

## **SMALLER HAEMOPHILIA CENTRES PRESENTATION**

### **WEST DORSET HOSPITAL, DORSET**

#### **The Centre**

1. The Dorchester Haemophilia Centre (the Centre) was based at West Dorset Hospital (Dorset County Hospital or County Laboratory). The Director during the 1970s to 1990s was Dr Gilliver. The Centre was designated in or around 1976 [OXUH0003752\_049] and was assigned centre number 7. The Centre was within the Wessex Regional Health Authority and was supplied by the Wessex Regional Transfusion Centre.

#### **Numbers of patients treated at the Centre**

2. In the following years, the numbers of patients treated at the Centre were as follows:
  - a. 1976: 2 patients attended the Centre and were treated [HCDO0000073\_002].
  - b. 1978: the Centre treated 5 haemophilia A patients [HCDO0001253].
  - c. 1979: the Centre treated 7 haemophilia A patients and 1 haemophilia B patient [HCDO0001320].
  - d. 1980: the Centre treated 6 haemophilia A patients and 2 haemophilia B patients [HCDO0001417].
  - e. 1982: the Centre treated 5 patients with haemophilia A and 1 patient with haemophilia B [HCDO0001616].
  - f. 1983: the Centre treated 8 patients with haemophilia A, 1 carrier of haemophilia A, 2 haemophilia B patients and 1 von Willebrand's disease patient [HCDO0001713].

- g. 1984: the Centre treated 9 patients with haemophilia A, 1 carrier of haemophilia A, 1 patient with von Willebrand's disease and 2 haemophilia B patients [HCDO0001808].
- h. 1985: the Centre treated 7 haemophilia A patients and 2 patients with haemophilia B [HCDO0001900].

### **Treatment policies and blood product usage**

3. The Annual Returns for the Centre show that the following products were used in the following years:

- a. 1976: the Centre treated its patients with cryoprecipitate (24 units) [HCDO0000073\_002].
- b. 1978: the Centre treated its haemophilia A patients with cryoprecipitate, NHS concentrate and commercial concentrate (Factorate). The main product used was commercial concentrate (16,096 units), followed by cryoprecipitate (13,650 units) and then NHS concentrate (13,200 units) [HCDO0001253].
- c. 1979: the Centre treated its haemophilia A patients with cryoprecipitate, Lister concentrate and commercial concentrate (Factorate). The main product used was Lister VIII concentrate (2,300 units), followed by commercial concentrate (1,900 units) and then cryoprecipitate (70 packs). The Centre treated its haemophilia B patient with plasma and Oxford Factor IX concentrate [HCDO0001320].
- d. 1980: the Centre treated its haemophilia A patients with cryoprecipitate and NHS concentrate. The annual return shows the Centre used 60 packs of cryoprecipitate.<sup>1</sup> The Centre treated its haemophilia B patient with NHS Factor IX concentrate [HCDO0001417].

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<sup>1</sup> The amount of NHS concentrate used is illegible.

- e. 1982: the Centre treated its haemophilia A patients with NHS concentrate and commercial concentrate (Factorate, Hemofil and Kryobulin). The Centre primarily used NHS concentrate (78,750 units), followed by 58,250 units of commercial concentrate. The Centre treated its haemophilia B patient with NHS Factor IX concentrate [[HCDO0001616](#)].
  - f. 1983: the Centre treated its haemophilia A patients with cryoprecipitate, NHS concentrate and commercial concentrate (Factorate). The main product used was NHS concentrate (80,284 units), followed by commercial concentrate (9,430 units) and finally cryoprecipitate (420 units). The Centre's carrier of haemophilia A was treated with commercial concentrate. The Centre treated its von Willebrand's disease patient with cryoprecipitate. Haemophilia B patients were treated with NHS concentrate [[HCDO0001713](#)].
  - g. 1984: the Centre treated its haemophilia A patients with cryoprecipitate and NHS concentrate. Patients were treated primarily with NHS concentrate (112,075 units), followed by 19,530 units of cryoprecipitate. The Centre treated the carrier of haemophilia A with NHS concentrate, and the von Willebrand's disease patient with cryoprecipitate. NHS concentrate was used for the treatment of haemophilia B patients [[HCDO0001808](#)].
  - h. 1985: the Centre treated its haemophilia A patients with cryoprecipitate, NHS concentrate and commercial concentrate (Profilate, Factorate, Koate and Hemofil). Commercial concentrate was the main product used (93,625 units), followed by NHS concentrate (29,600 units) and then cryoprecipitate (2,870 units). The Centre's haemophilia B patients were treated with NHS concentrate [[HCDO0001900](#)].
4. A letter dated 21 May 1985, sent by Peter Johnston (Consultant Paediatrician, Dorset County Hospital), states that the Hospital was at that time in the process of obtaining British produced Factor VIII for patients [[TREL0000062\\_222](#)].

### Testing for HIV / numbers infected

5. Provisional UKHCDO data available to the Inquiry suggests that 3 people were infected with HIV at the Centre: 1 HIV positive test was identified in each of the years 1984, 1985 and 1986 [INQY0000250].
6. On 4 October 1984, the Centre received notification for the recall of BPL Factor VIII after a donor was thought to be suffering with AIDS [DHSC0002247\_090]. The diagnosis was subsequently confirmed on 16 October 1984 [DHSC0002247\_093]. By 8 October 1984, 5 out of 25 vials of the relevant batch (Batch HL3186) had been returned [CBLA0000010\_211]. A document available to the Inquiry suggests that the remaining 20 vials were transfused to patients [BPLL0016023\_009]. In total, 4 of the Hospital's patients were exposed [CBLA0000010\_191]. The Centre received the following advice:
  - a. The Centre was initially asked by the Wessex Regional Transfusion Centre to keep the news to itself [DHSC0002247\_090], and was later advised to pursue a policy of “discrete surveillance” after the AIDS diagnosis had been confirmed [DHSC0002247\_093].
  - b. Dr Craske advised affected Centres to identify all patients who had received product from the batch and to test specimens, with follow up for patients identified at least at four monthly intervals for 6 years. Dr Craske proposed two alternative strategies during the follow-up, one of which “*would be not to tell the patient of the risk involved but to observe him at regular clinical review four monthly, to collect serum specimens for HTLV-3 antibody examination and send them to me at Manchester. These would not be examined until two years after initial exposure, or until the patient develops clinical features suggestive of AIDS, or testing is requested by the Haemophilia Centre Director*”. Dr Craske concluded that the patient should

ideally be told, but that the decision would depend on many factors, including the amount of anxiety concerning AIDS and the degree to which the patient was capable of understanding the situation [CBLA0000010\_188].

- c. A letter sent by the Regional Medical Officer at the Wessex Regional Health Authority, copied to Dr Gilliver, advised that patients who received the batch should be told, with emphasis placed that the benefits of treatment by Factor VIII far outweigh the small risk to the patient developing AIDS [HHFT0001026\_004].

- 7. A letter from Dr Gilliver dated 13 February 1985 confirms that a patient had tested HTLV III positive prior to exposure to Batch HL3186 [TREL0000077\_073]. A further letter dated 14 February 1985 confirms that, by that date, 2 of the 4 patients exposed were HTLV III positive [CBLA0002039]. On 20 February 1985, in a letter to Dr Gilliver, Dr Aronstam confirmed that another of the 4 exposed patients was HTLV III positive [TREL0000062\_224].

#### **Knowledge of risk of hepatitis / AIDS and response to risk**

- 8. Dr Gilliver attended the Meeting of Haemophilia Centre Directors and Blood Transfusion Centre Directors within the Oxford Supraregion on 19 June 1978 [OXUH0003765\_005]. UKHCDO minutes show that Dr Gilliver also attended the UKHCDO meetings of haemophilia centre directors on the following dates: 13 September 1982 [CBLA0001619]; 17 March 1986 [PRSE0001688]; 29 September 1988 [BART0002329]; 21 September 1990 [BART0002382]; and 18 September 1992 [HCDO0000248\_013].
- 9. It may be reasonable to assume that, as a director, Dr Gilliver would have received copies of the reports circulated for, and the minutes of, UKHCDO meetings for any meetings at which he was not in attendance.

10. The Inquiry does not currently have information as to the numbers of patients infected with hepatitis C in consequence of their treatment for haemophilia at West Dorset Hospital. A hepatitis survey was completed by Dr Gilliver in January 1978 [NHBT0144850] and in February 1984 [HCDO0000256 142].

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