITN3503004
[23] §25 of WITN3503004
[24] §25 of WITN3503004

With regard to the records of material which we used in treatment, the North-East Blood Transfusion Service actually obtained the material for us, and kept detailed records of batch numbers, etc; while we (i.e. Haemophilia Centre) kept only minimal records of this in the clinic/ward, and this mainly related to the amount and type of material. Even these latter records would have fallen victim to the Grampian clinical records system, where material which was considered transitory was culled in the 1980s, in order to try to contain the bulk of the clinical notes.'[25]

18. The UKHCDO annual return for 1976 states that 9 haemophilia A and five von Willebrand's patients were treated in that year.[26] There were no deaths recorded. The treatment given was cryoprecipitate and Edinburgh NHS factor VIII.

19. The UKHCDO annual return for 1977 states that 14 haemophilia A and five von Willebrand's patients were treated in that year.[27] There were no deaths recorded. The treatment given was cryoprecipitate and Edinburgh NHS factor VIII.

20. The UKHCDO annual return for 1978 states that 16 haemophilia A, one haemophilia B patient and two von Willebrand's patients were treated in that year.[28] There was one death recorded of a haemophilia A patient who was aged 33. One patient was listed as being on home therapy and two further patients were considered suitable for home therapy. In addition to cryoprecipitate and Edinburgh NHS factor VIII, 4,890 units of Hemofil (Hyland factor VIII) were used.

21. The UKHCDO annual return for 1979 states that 18 haemophilia A, one haemophilia B patient and three von Willebrand's patients were treated in that year.[29] No deaths were recorded. In addition to cryoprecipitate and Edinburgh NHS factor products, 4,860 units of Hemofil (Hyland factor VIII) were used as well as FEIBA.

22. The UKHCDO annual return for 1980 states that 16 haemophilia A, one haemophilia B patient and four von Willebrand's patients were treated in that

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[25] STHB0000568
[26] HCDO00002429
[27] HCDO00002430
[28] HCDO00002431
[29] HCDO00002432

year.[30] In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA was used.

23. The UKHCDO annual return for 1981 states that 17 haemophilia A and three von Willebrand's patients were treated in that year.[31] In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA was used.

24. The UKHCDO annual return for 1982 states that 13 haemophilia A and seven to eight von Willebrand's patients[32] were treated in that year.[33] The return notes that three '*Islanders*' were also treated at the Centre that year. In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA was used.

25. The UKHCDO annual return for 1983 states that 12 haemophilia A and eight von Willebrand's patients were treated in that year.[34] No von Willebrand's patients received home treatment that year. The return notes that material was sent to Orkney and Shetland. In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA, whole blood and porcine factor VIII was used.

26. The UKHCDO annual return for 1984 states that 16 haemophilia A and nine von Willebrand's patients were treated in that year.[35] As with previous returns, it was noted that material was sent to the Islands. All treatment to those with von Willebrand's was given in hospital. In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA and plasma were used.

27. The UKHCDO annual return for 1985 states that 18 haemophilia A and two von Willebrand's patients were treated in that year.[36] One patient with haemophilia B was treated. In addition to cryoprecipitate and Edinburgh NHS factor products, FEIBA and plasma were used.

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[30] HCDO0002433
[31] HCDO0002434
[32] Different parts of the return give different numbers.
[33] HCDO0002435
[34] HCDO0002436
[35] HCDO0002437
[36] HCDO0002438

28. The primarily handwritten UKHCDO annual return for 1986 states that 15 haemophilia A and four von Willebrand's patients were treated in that year.[37] As with previous returns, it was noted that material was sent to the Islands. In addition to cryoprecipitate and Edinburgh NHS factor VIII and IX, FEIBA was used.

29. Dr King, following discussion with Professor Watson, has provided the following figures for paediatric patients at the RACH. In 1985 there were 3 severe and 4 mild/moderate haemophiliacs. In the same year there were no haemophilia B patients and 5 with von Willebrand's disease.[38]

Treatment policies and blood product usage

30. In her statement to the Inquiry Dr Dawson states that, due to the passage of time, she has '*little or no recall of the processes in place for ordering factor concentrates.*'[39] Dr Dawson's recollection is that blood products were sourced from the Protein Fractionation Centre ("PFC") at Edinburgh and '*when we did not have enough of a product we would have used commercial factor, although I think in Aberdeen that was rarely the case.*'[40]

31. As evidenced by the UKHCDO annual returns set out above, the Centre almost exclusively used Edinburgh factor VIII and IX concentrates from the mid 1970s onwards. A document from 11 March 1980 entitled '*Purchase of Commercial Blood Products as Reported by Transfusion Directors*' states that in the year to 31 August 1979 the Aberdeen Royal Infirmary purchased 9,780 iu of Hemofil, 1,000 iu of Feiba and 750 ml of Buminate.[41]

32. The Penrose Inquiry concluded that the preference at Aberdeen, as in Dundee and Inverness, '*point[ed] clearly towards a preference for NHS products*' and that the

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[37] HCDO0002439
[38] §8 of WITN4535001
[39] §6 of WITN3503004
[40] §6 of WITN3503004
[41] SBTS0000223_008

use of imported commercial concentrates was '*very infrequent throughout the material time*'.[42]

33. Factor VIII Working Party Minutes from a meeting on 2 February 1989 at the Royal Infirmary of Edinburgh record that no commercial factor VIII was used at Aberdeen in 1987 whereas in 1988 0.03 mu of commercial factor VIII was used, in contrast to 0.37 mu of NHS factor VIII.[43]

34. In relation to the use of blood products Dr Dawson has told the Inquiry in her statement that '*most of the boys and men that we treated had severe haemophilia and so had no alternative to factor concentrates.*' She states that in her view home therapy could not have continued with cryoprecipitate. Gena Andrew, nurse, recalls that Dr Dawson and Dr Bennett '*were keen to get as many patients as possible on home treatment*'.[44] She describes that '*later, once most of the boys were on home treatment, the numbers coming into the ward decreased dramatically as most of them didn't require admission any more.*'[45]

35. For mild haemophiliacs Dr Dawson has told the Inquiry that '*we would have used concentrate when we felt that was required for difficult operations or for bleeding that didn't respond to DDAVP ... In some situations we did use DDAVP for haemophilia A and use of this increased with time in appropriate cases.*'[46]

36. The Inquiry has received evidence from a patient of Dr Dawson who has von Willebrand's disease and was infected with HCV. The patient describes that she was treated with cryoprecipitate and DDAVP until 1989 when she received factor VIII on one occasion.[47] The witness recalls Dr Dawson stating: "*Let's hope it didn't have any nasties in it*" after she had given the witness factor VIII.[48]

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[42] §12.24, chapter 12 of PRSE0007002
[43] SBTS0000298_005
[44] §8 of WITN4045001
[45] §8 of WITN4045001
[46] §6 of WITN3503004
[47] §3 of WITN2254001
[48] §6 of WITN2254001

37. It appears that the Centre frequently supported the approach taken by the larger Scottish Centres of Edinburgh and Glasgow. For example, Drs Dawson and Bennett supported the points made by Dr Ludlam in 1987.[49] Drs Dawson and King were copied into Dr Ludlam's request on 19 November 1990 to SNBTS for supply of purity factor VIII over the next two years[50] to treat the patient groups identified in the UKHCDO Recommendations.[51]

Knowledge of risk of hepatitis and response to risk

38. Dr Dawson has told the Inquiry that in the early 1970s she was aware that HBV could be transmitted by blood but was '*unaware of any other pathogens*' that were similarly transmitted.[52]

39. Dr Dawson has told the Inquiry that in the 1970s she became aware of non-A non-B hepatitis.[53]

40. In the Centre's 1978 UKHCDO annual return a number of haemophilia A patients are described as jaundiced in 1969, 1975, 1976 and 1978.[54] In July 1978 Dr Dawson submitted the details of one of her patient's negative HBV results to Dr Ghosh at the Oxford Haemophilia Centre.[55] In November 1977 Dr Dawson submitted forms for the purposes of the UKHCDO's Hepatitis survey.[56]

41. Dr Dawson attended the 5 April 1971 UKHCDO meeting.[57] At that meeting Dr Biggs provided a short summary of her report on the incidence of jaundice and inhibitors in haemophilia and Christmas disease patients treated during 1969.

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[49] PRSE0003233
[50] SBTS0000706_224
[51] I.e. 1. HIV positive patients 2. PUPs 3. Children up to the age of 5. 4. Patients undergoing surgery or receiving high dose.
[52] §8 of WITN3503004
[53] §8 of WITN3503004
[54] HCDO00002431
[55] OXUH0000351
[56] HCDO00000259_128 and HCDO00000259_055
[57] HCDO00001014

Directors were asked about their figures of Australian antigen and antibody testing. Drs Dawson and Bennett attended the 27 October 1972 meeting where Dr Biggs stated that information over the last three years had not shown an increase in jaundice or antibodies directed against factor VIII and IX.[58]

42. Dr Dawson attended the 1 November 1974 UKHCDO meeting where Dr Biggs presented the results of the 1974 jaundice and factor VIII study and Dr Craske discussed an epidemic of HAV and HBV in Bournemouth haemophiliac patients who had received a particular batch of commercial factor VIII and there was a discussion about the safety of commercial versus NHS factor products.[59] Dr Dawson also attended the 18 September 1975 meeting where Dr Biggs again presented on the jaundice and factor VIII study and the Directors discussed the incidence of hepatitis.[60]

43. Dr Dawson also attended the 20-21 November 1979 UKHCDO meeting where Dr Craske noted that there were various possible causes of hepatitis and there were two types of non-A non-B hepatitis.[61]

44. Dr Dawson has told the Inquiry that when she became aware of non-A non-B hepatitis in the 1970s '*it did not change treatment much as it did not appear to be a progressive condition and none of the patients were dying of liver disease, but would have suffered seriously if we had stopped their factor VIII treatment.*'[62]

Knowledge of risk of AIDS and response to risk

45. Dr Dawson has told the Inquiry that the risk of AIDS was '*highlighted*' in the Scottish Haemophilia Centre Director meetings.[63]

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[58] HCDO0001015
[59] HCDO0001017
[60] OXUH0003735
[61] CBLA0001028
[62] §8 of WITN3503004
[63] §10 of WITN3503004

46. Dr Dawson did not attend the meeting of the Directors of SNBTS and the Centre Directors on 21 January 1983 where Dr Cash drew attention to recent articles in the United States and in *the Observer* and *The Lancet* about AIDS.[64] Dr Dawson also did not attend the 27 September 1984 UKHCDO meeting where Dr Craske referred the Directors to his report on AIDS and outlined the relevant literature.[65] However, Dr Bennett was in attendance at both of these meetings and it is reasonable to assume that Dr Dawson would have been made aware of the contents of those meetings either from reading the minutes or from discussions with Dr Bennett.

47. Dr Bennett also attended the 7 March 1985 meeting of Scottish Haemophilia Centre Directors.[66] At that meeting Dr Perry informed the Directors that there were plans for new screening tests for HTLV III antibodies to be evaluated on a UK basis: '*there was deep concern about reports indicating a high proportion of false positives*' in the trials carried out in the United States.

48. Dr Dawson attended the 23 September 1985 meeting of Scottish Haemophilia Centre Directors meeting.[67] At the September meeting it was stated that '*most*' Scottish haemophiliacs had undergone anti-HTLV III testing. The possibility of sexual and family transmission of HTLV III was discussed and it was noted that '*no contact living in Scotland was known to be anti-HTLV III positive.*'[68]

49. Dr Bennett attended the 21 October 1985 UKHCDO meeting.[69] At this meeting Dr Craske presented his report and described an '*upward curve*' of AIDS/ARC cases in the UK. Issues such as testing, further studies and counselling were discussed.

50. Dr Dawson attended the 9 October 1986 UKHCDO meeting where the UKHCDO AIDS group's first report on HIV sero-positivity in UK haemophiliacs was discussed.[70]

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[64] PRSE0001736
[65] PRSE0003659
[66] SBTS0000829
[67] MACK0001055_001
[68] MACK0001055_001
[69] PRSE0001638
[70] PRSE0004317

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

51. Dr Dawson states that patients were not told of their infections as a group but at individual appointments.[71] One severe haemophiliac who was infected with HIV and HCV has told the Inquiry that he was informed of his HIV infection in around 1985 or 1986 and was told face to face by Dr Bennett in a side room.[72] He recalls there being '*no real information*' at that time.[73] A letter from Dr Bennett to the witness' GP on 27 February 1986 states that Dr Bennett had not informed the witness' parents of the witness' HIV infection because that was a matter for him.[74] The witness met with Dr Bennett with his then partner in June 1987 where there was a detailed discussion about the dangers of the couple having children.[75]

52. Dr Dawson states that HIV '*testing of family members was not routine*' but states she is '*sure that it would have been offered if the request was made.*'[76] One witness has told the Inquiry that when his wife was pregnant the couple requested a HIV test, which was fortunately negative.[77]

53. Dr Dawson has told the Inquiry that patients with HIV were referred '*to colleagues in the infection unit locally.*'[78]

54. In response to a potential legal claim, Dr Dawson wrote to John Cash in December 1990. As part of that correspondence she stated that there was no blood stored before October 1985. For that patient, there was an HIV positive test in October 1985.[79] John Cash replied stating that: '*My money would be on the FEIBA!*'[80]

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[71] §14 of WITN3503004
[72] §7 of WITN2223001
[73] §7 of WITN2223001
[74] WITN2223009
[75] WITN2223008
[76] 14 of WITN3503004
[77] §9 of WITN2223001
[78] §10 of WITN3503004
[79] SBTS0000652_083
[80] SBTS0000635_069

55. On 22 May 1989 the General Secretary of the Haemophilia Society, David Watters, wrote to Dr Rizza of the Oxford Haemophilia Centre stating that he had '*learned recently that patients with haemophilia attending Raigmore Hospital in Inverness and Aberdeen Royal Infirmary are not necessarily being advised [of] their HIV status.*'[81] The letter states that there were two patients at Aberdeen Royal Infirmary where '*there was a long delay in giving the information [i.e. of HIV positivity] to the patients or their families.*'

Numbers infected with HIV

56. Dr Dawson has told the Inquiry that three patients at the Centre were infected with HIV. She states that all had severe haemophilia A.[82]
57. Dr Henry Watson provided written witness evidence to the Penrose Inquiry that three patients were considered to have acquired HIV as a result of treatment at Aberdeen '*on the basis that these patients had been treated only at the Aberdeen centre or had received minimal treatment elsewhere.*'[83] It was noted that two of these patients had severe haemophilia, while one had moderate haemophilia. In Chapter 3 of the Penrose report the following additional details were given about these patients:

> *'One patient had been treated only with SNBTS product (PFC Factor VIII and cryoprecipitate) during the relevant period. 293 This patient's last negative test for HIV was 14 July 1983 and he first tested positive for HIV on 18 December 1984. One patient received commercial product in small amounts in 1978 and 1979 (Baxter 'Hemofil') but otherwise received treatment only with SNBTS product (PFC FVIII and cryoprecipitate). This patient's last negative test for HIV is not known and the patient first tested positive for HIV in January 1985. One patient regularly received commercial product and from time to time received PFC product. Again, this patient's last negative test for HIV is not known and the patient first tested positive for HIV on 1 January 1985*
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> *Two of these patients were known to have died. If these patients were infected by Scottish products (which was clearly the position in the first and third cases) all*

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[81] LOTH0000006_028

[82] §17 of WITN3503004

[83] PRSE0005027, page 74.

had PFC factor VIII in 1983 and 1984. Patient A3 is likely to have been infected by the batch implicated in the infection of the Edinburgh Cohort.'[84]

58. However, the Penrose Inquiry received further information from the UKHCDO following its oral hearings, which stated that seven patients from Aberdeen had tested positive for HIV.[85] That is consistent with the provisional UKHCDO data this Inquiry has received which show that, up to 1988, there were seven positive cases at Aberdeen.[86]

59. No paediatric patients were infected with HIV.[87]

Testing for Hepatitis C

60. Dr Dawson has told the Inquiry that upon the advent of HCV testing the Centre tested '*some*' of the patients '*but we did not know what to tell the patients because we were not sure how the virus behaved and whether having it meant that the patients would go on to have liver disease or be able to transmit it or not.*'[88]

61. Dr Dawson has told the Inquiry that there was a policy of offering testing for HCV to all patients who '*came to attention*' and who had treatment with factor concentrate in the 1970s and 1980s.[89] No date is given for this policy in Dr Dawson's statement. It is further unclear what is meant by patients who '*came to attention*' of the Centre.

62. The Inquiry has received evidence from infected individuals and their families that is critical of how they were informed about their HCV infections and the

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[84] Page 74-75 of PRSE0005027
[85] Page 76 of PRSE0005027
[86] INQY0000250
[87] §32 of WITN4535001
[88] §9 of WITN3503004
[89] §21 of WITN3503004

information provided upon diagnosis.[90] For example, one patient describes that in 1992 she was admitted to the Aberdeen Royal Infirmary following an asthma attack and was admitted into '*an isolated cubicle which had contamination labels everywhere.*'[91] She describes finding out about her infection in the following terms:

'*Everyone was wearing [masks], gloves and aprons. It was quite disorientating and I had a bad nose bleed. Dr Dawson walked in the room while this was going on and turned to me and said "Make sure you put the tissues in the red bin", she then turned to me and said in a very callous voice, "We don't want to catch anything from you". I asked her what she meant by this and she told me I had hepatitis C. I was absolutely shocked and confused it was an extremely upsetting and embarrassing experience.*'[92]

63. The witness is further critical about the lack of explanation as to what HCV was and the absence of practical information about how to manage her infection.[93] Another witness states that when she was first diagnosed in 1993 she was given '*no information*' upon diagnosis and relied on a leaflet given to her from a friend.[94] She describes having to seek out information rather than information being provided to her.[95] She recalls that in around 1996 a HCV clinic was started at the ARI and attending the clinic was the first appointment she had with a medical professional following her diagnosis.[96]

64. A letter from Dr Dawson on 8 January 1992 states that he had undergone '*various viral investigations*' which showed that he had '*antibodies to Hepatitis C'*.[97]

65. In 1995 a clinic was set up with Dr Molyneaux, a virologist, and Dr Peter Brunt, gastroenterologist. Dr Dawson's recollection is that this is when they started doing PCR tests.[98]

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[90] For example, WITN1299001
[91] §7 of WITN2254001
[92] §7 of WITN2254001
[93] §7 of WITN2254001
[94] §21 of WITN0850001
[95] §21 of WITN0850001
[96] §22 of WITN0850001
[97] WITN2223012
[98] §9 of WITN3503004

Treatment arrangements for HCV patients

66. Dr King has told the Inquiry that one paediatric patient[99] was infected with HCV and was transferred to adult services under the care of Dr Dawson.[100]

67. Dr Dawson has told the Inquiry that interferon was used at the Centre from 1995 or 1996.[101] As referenced above, there was a combined clinic between virology, hepatology and haematology. She recalls telling patients about the side effects of interferon '*and saying that the most common side effect was feeling as if you had flu'*.[102]

68. Evidence provided to the Inquiry by infected individuals describes treatment with interferon, as well as Harvoni.[103]

Treatment arrangements for HIV

69. Dr Dawson has told the Inquiry that at least one of the three patients infected with HIV was treated with AZT prior to her retirement in 1996.[104] One man infected with HIV describes receiving Kaletra since around 2005 to 2006. His medical records show use of AZT since 1992.[105]

UKHCDO

70. Dr Dawson had told the Inquiry that she had '*little involvement*' with UKHCDO. The Centre supplied data to UKHCDO on an annual basis. She states that '*most of the UKHCDO involvement for Scotland was carried out by Edinburgh and Glasgow*

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[99] Dr King describes this patient as one '*with a condition requiring multiple transfusions of blood and blood products*.'
[100] §59 of WITN4535001
[101] §20 of WITN3503004
[102] §20 of WITN3503004
[103] See for example § 22 of WITN2223001
[104] §19 of WITN3503004
[105] WITN2223018

who were the bigger centres.' She states that information from the UKHCDO was '*passed on*' to the Scottish Centre Directors.[106]

71. Dr Dawson is listed as attending the 21 June 1976 UKHCDO meeting at Glasgow where Dr Biggs presented a paper on jaundice and factor VIII antibodies, and Dr Ingram highlighted that NHS factor VIII pool sizes were smaller than commercial factor VIII products.[107] There are key UKHCDO meetings, particularly in the early to mid-1980s, where Dr Dawson is listed as not attending. In the same timeframe, she is listed as attending Scottish Haemophilia Directors Meeting, for example, on 23 September 1985.[108]

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JUNE 2021

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[106] §26 of WITN3503004
[107] OXUH0003735
[108] MACK0001055_001