SMALLER HAEMOPHILIA CENTRES

Harrogate Haemophilia Centre, Harrogate General Hospital, North Yorkshire

The Centre

1. The Haemophilia Centre at Harrogate General Hospital in North Yorkshire was designated the centre number 46. The Director from 1974 to 2003 was Dr Michael William McEvoy. Dr McEvoy has given a witness statement to the Inquiry which should be read in conjunction with this presentation.[1]

2. Dr McEvoy consulted with the larger Leeds and Newcastle Haemophilia Centres for advice and support.[2] The centre was active from 1975 up until 2003,[3] when its activities were subsumed into the Leeds Haemophilia Centre.

Patients treated

3. The following numbers of patients were treated at the Centre:

    a. 1976: 9 haemophilia A patients and 1 patient with Von Willebrand's disease were treated.[4]

    b. 1977: 9 haemophilia A patients, 1 haemophilia B patient and 1 patient with Von Willebrand's disease were treated were treated.[5]

    c. 1978: 8 haemophilia A patients, 1 haemophilia B patient and 2 patients with Von Willebrand's disease were treated.[6]

    d. 1982: 10 patients with haemophilia A, and 1 patient with Von Willebrand's disease were treated.[7]

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[1] WITN4742001
[2] HCDO0001082, WITN4742001 para 6.1
[3] WITN3826016
[4] HCDO0000071_005
[5] HCDO0001164
[6] HCDO0001261
[7] HCDO0001626

e. 1985: 7 haemophilia A patients were treated.[8]

Blood products used

4. The following blood products were used:

a. 1976: 1,125 bottles / 78,750 units of cryoprecipitate were used to treat patients with haemophilia A, and a further 10 bottles for the treatment of a Von Willebrand's patient.[9]

b. 1977: 720 bottles / 50,000 units of cryoprecipitate and 150 bottles / 36,000 units of NHS factor VIII concentrate were used for Haemophilia A patients. Of these materials, 37 bottles / 8,880 units of factor VIII were used for home treatment. The patient with Von Willebrand's was issued 10 bottles / 700 units of cryoprecipitate. The haemophilia B patient received NHS factor IX concentrate.[10]

c. 1978: 110 bottles / 7,700 units of cryoprecipitate, 158 bottles / 39,500 units of NHS factor VIII and 91 bottles / 22,750 units of Armour Factorate were used to treat patients with haemophilia A. A further 60 bottles / 4,200 units of cryoprecipitate were used for Von Willebrand's patients. The haemophilia B patient received NHS factor IX concentrate.[11]

d. 1982: 77,500 units of NHS factor VIII concentrate and 1,250 units of Armour Factorate were used to treat haemophilia A patients in hospital. At home, 47,500 units of NHS factor VIII concentrate were used for home treatment of haemophilia A patients. A further 500 units were used to treat the patient with Von Willebrand's disease in hospital.[12]

e. 1985: At the hospital 3,510 units of NHS factor VIII concentrate were used and at home 77,860 units of NHS factor VIII concentrate and 28,000 units of

[8] HCDO0001910
[9] HCDO0000071_005
[10] HCDO0001164
[11] HCDO0001261
[12] HCDO0001626

Armour Factorate were used.[13] A letter from Dr McEvoy to Dr Snape (Head of Quality Control, BPL) regarding an update on supplies of 'Heated Factor VIII Concentrates' listed 6 patients as suitable for heat-treated factor VIII. In the letter, he stated that he had intended to use a mixture of heat-treated commercial product and non-heat-treated NHS factor VIII until the full stock of BPL products were heat-treated.[14] Dr McEvoy commented in his statement that the intention had been to use the non-heat-treated product for patients already known to be HIV positive, but in the event heat-treated supplies were secured for all patients.[15]

f. 1986: A letter from Cutter shows that the Centre had commenced using heat-treated Koate factor VIII concentrate.[16]

5. Dr McEvoy recalls that once the risk of HIV transmission by blood products was known, the Centre reverted to the use of cryoprecipitate for a short period while sourcing heat treated products.[17]

Knowledge of risk

6. Dr McEvoy attended the Twelfth Meeting of UK Haemophilia Centre Directors held at the Royal Free Hospital on 9 October 1981,[18] the 17th (extraordinary) meeting on 17 March 1986,[19] and the extraordinary general meeting to discuss haemophilia, HIV and litigation on 16 June 1989.[20] It may be reasonable to assume that as Director of the Harrogate Centre, Dr McEvoy would have received copies of the reports circulated for, and the minutes of, UKHCDO meetings that he did not attend.

7. On 3 June 1985, Dr McEvoy wrote to BPL complaining that heat-treated BPL factor VIII had been issued without a legible protocol being provided, and he had issued it to

[13] HCDO0001910
[14] CBLA0002071
[15] WITN4742001 para 39.1
[16] BAYP0000009_026
[17] WITN4742001 para 34.1
[18] CBLA0001464
[19] PRSE0001688
[20] PRSE0002656

two patients on home treatment who had tested positive for the HTLV-III antibody.[21] In response to this Dr Snape outlined the process in a subsequent letter. [22]

8. Dr McEvoy wrote to Dr Cash of SNBTS in 1991:

> "*Thank you for your most helpful contribution to the education and debate section of the British Medical Journal this week. I am the director of a small haemophilia centre and director of pathology for the health district so that my budgetary responsibility is much wider than that of more dedicated haemophilia care directors. Accordingly I had been coming under pressure from the publications of the haemophilia society and the blandishments of the sales representatives to change my present practice of using high purity Factor VIII in the manner that you recommend in your article. The problem in England is now compounded by the purchaser/provider split at the plethora of trust hospitals in my region. It is interesting to speculate whether the responsibility for witholding this more expensive concentrate should lie with the clinician who prescribes the drug or with the purchaser who agrees the contract with the clinician or yet again with the patient who may vote with him feet and move to an adjacent haemophilia centre where high purity Factor VIII is more readily available. At present as far as I am aware my patients are prepared to accept my advice but, I fear that a concerted publicity campaign by the haemophilia society together with the recommendations of sundry experts who may themselves have been the beneficiaries of the drug companies will compound to force us to prescribe the more extravagant products unless a clear lead is given by experts such as yourself.*"[23]

HIV testing

9. UKHCDO data available to the Inquiry suggests that 5 patients in or around 1985 were identified at the Centre as having been infected with HIV.[24]

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[21] CBLA0002174
[22] CBLA0002195
[23] SBTS0000024_086
[24] INQY0000250

10. A witness to the Inquiry has recounted that his father, a haemophiliac under the care of the Centre, was informed in 1985 that he had been infected with HIV. He says that insufficient information was provided about the risk of onward transmission to his mother.[25] Another witness whose brother was diagnosed as HIV positive while under the care of the Centre has told the Inquiry that their parents were told of the diagnosis, but her brother was not until he was about to turn 15, and that the family was not provided with sufficient information about the risks.[26]

11. On 14 December 1987, Dr McEvoy wrote to Robert Banks MP in support of compensation for patients infected by blood transfusions:

> "*Thank you for your letter and for the support that you and your colleague, Mr Curry, have given to the haemophiliacs. We are all most grateful for the flexibility shown by the Government. There is one other small group of comparable patients who are, as yet, uncovered by any special arrangements. These are the handful of patients who have been infected with the HIV virus following a contaminated blood transfusion given in this country. There are only two patients in the Yorkshire Region who have, to our knowledge, been given the infection in this way and both are young adults who, at present, remain free of symptoms associated with AIDS. However, they have no pressure group acting on their behalf and the argument that has been successfully applied to the haemophiliac community could equally well be made on their account. When blood donors were first tested for the HIV antibody a few regular donors were found to be positive and, where possible, the Blood Transfusion Service have traced recipients of blood donated by these donors in previous years. There are only a handful of such blood recipients known to have been infected through the National Blood Transfusion Service and, due to its testing and donor selection, we hope that no further patients will be put at risk, but the few dotted around the country are disadvantaged in the same way that the haemophiliacs have been disadvantaged and extension of the compensation scheme to cover them would*

[25] WITN1250001
[26] WITN1700001

seem to be just. I would be most grateful if you could consider extending your help to these people."

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January 2023