I [redacted] NEXT FRIEND S of

will say:-

I am the mother of [redacted] the Plaintiff in this case and next friend. My son was born on the [redacted]. A blood test was taken from my son at birth at New Cross Hospital. However the blood sample clotted before it could be tested. I discovered my son was a haemophiliac when he was aged two weeks old when I found digested blood in his nappy. After that I took him to hospital and discovered he was a haemophiliac as I suspected. During the first four years of my son's life he received various sorts of treatment while attending hospital. We were not aware of the risk of viral contamination in concentrates until 1985. During 1981, 1982, 1983 and 1984 I would take my son to hospital for any bleed that needed treatment. Usually because of the age of my son, bleeds would be muscular in the buttocks when my son fell over whilst toddling but also involved bruises on his forehead and a bitten tongue due to the child's lack of co-ordination at this age. Bleeds in my son's joints did not occur until 1983. Whenever we attended hospital for treatment EACA was used as appropriate. I have only discovered since 1985 what actual risks were involved with each different type of treatment. Between 1981 and 1985 we were not warned of the risk of Hepatitis B being contracted through infected blood products. We were not aware of the risk until a vaccine became available and our son was called for vaccination. In the same way we were not warned from 1982 until 1985 regarding the risk of contracting AIDS

through blood products. The only time a change of treatment was explained to us was when my son reacted adversely to treatment with Armour Factor VIII and was put immediately on the N.H.S. Factor VIII to avoid the allergic reaction recurring. Prior to this we were told that there was not enough N.H.S. product to treat my son and therefore he was given product imported from abroad. Again when this was mentioned no warnings of the risk involved with using this type of product were explained to us. Although blood tests were taken at very regular intervals and quite frequently from my son we were only informed of haemoglobin results until 1985. During 1983 we learned from the news media of the risk to haemophiliacs from infected blood products. In October 1984 we were called by Doctor Hill to a large meeting of parents of haemophiliacs. We were told that some boys, mainly those treated with large numbers of units of Factor VIII were at risk. However, shortly after this I saw a list of patients on the blood storage fridge door which included the name of my son. Although the list was not marked to indicate those on it were HIV+ I suspected at that moment that my son was positive and requested to speak to Doctor Hill. When I saw Doctor Hill he told me my son was in fact HIV+. We were told that the blood sample taken in early 1983 had been retrospectively tested and had revealed that my son probably sero converted in late 1982. This would have been about the time that my son was receiving cryoprecipitate and commercial products at the same time.

This blood had been collected and stored as part of an investigation into an outbreak of T.B. on Ward 6. Leukaemia

patients, known to be immune suppressed, and haemophiliacs nursed alongside them contracted T.B. at about the same rate from a visitor to the ward. Researchers were examining the bloods to determine the extent to which haemophiliacs are immune suppressed.

We were not consulted regarding the risk of infection or given warnings about the possible danger of treatment until 1984. Soon after being told about our son's diagnosis as HIV+ we were requested, via a meeting of Dr. Hill with parents of haemophiliacs, to seek support elsewhere because the staff at the hospital were becoming over-burdened.

SIGNED. [redacted] ..... 20 April 1992

NEXT FRIEND