PRESENTATION NOTE ON FOUR SCOTTISH TRANSFUSION CENTRES

1 This presentation note provides an overview of, and a summary of some of the relevant documentation in relation to, the following four Blood Transfusion Centres ("BTCs") in Scotland: the West of Scotland BTC in Glasgow, the North East of Scotland BTC in Aberdeen, the East of Scotland BTC in Dundee and the North of Scotland BTC in Inverness.

2 Earlier presentation notes on the Blood Services in Scotland focused on: the organisation and history of the Blood Services [**INQY0000307**, **INQY1000159**]; and the work of Professor John Cash [**INQY0000308**, **INQY1000160**, **INQY1000161**].

3 The particular RTCs covered in this presentation note have not previously been the main focus of oral evidence or an oral presentation[1]. The Inquiry has, of course, already received and heard evidence in relation to the South East of Scotland BTC in Edinburgh from Dr B McClelland [**WITN6666001**]; [**INQY1000178**].

4 A similar presentation note is being prepared in relation to the English Regional Transfusion Centres which have not already been considered in the Inquiry's oral hearings.

[1] The Inquiry has heard oral evidence from Dr Gamal Gabra who was a consultant at the Glasgow BTC between 1974 and 1989 [**WITN5495001**] [**INQY1000180**], this presentation note therefore only provides further information about Glasgow from 1989 onwards. The Inquiry has also heard evidence from Dr Galea who was a consultant at Aberdeen between 1989 -1993 and the Director of the Inverness BTC from 1993 -1996 and of Dundee BTC from 1996 – 1999 [**WITN6931001**] [**INQY1000168**]. This presentation note therefore only provides further information about Aberdeen BTC in the period prior to 1989, Inverness BTC in the period prior to 1993 and Dundee BTC in the period before 1996.

THE NORTH EAST OF SCOTLAND BLOOD TRANSFUSION CENTRE AT ABERDEEN

Background

5 The directors of the North East of Scotland Blood Transfusion Centre at Aberdeen (NESBTC) were Dr Brodie Lewis between 1964 and 1983 and Professor Stanley Urbaniak between 1983 and 1988 (albeit he was Director Designate from 1982). The Inquiry has a witness statement from Professor Urbaniak which much of this part of the presentation is drawn from [**WITN6960001**].

6 NESBTC was based at the Fosterhill medical centre in Aberdeen on the site of the Aberdeen Royal Infirmary (ARI). It held donor sessions there. At paragraph 55 of his witness statement, Professor Urbaniak described how the donor office and records were housed in a wooden hut in the car park.

7 When Professor Urbaniak took up his post, his was the only consultant post at NESBTC, assisted by one '*elderly*' Associate Specialist who shared the 24 hour on call rota with him [**WITN6960001** paragraph 1]. About 90% of blood and blood product usage in the region was in the Aberdeen Hospitals complex. This complex was served by the blood bank at NESBTC. Professor Urbaniak described the work load in the blood bank as similar to that at the Edinburgh BTC, but in Edinburgh the work was shared between four consultants.

8 In 1989 a second consultant post was created at NESBTC to look after the management of donors and the micro-biological testing of donations.

9 The Scottish National Blood Transfusion Association Report for the year ended 31 March 1968 described the accommodation at Aberdeen as inadequate - **SBTS0000554**. Concerns continued to be expressed about the accommodation in 1977 - **SCGV0000125_071**, **SCGV0000125_072**.

10 The Medicines Inspectorate inspected NESRTC in March 1982. The report noted that the Centre collected 35,000 donations per annum and supplied blood to the Orkney and Shetland Islands. The report went on to state that '*serious consideration must be given to a new Centre by June 1987*' - **PRSE0003178**.

11 In his response to this report dated December 1982 Professor Urbaniak stated that '*Many of the problems noted by the Inspectors are due to the inadequacy of the present accommodation. This had already been recognised and plans for upgrading were in hand*

at the time of the Inspection.' The plan was for interim works to be done to the existing building, alongside planning for a new Centre - **PRSE0004141.**

12 The next Medicines Inspectorate inspection was January 1990 **SBTS0003916_257**. This provided the following information about the Centre:

a. The new centre had still not been built.
b. NESBTC served a population of around 537,000, collecting about 32,000 donations annually.
c. Donor records were still not computerised.
d. There was an apheresis suite at the centre, with six machines.
e. Due to the lack of space, plasma was stored in two off site location. These were visited and the conditions were said to be totally unacceptable.

13 The report concluded by stating *'It is not possible to achieve acceptable standards of GMP in the existing BTS facility and the planned new Centre should be built without further delay.'* Professor Urbaniak's response dated October 1990 is at **SBTS0000707_167.**

14 By 1993 NESBTC had a new centre on the Aberdeen Royal Infirmary site. By this time, the North East of Scotland was said to have a population of 514,400, with 31,103 donors, and 21 acute hospitals - **NHBT0002938**.

Blood collections and targets

15 At paragraph 66 of his witness statement **WITN6960001**, Professor Urbaniak confirmed that the targets sufficient to meet the transfusion needs of the hospitals served by the Centre were set by him as the Director, while the targets for the amount of plasma to be sent to PFC were set nationally by PFC.

16 In the year ended 31 March 1968 the number of donations collected were 16,337 and the donations issued 14,668. Of those, 11,194 were issued as whole blood and 3,528 donations were processed - **SBTS0000554**. The figures for blood collection in 1970/1971 are at **SCGV0000212_041**, and 1971/1972 and 1972/1973 are at **SCGV0000212_026.**

17 In the year 1974 – 1975, 25,612 donations were collected by NESBTC - out of a total collection in Scotland of over 252,500 donations. The target figures for 1978 were to collect 34,600 donations and to use 4,800 donations as whole blood, and 30 litres as cryoprecipitate, with over 5,300 litres to be made available for PFC - **PRSE0002133**.

18 By 1980/1981 NESBTC collected 31,792 donations - **PRSE0003178**.

19 On 18 February 1981 Dr Brodie wrote to Dr Cash setting out how NESBTC could reach the targets given to them for plasma collection. His plan was to increase the use of plasmapheresis at NESBTC, which would involve a large increase in the amount of donations collected from the centre - **SBTS0000230_055.**

20 According to the Medicines Inspectorate report in March 1982, cryoprecipitate had been discontinued at the Centre - **PRSE0003178**. In April 1983 Professor Urbaniak discussed the possibility of increasing the availability of cryoprecipitate with the haemophilia director Dr Bruce Bennett as a response to the threat of AIDS – **WITN6960010**. Between 1983 and 1986 he was able to increase production of cryoprecipitate from 153 units to 425 units – **SBTS0004066_028**. During that period the number of donations collected reduced from 35,678 to 33,192.

21 NESBTC increased its plasma production for fractionation from 5,691 units in 1983 to 7,856 units in 1986 – **SBTS0004066_028**.

22 During Professor Urbaniak's directorship the region was self-sufficient in red cells - **WITN6960001** paragraph 32. At paragraph 54 of this statement Professor Urbaniak asserts that during his time at NESBTC, it always met its targets and was in fact a net exporter to the SNBTS as a whole.

Blood use

23 At paragraph 80 of his witness statement Professor Urbaniak described how he held meetings with colleagues to agree a series of Maximum Surgical Blood Ordering Schedules for each procedure that might require blood, with a view to reducing blood usage.

24 Professor Urbaniak also set up a hospital transfusion committee at the ARI.

Donor selection

25 At the time Professor Urbaniak took up his post as director, donor sessions were taking place in HMP Craiginches in Aberdeen and HMP Peterhead, twice a year. The number of donations collected in this way is set out in **PRSE0002164**.

26 Following the discussion at his first meeting of the SNBTS directors. as a director, on 29 March 1983 [**PRSE0000193**], Professor Urbaniak visited a donor session at one of the prisons and decided that there was potentially '*undesirable peer pressure to donate, confidentiality problems. And the unreliability of the medical history given'*, so decided to cancel all further sessions. The last prison session was held on 28 July 1983 at HMP Peterhead. [**PRSE0001873**, **WITN6960007 WITN6960008**].

27 In his statement at paragraph 39 - **WITN6960001** – Professor Urbaniak describes how he undertook an investigation into how HBV prevalence varied from one region to another, by doing a cluster analysis of the historical data from NESBTS records. He noted that there were two HBV hot spots, HMP Craiginches and HMP Peterhead. He used this as evidence to support his decision not to continue with sessions at penal institutions.

28 On 5 May 1983 Professor Urbaniak received a copy of Dr McClelland's AIDS leaflet. After consulting with his clinical colleagues in the region, Professor Urbaniak wrote to Dr McClelland stating that he thought it would be premature to introduce a similar leaflet in the North East - **WITN6960012** and paragraph 184 of **WITN6960001**.

29 In December 1984 Professor Urbaniak wrote to Professor Cash to say that the publication of the AIDS leaflet in the local newspaper had attracted some positive feedback from certain donors - **WITN6960013**.

Testing for blood borne viruses

HBV

30 The history of HBV testing at NESBTC is set out at **SBTS0000352_270** and provides as follows:

a. In June 1971 they began routine testing of donations using CIE.
b. In October 1975 – RPHA substituted, overlapping with RIA.
c. In August 1978 – RIA substituted.

31 When a plasma pool containing plasma sent to PFC from NESBTC tested positive for HBsAg positive at PFC (which had a more sensitive reference test than they had at NESBTC), repeat testing on archived NESBTS donor samples was carried out by the SNBTS microbiology reference laboratory using more sensitive tests to identify which was the infected donation [see paragraph 82 of **WITN6960001**].

HIV

32 NESBTS had found no HIV positive donors between 1985 and 1989, and only four by 1995 [WITN6960001 para 117 and **WITN6960011**]. The records of these donors were kept in a locked drawer in Professor Urbaniak's desk. The cases were reported to the Scottish Centre for Infection and Environmental Health (SCIEH) [paragraphs 145 and 149].

33 Infected donors were informed of their infections by NESBTC and then referred on to their GP and specialists for further counselling and treatment.

Arrangements for the purchase and supply of factor products

34 Prior to PFC taking over the ordering of products nationally in the late 1980s, NESBTC had an arrangement with the Chief Administrative Medical Officer (CAMO) of the Grampion Health Board that the Haemophilia Director at the Aberdeen Haemophilia Centre would order the commercial products required, the Health Board would pay for them, and NESBTC would store and issue them as required [paragraph 86 **WITN6960001**]. Accordingly, NESBTS held all stocks for the region. However, it did not get involved in decisions about allocation of product, this was decided between the PFC and the Haemophilia Directors (paragraph 92).

Other

35 There is evidence of NESBTC informing hospitals that they had received donations from donors who had tested positive for viruses such as HTLV-III - **NHBT0027607**.

36 There is evidence of NESBTC sharing information with SHHD about infected donations - **SCGV0000204_137**.

THE EAST OF SCOTLAND BLOOD TRANSFUSION CENTRE AT DUNDEE

Background

37 The directors of the East of Scotland Blood Transfusion Centre (ESBTS) based in Dundee were Dr Charles Cameron from 1954 to 1981, Dr Ewa Brookes from 1981 to 1996 and Dr Galea from 1996 to 1999. The Inquiry has received both written and oral evidence from Dr Galea **[WITN6931001]** and **[INQY1000168]** and so this part of the presentation draws together some of the evidence the Inquiry has received about ESBTS prior to him taking up his directorship in 1996.

38 The SNBTS annual report of 1975 - 1976 provides that unallocated space in Ninewells Hopsital was developed as a donor centre, in the financial year 1976 – 77 - **PRSE0002133**.

39 In March 1982 there was a Medicines Inspectorate report of ESBTS. This revealed that the Centre took about 33,000 donations per annum and it cross-matched about 70% of the regions' requirements. The report concluded as follows:

'*This Centre, located in a comparatively new hospital, already needs to be provided with more and suitable facilities.....It was felt by the Inspector that this was a well run Centre staffed by competent people.*'
ARCH0002306_002.

40 Dr Brookes' response of February 1983 is at **SBTS0000408_081**.

41 In December 1982 Dr Brookes proposed bringing forward the re-development of the Blood Processing Laboratory and a range of other measures to improve the performance of ESBTC- **SBTS0003964_115**.

42 In mid-1983, ESBTC started to keep library samples of previous donations for between 6 – 12 months - **SBTS0000416_058**.

43 In August 1983 Dr Brookes wrote to Dr Cash in the following terms:

'Although I was appointed as Director of Blood Transfusion to run the Blood Transfusion Service in this Region, I have come to realise that a very large part of my time and attention is taken up by the cross-match service and the clinical aspects of blood transfusion in the region. .....

I am directly accessible to M.L.S.O.s on call, not only for Ninewalls, D.R.I and Stracathro as before, but for Perth and Bridge of Earn also. I am of course, also available to medical staff of all grades for consultation on all transfusion problems. My only support in this is my Deputy Director, Dr. Jack Boswell, an Associate Specialist without a higher qualification, now aged 60 years and contemplating retirement. .....
The early appointment of a second full time consultant in the Transfusion Centre would substantially safeguard the service to patients with transfusion problems in the region....'
SBTS0000236_014

44 In September 1985 Dr Brookes sent Dr Cash a proposed plasmapheresis programme for ESBTC, which at that time only undertook manual plasmapheresis - **SBTS0000243_037** and **SBTS0000243_038**.

45 In May 1989 Dr Brookes wrote to Dr Cash to alert him to the fact that the long term problem of space shortage at Dundee had become critical as a result of the increased plasma being sent to PFC. PFC only collected plasma once a month and had apparently refused to do this more frequently due to the expense. This was causing ESBTC to consider jettisoning their library samples - **SBTS0000255_053**.

Blood donations and plasma targets

46 In the year ended 31 March 1968 the number of donations collected were 20,086 and the total donations issued were 13,564. Of those, 9419 were issued as whole blood and 8,826 donations were processed - **SBTS0000554**. This report also states that there was a busy apheresis programme in Dundee with around 300 donors regularly giving their plasma and platelets.

47 In the year 1974 – 1975, 30779 donations were collected by Dundee out of a total collection in Scotland of over 252,500 donations - **PRSE0002133**.

48 The target figure for 1978 was for 30,800 donations to be collected, with 6,300 donations to be used as whole blood, 20% of the donations to be used for 'blood bank maintenance', with 40 litres to be used for cryoprecipitate and over 5,300 litres to be made available for PFC - **PRSE0002133**.

49 In the 1992/93 SNBTS annual report the East of Scotland was said to have a population of 461,830, with 31,104 donors, and 14 acute hospitals - **NHBT0002938**.

High Risk Donors

50 In March 1982 there was a Medicines Inspectorate report of ESBTS. This found that '*…it would seem most unlikely that we could continue to endorse the continued collection of blood from such places as Prisons and Borstals'* because of the following:

i. The Prison Medical Officers were often not involved in assessing the suitability of donors.
ii. The increased risk of infections associated with the prison population.
iii. The increased risk of transmitting disease through such donations.
iv. The unreliable answers in the pre-donation questionnaire that can occur in such an environment as well as the motivation of some of the donors.

ARCH0002306_002

51 According to an SNBTS report prepared for Penrose the last prison collection in the East of Scotland was on 2 August 1983 at HMP Perth - **PRSE0002164**.

52 Dr Brookes was a member of the Working Party on the Selection of Donors. The following documents are of interest in relation to her work on this committee:

a. On 9 July 1982 Dr Cash wrote to her, reminding her that the Medicines Inspectorate had said that in the SNBTS '*the acceptance of a donor was 'largely a matter of chance*'' and asking her whether she would agree to study the position in Scotland with a view to having a '*more consistent policy in the future*' - **PRSE0003112**.
b. Dr Brookes wrote to Dr Cash in August 1983 to report back on the work of the committee. Dr Cash had asked her to discuss donor sessions in prisons and borstals with her colleagues and she stated:

'In fact, no discussion was necessary since as far as England and Wales are concerned these sessions have already been stopped. It is now left to the Scottish regions to decide whether they will do the same.'

PRSE0002981

53 In 1988 there was correspondence between Dr Gunson and Dr Brookes about HIV positive donors who denied being in at risk categories. Dr Brookes passed on details of such cases, which in turn were passed on by Dr Gunson to Dr Acheson, the CMO in England - **NHBT0006812** and **NHBT0006811**.

Screening for viruses

Hepatitis B

54 In December 1970 Dr Cameron wrote to the SHHD to inform them that ESBTC was screening all donors for both hepatitis associated antigen and antibody - **SCGV0000279_022** and **SCGV0000279_014**. Dr Cameron hoped to be able to interview infected individuals himself '*in order to obtain a detailed history and to arrange for appropriate follow-up'* - **DHSC0100004_063** and **SCGV0000279_037**.

55 In 1972, 25,258 donors were bled at ESBTC, including 6,263 new donors. Five tested positive of whom two were new donors- **NHBT0080195**.

56 In 1975, 27,278 donors were bled at ESBTC, including 3,722 new donors. Three tested positive all of whom were new donors- **NHBT0080192**.

57 In 1985, 30,685 donors were bled at ESBTC, including 5,549 new donors. Five tested positive of whom three were new donors-**NHBT0080182_001.**

58 Reports for HBsAg rates at ESBTC in 1987 and 1988 were as follows:

a. 1987 – 28,637 donors bled, including 4.144 new donors. Two tested positive, both of whom were new donors. The test used was the Abbott RIA test. The results were confirmed by the virology laboratory at Ninewells Hospital Dundee.

b. 1988 - 20,038 donors were bled, including 3,924 new donors. Two tested positive, both were new donors. The EIA (Wellcome) test was used. The results were confirmed by the virology laboratory at Ninewells Hospital Dundee.

NHBT0080180

59 In 1989, 29,666 donors were bled at ESBTC, including 3,743 new donors. One tested positive. This was not a new donor. The EIA (Wellcome) test was used. The results were confirmed by the Department of Bacteriology, at the University of Edinburgh.

NHBT0080199

60 In July 1982, Dr Brookes wrote to Dr Cuthbertson of the SNBTS setting out the recent history of hepatitis testing at ESRTC as follows:

a. From February 1978 donor samples were put into pools of 10 and tested with R.I.A. using Abbott reagents, and each sample was tested individually using ahaemagglutination method (three different methods were used in that year – the Edinburgh inhibition method, the Wellcome hepatest and Abbott Ahscell).

b. From May 1979 donor samples were tested individually by R.I.A suing Abbott reagents

c. Since November 1981, the assay kit used was Hepatube R.I.A. from Wellcome. **SBTS0000352_268**

HIV

61 By April 1986, ESBTC had only found one donor positive for HTLV-III - **SBTS0000416_058**.

Arrangements for the procurement of factor products

62 There is evidence to suggest that ESBTC obtained product from PFC for the region - **SBTS0000306_087.**

63 Correspondence between Tayside Health Board and the Commons Services Agency (CSA) regarding supplies of SNBTS Factor VIII to ESBTC can be seen at **SCGV0000110_080**. This shows a reduction in the SNBTS products being supplied to the regions for the year to 31/3/1989.

64 In August 1988 Dr Brookes confirmed to the Tayside Health Board that there had been a shortfall in the allocation of Factor VIII to the region, stating that '*we have a real problem here.*' The amount of product sent from PFC was lower than it had been the year before, and the amount used by patients '*has been very much higher'*. She requested an urgent meeting to plan how to conserve supplies and to deal with the shortfall - **SCGV0000110_050**.

65 It seems as though the Tayside Health Board took the matter up with Dr Cash (the Inquiry cannot find the letter to Dr Cash), who replied on 6 September 1988 in the following terms:

'I believe your point about who pays when the SNBTS fails is well made. It has always been my view that the current arrangements are wholly unsatisfactory in management terms. The facility to 'cop out' and expect AHBs to pick up the pieces is, I would suggest, not conducive to the good management of the SNBTS or in the best interests of using NHS resources. I would advise that you and the other AHB General Managers take up this matter with the SSHD for it requires a major and central policy change.'

SBTS0000627_012

66 In March 1990, Dr Brookes agreed to transfer 50,000 IU of Z8 from her centre to the West of Scotland - **SBTS0000338_035**.

Communication regarding infected donors and donations

67 There is evidence of ESBTC informing PFC that donors had tested positive for viruses, and asking for feedback from PFC as to what had happened to their donations - **SBTS0000393_039**.

68 There is evidence of ESBTC informing hospitals that infected donations (discovered when testing the library samples of a donor who tested positive for HTLV-III once screening was introduced) were sent to their hospital - **SBTS0000416_058**.

69 There is evidence of information being shared between England and ESBTC about infected donors - **NHBT0090917**.

70 There is evidence of Dr Brookes being asked to counsel recipients of infected donations living in the East of Scotland, who had been identified as part of the English Look back exercise in 1995 - **NHBT0095643_011**.

THE NORTH OF SCOTLAND BLOOD TRANSFUSION SERVICE AT INVERNESS

Background

71 As set out above, the Inquiry heard oral evidence from Dr Galea who was the Director of the North of Scotland Blood Transfusion Service at Inverness (NSBTS) from 1993 -1999. This part of the presentation therefore only addresses the evidence the Inquiry has prior to his taking up this post.

72 The previous directors were Dr I A Cook from 1964 – 1982 and Dr William Whitrow from 1983 – 1993. Dr Cook was also the Director of the Inverness Haemophilia Centre from the 1970s until 1982 – **INQY0000271, HSOC0022904** and **PRSE0000581**.

73 The NSBTS was based in the Raigmore Hospital in Inverness from 1970. Prior to that it was in the Royal Northern Infirmary - **SBTS0000556_001**. It was the smallest Centre in Scotland by some margin. There were close links between the haemophilia centre at Inverness and NSBTS, as Dr Cook was the Director of both organisations.

74 In a document prepared by Dr Cook at the end of 1981, the population served by NSBTS was said to 224,000 strong. It also stated as follows:

a. There were small blood banks at the 12 blood banks outside Inverness. These were all supplied by NSBTS and 4 of these were more than 100 miles away.
b. Each week the mobile team undertook one major and one minor donor session.
c. There were no industrial sessions, so the sessions had to take place after working hours, which meant that the teams didn't get home before midnight.
d. The medical staff were six strong including two consultants – the regional director (Dr Cook) and the deputy director – Dr Taylor.

SCGV0000085_024

75 In the mid 1980s Dr Whitrow explained that the North of Scotland Region:

'.... covered some 10,000 square miles, being approximately half the total area of Scotland, but that the 250,000 population represented only some 5% of the population of Scotland. In view of the far flung nature of the areas of population, this caused a different approach to collection of blood from donors to that employed in other Regions of Scotland.'

SCGV0000050_001

76 Both Drs Cook and Whitrow sought to improve the facilities at the NSBTS:

a. In February 1982 Dr Cook made a formal request for the extension of the Centre. He noted that there was an '*increased clinical demand from blood alone since 1970*' which had led to the facilities becoming '*inadequate for local major blood donor sessions*'– **SBTS0000136_047** and **SBTS0000230_065**.
b. In December 1983 Dr Whitrow produced a case for the extension of the Centre on the basis that new laboratory facilities and clerical and donor areas were required. Dr Whitrow noted that there had been a '*steady and progressive increase in workload in all sections of the Centre since 1970. A greater proportion of the whole blood is now processed to produce specialised blood products.... Inverness has traditionally been in the fore in its programmes of manual plasmapheresis for anti-D immunoglobulin*'. In particular Dr Whitrow requested a purpose-built new blood processing area where hepatitis testing could take place– **SCGV0000271_018**.

77 The SNBTS 1988/1989 annual report stated that NSBTS had installed two plasmapheresis machines - **NHBT0002934**.

78 In the 1992/93 SNBTS annual report the North of Scotland was said to have a population of 233,620, with 18,069 donors, and 14 acute hospitals - **NHBT0002938**.

79 By 1992/1993 approval had been given for the creation of a new blood transfusion centre, which was a joint venture between the BTS and the Raigmore Hospital's Haematology Department – **NHBT0002938**.

80 Dr Cook described the existence of a '*very highly organised records system*' which enabled him '*within a few hours, to track down the name(s) of any patients receiving whole blood, concentrated red cells, platelet concentrates, fresh frozen plasma etc, or secondly blood products such as Factor VIII concentrates*' – **SBTS0000682_025**.

Blood donations and Targets

81 In the year ended 31 March 1968 the number of donations collected were 7,149 and the number of donations issued were 5,867. Of those, 3,847 were issued as whole blood and 2,903 donations were processed - **SBTS0000554**.

82 In the year 1973-74 the NSBTC sent about 30% of their total donations to PFC - **SCGV0000212_010**.

83 In the year 1974 – 1975 10,482 donations were collected at NSBTS out of a total collection in Scotland of over 252,500 donations. The target figures for 1978 were to collect 10,500 donations, out of which 2,800 were to be used as whole blood, with 10 litres being used for cryoprecipitate and over 1,200 litres being available for PFC - **PRSE0002133**.

84 In August 1978, people with haemophilia were being encouraged to donate at NSBTC in the plasmapheresis suite - **PRSE0000749**.

85 Dr Whitrow reported a drop in the number of donations between 1984 – 1985. He wondered '*if the misunderstanding arising from some donors wrongly imagining that donating blood could give risk to AIDS disease, might be in some part to blame'* **SCGV0000050_001.**

86 In November 1990 Dr Whitrow expressed dismay at his total plasma target of 5830Kg for 91/92 - **SBTS0000706_067**.

87 NSBTC exported red cell concentrate to England - **SBTS0003901_159**.

High risk donors

88 According to an SNBTS report prepared for Penrose the last prison collection in the North of Scotland was on 24 February 1983 at HMP Inverness - **PRSE0002164**

HBV testing

89 NSBTC started screening all donors in October 1970 by immune diffusion for both hepatitis associated antigen and also antibody. By December 1970 they had not found any positive samples - **SCGV0000279_015**.

90 On 31 May 1975 Dr Cook informed the SHHD that the NSBTC had started screening all donors for hepatitis two weeks previously by (i) immune diffusion and (ii) counter current immune electrophoresis methods. They had found 4 cases with hepatitis associated antigen in approximately 5,400 donors - **SCGV0000204_165**.

91 In October 1986 NSBTC switched from using the BPL RIA screening test to the ELISA technique - **CBLA0004188**.

HTLV-III testing

92 On 2nd August 1985 Dr Cash wrote to Dr Whitrow setting out that he expected NSBTC to begin HIV testing in October 1985 - **PRSE0000228**.

93 NSBTC used the laboratory at Ruchill as the reference centre for their HIV tests - **SBTS0003067_016.**

HCV screening

94 In March 1987 Dr Cash wrote to Dr Whitrow to remind him that the SNBTS had agreed that *'all efforts'* should be made to ensure that surrogate blood donation testing was introduced from 1 April 1988. In order for the SSHD to be able to consider the cost of this, Dr Whitrow needed to provide Dr Cash with NSBTC's associated estimated costs - **SBTS0000047_020**.

95 In September 1990 Dr Whitrow wrote to a consultant physician at the Raigmore Hospital suggesting that donors testing positive with HCV in *'distant areas'* be counselled and have basic further investigations performed by their GP. He also thought that patients ought to then be referred on to one of four centres in the region, for specialist follow up, those being Stornoway, Wick, Fort William and Inverness. He anticipated there would be 50 – 100 positive HCV donors in the first year, with a further 10-20 per year thereafter. He went on to say:

'As a single handed (often absent) BTS Consultant, I cannot get too personally involved in direct donor contact..... The concept of look back ie checking recipients of that donor's previous donations....is a nightmare which I shall resist until a decision is made Nationally.'

PRSE0002715

96 In a letter to Dr Cash of 6 December 1990, Dr Whitrow expressed himself in rather stronger terms:

'The whole question of donor counselling for HCV is a nightmare and to extend this to 'look back' I believe to be seriously impracticable.
To extend the study to families must of necessity involve General Practitioners and could not be undertaken by BTS resources in this region.'
SBTS0000029_005

97 In a further letter of the same date, Dr Whitrow wrote to Dr Cash informing him that NSBTC could start screening for HCV at very short notice, subject to buying a microplate washer, but the issue of counselling was very much more complex, and it would involve employing a session Medical Officer for one session a week for the first year. He would need two months to set this up. He also stated that he would have to use the Ortho kit - **PRSE0003042**.

98 In a further letter still on the same date, Dr Whitrow set out the costs to NSBTC of introducing ALT testing - **SBTS0000653_217**.

Arrangements for the distribution of blood products

99 In 1973 the Scottish Home and Health Department (SHHD) wrote to (amongst others) Dr Whitrow to inform him that the supply division of DHSS had negotiated with Travenol and Serological Products for the supply of AHG concentrate for the treatment of people with haemophilia. It appears from this letter that the Blood Transfusion Centres were not involved in this, either from a contracting or arrangement of supply position. Instead, the SNBTA was reminded of its role, to prepare and distribute AHG and cyroglobulin precipitate for the treatment of people with haemophilia - **PRSE0000432**.

100 On 19 December 1975 Dr Cook wrote to Major-General Jeffrey, the National Medical Director of the Scottish National Blood Transfusion Service (SNBTS) stating that NSBTC seemed to be getting *'the lions share'* of Factor VIII concentrate, which he thought was unfair to the other Centres. He had analysed their usage with a view to modifying their demands. He continued
'I have decided to return to using cryoprecipitate in all cases attending this Centre or Raigmore Hospital, as far as possible'
He was planning to restrict the use of Factor VIII to two patients and so suggested that the supply to Inverness could be reduced by 50%.
PRSE0003289

101 Major-General Jeffrey's response can be seen at **PRSE0003289**. NSBTC's supply was increased to allow their two '*major users'* to be put on home treatments. He urged Dr Cook to re-think his decision to return to using cryoprecipitate for patients attending the Haemophilia Centre and Raigmore Hospital, stating that the amount of Factor VIII that NSBTC had, could allow cryoprecipitate production to cease.

102 Dr Cook in a letter to Major-General Jeffrey of 10 August 1976 set out his requirement for PFC concentrate, arising from (i) the need to provide home therapy to a child attending a school in Fort William where cryoprecipitate could not be stored, and (ii) visitors from '*down South'* who attended for treatment after laboratory hours '*when it is much more convenient to offer PFC concentrate'* - **PRSE0000228**.

103 Major- General Jeffrey wrote to PFC on 17 August 1976 asking for them to satisfy Dr Cook's requests for FVIII on the basis of his '*outstanding contributions to the PFC'* in the form of FFP and specific immunoglobulins - **SBTS0000303_098**. Mr Watt's take on the subject is at **SBTS0000303_101**.

104 On 3 October 1977 Dr Cook wrote to PFC to inform them the previous week they had been left with 18 doses of Factor VIII. He went on to say that '*General Jeffrey was adamant that smaller Centres must no longer make cryoprecipitate and we have certainly not made any for about 18 months. I see no option but to produce some cryo now to bridge the gap between October/November supplies'.*
SBTS0000088_154

105 John Watts' reply is at **PRSE0004832**.

106 In July 1979 NSBTS had excess factor concentrate amounting to four months' supply, so suggested to Dr Cash that he refrain from sending further supplies for two months - **PRSE0000581**. Dr Cash's reply can be seen at **PRSE0001510**, where he suggested that the excess product could go towards starting a national stockpile.

107 There is a letter from Dr Cook to Speywood in August 1979 informing them that Scotland was largely self-sufficient in Factor VIII products so would not require their product - **IPSN0000324_015**.

Other

108 In July 1976 NSBTC was informed that a child who had received AHF had become jaundiced. The AHF batches that the child had received had also been sent to NSBTC. A look back was instituted of the 350 donors involved in contributing to the product. They were all found to be HBsAg negative, and 200 of them had since been tested and again reported as negative. In addition the recipients of the product were traced – **PRSE0004248**.

109 There is evidence of Dr Whitrow reporting incidences of jaundice to the Oxford Haemophilia Centre in respect of an English patient who received Factor VIII while on holiday in the North of Scotland, and who six weeks later developed jaundice - **HCDO0000263_028**.

Research

110 Dr Cook appears to have been given a research grant by the Inverness Hospitals Board of Management for a two year study into homologous serum jaundice in 1967 - **PRSE0001129**.

THE WEST OF SCOTLAND BLOOD TRANSFUSION CENTRE AT GLASGOW

111 The directors of the West of Scotland Blood Transfusion Centre (WSBTC) were Dr John Wallace between 1946 and 1978 and Dr Ruthven Mitchell between 1978 and 1995.

112 The following information about WSBTS can be gleaned from a draft of a report on the SNBTS from August 1991:

a. In 1956 the centre moved into the grounds of the Law Hospital.
b. There was a Donor Centre in the commercial centre of Glasgow.
c. The West of Scotland at that time, had around 3 million inhabitants. Of those 350,000 were active blood donors who give approximately 160,000 pints of blood per year for distribution to over 20 large hospitals in the region.
d. Over 30 tonnes of plasma were sent to PFC for fractionation.
e. The centre employed some 380 staff.

SBTS0000640_068.

113 In the 92/93 SNBTS annual report the West of Scotland was said to have a population of 2,716,900, of whom 161,161 were blood donors. The Centre served 74 acute hospitals - **NHBT0002938**.

114 By August 1992 there were plans for a new BTC in Glasgow - **SBTS0000025_015**.

Blood donations and targets

115 On 29 January 1990 Dr Crawford, one of the consultants at WSBTC, wrote to Dr Cash, giving an account of the actions he took on 10 January 1990 on account of the very low stock of blood held by the BTC, which had arisen because of a disappointing turn out at many of the donor sessions together with high demand from hospitals - **PRSE0001295**.

116 The plasma targets for WSBTC for 1992/1993 were 36,530 Kgs (out of a total target for Scotland of 79,000 Kgs) - **SBTS0000110_075**.

Products and prescribing policies

117 A letter from Dr Crawford to Professor Cash written in March 1990 exposes (i) the different haemostatic policies in the three open-heart surgery centres in Glasgow, and the differences in opinions between BTCs (and indeed WSBTC and what was set out in the Transfusion Medicine Handbook edited by Dr B McClelland) about cryoprecipitate - **SBTS0000055**_008.

118 On 8 October 1993, Dr Mitchell was urged to assess by way of a medical audit, whether there had been inappropriate use of Group O red cell concentrates in the Region - **SBTS0000411_109.**

High risk donors

119 13 July 1990 Mairi Thornton wrote to BTC Directors enclosing a paper with recommendations for a whole new set of procedures for donor health checks. This mandated three phases: the first (to be in place by Autumn 1990) being a basic standard questionnaire to be provided to all donors to read; phase two (1991) involved the streaming of donors so that new donors and those that had not donated for 2 years were more thoroughly questioned; with phase three being the longer term goal for all new and lapsed donors to undergo a medical interview with a nurse of doctor - **SBTS0004238_180** and **SBTS0004238_181.**

120 In his response to this letter, Dr Hopkins (Deputy Director of WSBTC) set out his objections in detail – in short he was of the view that the checks in phase 2 and 3 (which would, he thought, often necessitate new donors having to wait between 1 and 2 hours for an appropriate clinician to become free to conduct the interview) would discourage donors from donating, at a time when WSBTC were trying to collect 15,000 more donations than they had in the previous year - **SBTS0000651_002**.

121 It appears from a letter written by Dr Crawford to Dr Mitchell that WSBTC interviewed those donors who tested positive for HIV to try and understand whether they were from high risk groups, and if so, why they did not self-exclude - **SBTS0000707_026**.

HCV testing

122 Dr Mitchell attended the First International Meeting on Hepatitis C Virus in Rome on 14-15 September 1989. He reported that the Chiron test was being used in a large number of Blood Transfusion Laboratories throughout the World '*and one is struck by the rapidity of this introduction*'.
NHBT0000188_059

123 On 27 June 1990, Dr Mitchell, together with Dr Gunson wrote a paper entitled 'Comparative Study of Anti-HCV Testing Using Ortho and Abbott Test Systems'. The idea of the study was to test the 10,000 blood donations that had already been tested by the Ortho ELISA test with the Abbott test (once it had become available on 1 July 1990).

Any sample '*repeatably reactive*' by either or both tests was to be sent for supplementary testing at three specialist laboratories (Dr Mortimer at the Public Health Laboratory Service in Colindale, Dr Tedder in London and Dr Follett at Ruchill Hospital in Glasgow). Three BTCs would take part in the study - North London, Newcastle and Glasgow. Each were to perform 3,500 tests - **NHBT0000042_038**.

124 The final version of the proposed study was circulated by Dr Gunson on 30 August 1990, in the hope that the study could commence on 10 September 1990, however Dr Gunson was still '*pressing very hard for a positive response from the Department of Health*' to inform him as to whether the budget for the study was available - **NHBT0000189_211**.

125 On 7 May 1991 Dr Mitchell wrote to Dr Lloyd of the Newcastle BTC, informing him that at WSBTC they were engaged in assessing the differences, if any, between the Abbott Generation 1 test and the Abbott Generation 2 test - **NHBT0000074_017**. A report on the interim results (up to the end of July 1991) is set out in **NHBT0008846**.

126 In June 1991 Dr Mitchell wrote to Dr Crawford about collecting sera for a Dr Supran. The letter continues:

'*.....see if we could use some of the plasma donations which we already have in stock. This would avoid you counselling or talking to donors at this stage.*
Since, as you know, we have not started screening other than for evaluations purposes, any discussion with donors would have to be handled extremely carefully and with great tact.'
SBTS0000373_020.

Supply of product in the region

127 In November 1991, Dr Crawford (one of the consultants at WSBTC) wrote to PFC stating that no one knew that PFC had a supply of heat treated Factor VIII (8Y) for patients with Von Willebrand disease, and that the blood bank at the Royal had obtained their 8Y from a commercial purchase - PRSE0000212.

128 It would seem from correspondence in December 1992, that WSBTC issued blood products to the hospitals in the region - **SBTS0000343_067 and SBTS0000343_070.**

Look Backs and surveys

129 On 14 May 1990, Dr Mitchell wrote to Dr Cash in the following terms:

'Where alleged non-A, non-B transmission has occurred and is notified to the Regional Transfusion Centres, the problem is, should the BTS have a look-back policy so as to identify donors who may have transmitted the disease or should we not?.....

... at the present time ...we have no look-back policy, although you will understand that in doing so, the Service could be considered to be negligent in not advising about potential future use of donor blood'

NHBT0000189_131.

130 There is evidence of:

a. WSBTC sharing information about infected donors with NBTS in England - **NHBT0004714**, **NHBT0004713**, **NHBT0004712**.

b. NBTS sharing information with WSBTC about patients diagnosed with HIV in England where that patient had received blood in Scotland - **NHBT0004819**,

c. NBTS sharing information with WSBTC about donors diagnosed in England with a blood borne virus, where there was a history of that donor donating in the West of Scotland - **NHBT0089364_009**.

131 A look back done in relation to earlier donations from a donor who tested positive in 1994 for hepatitis C can be seen at **SBTS0000377_141**.

132 There is evidence of WSBTC sharing information about the number of donors found to have HBsAg with Dr Barbara at the North London Blood Transfusion Centre for the national survey - **NHBT0077898_001, NHBT0080202_001** and **NHBT0078118_001**.

JENNI RICHARDS KC

KATIE SCOTT

The Inquiry team

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