Tuesday, 12 January 2021

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Dr Bevan. Can you hear me?

A. Yes, I certainly can.

SIR BRIAN LANGSTAFF: And you can see me, can you?

THE WITNESS: I can.

SIR BRIAN LANGSTAFF: Good morning.

Just before we start, I have a few words to say to others who are listening, so excuse me for a moment.

THE WITNESS: Of course.

SIR BRIAN LANGSTAFF: The people I'm speaking to now are the hundred or so, maybe more, who are listening remotely to what I have to say.

This is our first day of hearings in the new year. Already in 2021 Covid has affected our plans, as it has affected the plans of so many others. It is important to make progress with the hearings but it is vital to stay safe. The way those two considerations fit together means that we cannot do things as we would have wished.

When I last spoke to you, early before Christmas, I had hoped we might be able to hear more evidence in person in 2021. All our witnesses this

week would have wished to be here in person. Participants in the Inquiry who wish to do so would have been able to come to Fleetbank House. Unfortunately, this is not to be.

You will, I trust, understand, why. Why, in these days of the new lockdown, this is the price of our making progress: safety, yours, ours, and mine, requires it.

You are, of course, listening remotely to me as I say this. It goes without saying that we will continue with the live broadcast, YouTube, and update meetings for Inquiry participants. I trust you will understand there may have to be further changes to the timetable until the siege imposed by Covid is lifted but I can assure you that, though more witnesses will be obliged to give evidence remotely, just as these week's witnesses will, the Inquiry's approach will be just as thorough as if witnesses were with us here in the hearing room.

Now, Dr Bevan, you are at home, are you?

THE WITNESS: I am, yes.

SIR BRIAN LANGSTAFF: And you are on your own, I think?

THE WITNESS: I think my daughter is somewhere in the house but essentially on my own.

SIR BRIAN LANGSTAFF: We, here, so I can tell you what

you're looking at, you are only seeing part of it, you are seeing me I think at the moment, in the hearing room there are three members of counsel's team, socially distanced to the extent of being almost remote from each other, across the room from me. There are three members of the Inquiry staff in the room, at the far corners of it. It's a room capable of holding 200. It holds at the moment less than ten.

One of those members of staff, Mary, will ask you to take the oath in a moment or two, and we have Soumik, whose job it is to make sure that if documents are referred to you can see them and so can those who are following remotely.

You are talking not only to us here in the room, Dr Bevan, but you're talking to everyone out there who is watching remotely. The number varies from time to time, understandably, but it will be, as I said, in the 100 or so, maybe more, people who are keen to hear what you have to say.

With that introduction, Mary, may we ask Dr Bevan to take the oath, please.

DR DAVID HUW BEVAN, affirmed

Questions by MS RICHARDS

MS RICHARDS: Dr Bevan, good morning. Can you see and hear me?

A. I can. Good morning.

Q. I'm going to start just by asking you to provide us with an outline of your career.

As I understand it from your witness statement, you had various general junior medical posts in the mid-70s, 1973 to 1976?

A. I did, yes.

Q. And --

A. Mostly in the North of England.

Q. Then you took up a senior house officer post in medical oncology at the Royal Marsden Hospital from late '76 into May of '77?

A. That's it, yes. That's right.

Q. Then from July of 1977 to December of 1978, you were a registrar in haematology at St George's Hospital.

A. Yes, and the rotation around local hospitals, which was the training regime there.

Q. Was this the beginning of your career in haematology?

A. It was.

Q. You've described in your statement this being, this first period, the 18 months or so from mid '77 to late '78, as being a rapid introductory period for the novel cohort of trainees who had no prior experience of laboratory work and who were recruited for their acute medical experience and MRCP in order to care for

patients with blood diseases.

Could you just outline a little what you meant by that?

A. Okay. Hitherto, haematology had been very much a laboratory specialty and part of the clinical pathology orbit in the NHS, and so the trainees who ended up in haematology had usually commenced by doing, soon after registration, a rota of jobs in the various aspects of pathology. So they would do some time in histopathology and autopsy work, they would do some time in bacteriology, microbiology, and they'd do haematology and also chemical pathology. So there was a rotation through the various laboratory disciplines in clinical pathology, and then they would choose which one of those disciplines they would specialise in, end up in, and then haematologists would come from that, that arena.

Haematologists began to realise that people with blood diseases, who at that time were clinically under the care of general physicians, some of whom supposedly were said to have an interest in haematology, some of which had no real interest in haematology, and the colleges -- joint committee between the College of Pathologists and the College of Physicians came to the conclusion that haematologists

where possible should look after their own patients clinically and that therefore they needed to recruit a new cohort of individuals into the subject who had general medical experience and therefore -- and the membership of the Royal College of Physicians, and therefore would have a decent basis to enter such a profession as a clinical haematologist is in the NHS. And basically, from then on, that became the approved mechanism for generating consultant haematologists.

Q. In that first 18 months or so, before your appointment as a senior registrar at the end of 1978, you described you spent your time first of all learning laboratory work without any haemophilia contact and then laboratory work for the purposes of haemophilia. Is that broadly correct?

A. Yes. They obviously had to give us a crash course in the laboratory aspects of the subject. So, for example, absolutely typical of a consultant haematologist, he's looking down a microscope at blood cells and deciding whether someone has leukaemia or another blood disease. So we had to be taught from scratch how to do that. In addition, we had to be taught about the semi-automated and automated machinery in the laboratory, methods of quality

control and, eventually, also that of the coagulation laboratory and its special tests, and there was a kind of internal rotation that accomplished this as well as possible.

Q. And then in December of --

A. Yes -- sorry.

Q. Carry on.

A. The other aspect was it was -- at that time, on-call work in laboratory overnight and at weekends was shared between professional technical staff, who were able to do it with great expertise, and haematologists and other pathologists in training as a kind of baptism of fire, having to cross-match, you know, blood for people in life-threatening emergencies, when one's experience and knowledge and technical skills were simply not up to it. So that was, I think, a period of considerable error, but I remember doing that. And while doing that, one was also on-call for the haemophilia patients of the unit, who used to gain entrance for treatment by battering on an outside door of the laboratory -- which in that time was in a series of sheds, basically -- to get in and to be administered usually cryoprecipitate.

I could manage that but my skills as a laboratory technician were minimal. I'm very glad

to say that whole system was abandoned very soon afterwards and on-call work was then done entirely by fully trained technical staff.

Q. Now, December 1978 you were appointed as Lecturer and Honorary Senior Registrar in Haematology at St George's Hospital Medical School, and that was an appointment that you fulfilled from December '78 until 1984; is that correct?

A. Yes. Yes, that's correct. It was a lecturer job -- technically it was a lectureship with the St George's Hospital Medical School -- sorry, honorary senior registrar role with the hospital. In fact, it was almost entirely a service job. At that stage, there was hardly any lecturing or teaching duties to do. One assisted at practical teaching but "lecturer" was -- it was a way to find the funding from a different source, basically.

Q. You have said during this period of five years or so it was part of the South-west Thames senior registrar training rotation and you worked in a number of different hospitals and locations over that period of time?

A. Yes, that was the official training rotation of the South West Thames region which was held with St George's as the teaching hospital base and then

a number of other hospitals which -- where one gained experience of specialist haematology. So one was -- part of it was spent at St George's but an equal part, a year I think, was spent in a district general hospital. At that time, I was at St James' Hospital Balham, which is very close to St George's but was, you know, a separate institution at that time. And then the specialised training was at the Royal Marsden Hospital, in haemato-oncology, because at that time it was -- and I think has always been the case, the majority of people training in haematology went into what's called haemato-oncology, treatment of leukaemia, lymphoma, myeloma. So there was a considerable amount of time spent at the Royal Marsden Hospital. Then also one had formal attachments to the National Blood Transfusion Service at Tooting.

So that was the rotation. So for most of that time I was outside St George's. But when I was in St George's obviously that was when I began to learn a bit more about the patients with haemophilia.

Q. Throughout that period, Professor Flute, and I'll come back to him in a few minutes, but Professor Flute was a consultant haematologist and the centre director for the purposes of the St George's Haemophilia Centre?

A. Yes, he was a professor of haematology at the medical school, an honorary consultant haematologist and Haemophilia Centre Director.

Q. In the course of this period you took your MRCPath exam?

A. Yes, at the end. I mean, the whole rotation was geared towards equipping someone to be able to take that exam and hopefully pass it, and that was done then towards the end, in 1983, in I think the autumn of 1983.

Q. You have observed -- sorry?

A. It's okay. That's it.

Q. You have observed in your statement that the two parts of that exam that were most frequently failed at that time were the practical exams in coagulation and blood transfusion. You didn't fail --

A. Yes.

Q. -- you passed --

A. More by the *(unclear)*, yes.

Q. Do you have any understanding as to why those two areas were the most frequently failed?

A. Well, they were wet practicals. This was abandoned several years afterwards but, at that time, one was expected to actually do a practical examination where one chose the test one was going to do, one carried

them out on the bench on blood and plasma and other substances, and then one analysed the results oneself and came to a conclusion and, once again, because we were not fundamentally trained in laboratory haematology the wet practical part could go badly wrong.

I remember at Oxford, at one stage during my blood transfusion practicals, I was faced with a water bath with all the tubes floating upside down in it. The other thing that happened in the coagulation practical, which has a strange bearing on it, was that the sample tubes with standard preparations of blood factors in them would go off during the actual hour or two of the practical, so you'd end up with something that had much less of substance X in it than there was at the beginning.

So the practical was a lottery, a lottery, and at some centres all the candidates would fail and they were notorious for this. Thankfully, I went to Oxford, which was one of the more civilised centres, as one would hope, and I managed to get through. But it was an ordeal and I was very glad I never had to sit it twice.

Q. Now, in 1984, having successfully passed the MRCPath exam, you were appointed senior lecturer and honorary

consultant in haematology at St George's and you remained in that post from 1984 until -- in reality, I think until 2008, although the titles and the contractual arrangements changed in 2004?

A. Yes.

Q. Initially, Professor Flute remained the centre director and head of department, but he took early retirement some time in 1985. Can you recall when?

A. Sorry, exactly what do you want me to --

Q. When Professor Flute took early retirement.

A. Yes. That was in '85. Up until then, St George's was more than just St George's still, the consultant staff were responsible for running the laboratory at St James'. I think my first year as a consultant was spent mainly there because the sitting consultant there had gone off with severe health reasons, and it was a bit of a surprise to the other two consultants in the department because, by losing that colleague through ill health, there were just the three of us, Professor Flute, Dr John Parker-Williams and myself, and it came as somewhat of a shock that Peter Flute left quite suddenly to become -- he didn't actually retire at that point, he became South-west Thames Postgraduate Dean. So he moved into a part-time training and academic role outside St George's and it

basically left the entire menu of haematologists at St George's to be run by myself and Dr John Parker-Williams.

Among the -- my half of the responsibility, before I took most of the responsibility for the clinical side of the operation, because John was excellent at the laboratory side -- haemophilia became a part of it and by becoming the consultant responsible for haemophilia, one sort of automatically became the centre director in relation to the UKHCDO and the national system.

Q. That was in the summer of 1985?

A. July, yes.

Q. Now, just following through your career before we come back to look at St George's in more detail, you described in your statement how in 1987 a professor of haematology, Professor Gordon-Smith, was appointed at St George's and that brought with it, in due course, more funding which allowed the employment of more staff or appointment of more staff, including, for the first time, a haemophilia nurse?

A. Yes. I think that was in the very early '90s that we managed to get our first haemophilia nurse and, from then on, we were allowed to -- as the funding became more channelled from the -- via the *Pan-Thames*

Haemophilia Consortium, which was a specialised commissioning group as part of NHS London, things were put on a much better basis, in that our needs, if we made a good case that we needed, say a second nurse or paediatric nurse, or we needed a centre organiser, administrator, then funding was released from the Pan-Thames Haemophilia Consortium to cover that.

So the appointment of Ted Gordon-Smith completely transformed the department from something that was becoming an extreme backwater, understaffed, into, you know, a major centre.

Q. Then in 2008, you moved to St Thomas' Hospital as consultant haematologist and the Haemophilia Centre Director for Guy's and St Thomas' NHS trust?

A. Yes, I did. I mean, I had -- at the beginning, I'd done everything including leukemic treatment, and so on, at St George's and then, as we appointed new younger consultants, most of them had a haemato-oncological bent, and so I moved out of that area and my patient base became -- it still remained multidisciplinary, but it became restricted mainly to haemophilia, bleeding disorders and thrombotic disorders, and sickle cell disease and other haemoglobinopathies.

Yes, so I was -- I had to think very carefully

before leaving my sickle cell practice but I worked on the basis that new blood was needed to look after that part of things and that things I'd wanted to do in terms of I wanted to accomplish something in the research line in one of the subjects I did, and this only seemed to be able to be facilitated through going into this very specialised role as a Haemophilia Centre Director.

Of course, because, throughout one's tenure as a haemophilia doctor at St George's, the centre at St Thomas' -- Guy's and St Thomas' Hospital had been, you know, very large in our lives and it was a considerable challenge to go and take over that centre. But, luckily, they suggested it to me so I -- eventually I decided to go there. In fact, it did turn out that way with the research, but I was able to participate in proper research there.

Q. You remained as director until 2016 when you relinquished your director role to Dr Dolan, but you remained a consultant full time, and then part time, until March 2018 when you retired but then you came back as a locum consultant, I think, until March 2019?

A. Yes, I was one of the senior consultants that was in a position of possibly being caught in a retirement trap. Basically, one took retirement when it was

available on the understanding that one would retire and return to work, first of all, in a general capacity to support Dr Dolan during his initial years, and then, as I said, a tragedy which affected a close colleague at St Thomas' unexpectedly, I was called back from retirement to help out for a further year. So my retirement was somewhat delayed but eventually happened.

Q. Throughout the period from 1985 to your eventual retirement in 2019 you were a member of UKHCDO?

A. Yes.

Q. We'll come back to UKHCDO in a little more detail later but you were not, for the most part and for most of that time, involved with its working parties or its committees?

A. Not at all. I think the haemophilia directors of smaller centres -- we were a kind of medium-sized centre -- as Mark Winter's study showed in the south of England there were haemophilia centres with directors who attended regular meetings who had no actual patients or very few or mild patients only. But we did have a substantial number at St George's. Nonetheless, at UKHCDO, the roles on special working parties and their special committees were reserved for major centre directors, so-called Reference Centre

Directors, and later comprehensive care centre directors. No doubt, if I had specifically asked to be included on such a working party, I would have been, but because haemophilia was still only, I would say, even at the height of involvement, about 10 per cent of my workload at St George's, I never quite had the time to devote to such working parties.

Q. Now, if I can turn to the physical facilities of the haemophilia centre at St George's, when you first arrived there and over the following few years through into the mid-and late 1980s, what was the centre? What physically did it comprise?

A. When I joined, the Haematology Department of St George's in Tooting was accommodated within -- and in fact the entire haematology laboratories -- were accommodated within a strange improvised structure between several of the Victorian hospital blocks with wooden walls and a ceiling, which was bit like a rabbit warren, and then, at one stage, it had an external door and inside that external door was a series of little clinical rooms, which were used for every conceivable purpose for patients. The haemophilia patients came in and were treated in one of those rooms, where there was a bedstead and a chair, where intravenous therapy could be

administered and people could be examined.

There was no specific haemophilia office or centre in the way in which, you know, anybody understood it, what that might mean. A specific clinical space devoted entirely to haemophilia and with special facilities for children, and so on, were simply not there. Then there was the laboratory and all the treatment product was stored in refrigerators and freezers in the haemophilia laboratory, and the telephones that patients accessed were in the haemophilia laboratory or the haemostasis laboratory, haemostasis blood clotting laboratory.

So it was -- it didn't fulfil any of the definitions which centres were supposed to fulfil. So that's about it.

Q. Did you get the sense that laboratory facilities were prioritised over clinical facilities for any available funding?

A. I think we -- we made various efforts to establish a clinical haemophilia centre, somewhere in the building. That Jerry-built haematology complex was itself left within my period of time as a senior registrar and re-established within the medical school block, in a kind of large functional hanger-like space, absolutely fine for a laboratory but not very

suitable for a clinical facility, since it was actually removed from the clinical facilities of the hospital. You would have to set up your own kind of crash trolley and emergency system there.

So we kept appealing for a proper clinical space and the hospital never decided that it was one of its priorities. Instead, of course, our patients were treated in an increasingly sophisticated day unit but they shared that unit with all other haematology patients. But the day unit was well equipped, well staffed and safe, and the children used to go to the Pinckney Children's Ward, which already ran a kind of out-patient for children. So, in that way, it complied with the preferred model for children, which was it was in the paediatric part of the hospital.

So things worked but we never had that single haemophilia centre, where all the patients knew they could go.

Q. Now, in terms of the numbers of patients, we'll look at a couple of annual returns in a moment but your recollection in your statement was that there were -- in the late 1970s, early 1980s there were around 25 severely affected patients, haemophilia A and B --

A. Yes.

Q. -- including approximately eight children, and that

those numbers increased over the years that you were at St George's until the number was in the region of about 35?

A. Yes. One was at least sensitive to these numbers because, certainly during my time as consultant, the UKHCDO was looking at definitions of various grades of centre, and they were looking at a definition for a comprehensive care centre and, for one reason or another, they settled on the number of 40 severely affected patients treated in a year, on a consistent basis, and one was always aware that one was just underneath that. Sometimes one might have had 40 severes but they weren't all treated in a year. The others, the numbers just came slightly under. So we never quite reached that 40 patient mark. But I remember that at the end we were certainly very close to it.

Q. Again, in that period, late 1970s, first half of the 1980s, do you have any recollection as to how many patients not severely affected but mild or moderate were patients of the centre?

A. This is where, I'm afraid, my memory begins to fail me in the fact of being retired I have no access to any kind of electronic database but, by definition, it's normally assumed that someone -- a certain number of

severely affected haemophilia patients were accompanied by a slightly greater number of moderately affected and very great number of mild. In fact, it's not like that at all with haemophilia.

Moderate haemophilia is perhaps slightly rarer and the mild haemophilia group is a somewhat amorphous -- it changes from time to time. So my feeling would be there would be about another 50 or so in those two categories, mild and moderate, and then, of course, one was responsible for a considerable number of people with von Willebrand's disease and other bleeding disorders, and von Willebrand's disease was about equivalent to the number of severe haemophiliacs. That, again, the definitions changed, so mild von Willebrand's disease you might be looking at up to 100 people with von Willebrand's disease who were attached to the centre.

A lot of the clinical work, clinic work, out-patient clinics, involved seeing people on a routine basis with mild bleeding disorders and looking after them then when perhaps they needed surgical operations, and so on. So you had to be always ready for that. In surgery, the adage is there's no such thing as a mild bleeding disorder, if they are having surgery; take it all seriously.

Q. I just wanted to come back to your relationship with St Thomas', which was the reference centre certainly geographically closest to St George's. To what extent was there any kind of relationship between St George's haemophilia centre and St Thomas' haemophilia centre in the late 1970s or in the course of the 1980s?

A. When I started out, Professor Flute had, I think, a good relationship with Professor Ilsley Ingram, who had started the St Thomas' haemophilia centre and was an extremely multi-talented and senior individual, and Ilsley Ingram ran this thing called the Coagulation Club, Clotters --

Q. Haemostasis club?

A. Haemostasis club, that's right, sorry. He ran this thing called the haemostasis club, which was like on the British model of genteel academia where enthusiasts for a certain subject would gather and hear presentations and chat and discuss the presentations and generally form a community.

So, as a registrar, I was encouraged by Professor Flute to attend the haemostasis club, if I could, to get a flavour of this and I did, not that I comprehended much of the presentations.

So it was all good in that, and then when Geoffrey Savidge took over from

Professor Ilsley Ingram there was definitely a change. As, again, this was only by kind of hearsay and from Professor Flute himself, I think he found Professor Savidge a somewhat rebarbative colleague, not afraid in any way to criticise the actions of a smaller centre or people he considered to be less expert in the treatment of haemophilia, and at one early stage, I think something must have been said that offended Peter Flute deeply and so he came and said "Oh, there's a chap new chap at St Thomas', very difficult man". So there was just a feeling that there was a possible conflict there.

Now, in myself as a Haemophilia Centre Director, I find that if I needed advice on a particularly difficult or a case that wasn't going quite as planned, I would ring Geoff Savidge at St Thomas', and he was always very helpful, on a personal level he was always perfectly helpful. But one knew at the same time that he was attempting to take over the care of patients from the smaller centres in the region and he did this out of a principled stance that they would get better care at St Thomas', which of course when I eventually came to St Thomas' I saw was possibly the case.

Certainly, before we had a haemophilia nurse he

had haemophilia nurses and they were very good. There's absolutely no doubt that the care of an individual with haemophilia in a centre is -- the role of a haemophilia nurse is absolutely critical. It's the reason why a centre exists. I don't think now that I would say that anybody could have a haemophilia centre, in a meaningful term of the word, without a haemophilia nurse to look after patients because the consultant, who will have many other concerns, is a very variable presence and focus, whereas a haemophilia nurse will look after patients.

So, in that way, he was completely right, completely right.

Q. Some witnesses who have provided statements to the Inquiry have described being treated at both St George's and St Thomas'. Did that happen during this period? Might there be a patient who might be treated at St George's for one purpose and then treated at St Thomas'?

A. Yes. At St George's there were, of course, truly excellent orthopaedic surgeons but they were excellent enough to recognise that operating on a haemophilia joint, particularly one that had undergone substantial damage through chronic haemophilic arthropathy over the years, where there were forms of contraction and

synovial hypertrophy that orthopaedic surgeons in general practice would almost never see, and very difficult to operate on those joints to do a joint replacement, that there was, on the other hand, a consultant orthopaedic surgeon at St Thomas' with experience of many such operations and, therefore, the most likely cause for a patient to be under joint care of the centre was that I had referred them on to Geoff Savidge and his orthopaedic surgeon for joint replacement treatment. So that was the main thought.

Q. Just going to look and a couple of annual returns for St George's with you, just to see what we can see from it in terms of numbers of patients treated in two particular years and products used. The first is for 1976, the second for 1983, those are the two returns we have for that period. Soumik could we have HCDO0000024_004, please.

That's just a covering letter from Professor Flute to Ms Spooner at Oxford, but if we can go to the next page please, Soumik, we can see here this is the annual return for 1976, St George's Hospital, Professor Flute, number of haemophilic patients treated during the year 25, total number of Christmas disease patients treated during the year 5, and then we can see, in terms of the products being

used, cryoprecipitate and NHS Factor VIII concentrate in that year, and we have the figures there. So predominantly cryoprecipitate usage, it would seem. Then NHS Factor IX further down for the Christmas disease patients.

A. Yes.

Q. Then, if we go to the next page please, Soumik --

A. That's the first time I've ever seen that one. That's very interesting. That was, of course, before I was a haematologist even.

Q. Then, we'll go to the next page and we can see number of patients with von Willebrand's disease treated during the year 3, and the treatment there cryoprecipitate.

A. Yes.

Q. That's just to give us such information as we have from 1976. The next return we have, Dr Bevan, is 1983 so we'll look at that next please HCDO0000143_003, please. If we go to the next page. We can see here, Dr Bevan, again this is the annual return for 1983, completed by Professor Flute. Total number of haemophilia A patients treated during the year 31, von Willebrand's disease patients treated during the year 4, and then if we look at the rest of the document please, Soumik, the whole of the page

please -- thank you. We can see there now the amount of cryoprecipitate identified significantly less than 1976, and it would appear used for hospital in-patients, and then we have, for NHS Factor VIII concentrate 62,770 units in hospital, 71,950 units for home treatment, and then we can see the use of Armour Factor VIII concentrate 270,755 and 309,680 respectively for hospital and home treatment. A small amount of Koate being used, Cutter's Koate, and then we can see on the right-hand side cryoprecipitate being used for the treatment of von Willebrand's disease patients in hospital.

Then, if we just go to the next page please, Soumik --

SIR BRIAN LANGSTAFF: Just before you do, the cryoprecipitate, there's a note there in handwriting based on 50 units per pack. If we are to draw a comparison between this and the 1976 return, which is 0000024_004 -- let's just have a look at that --

MS RICHARDS: HCDO0000024_004.

SIR BRIAN LANGSTAFF: What I'm going to ask is: is there a like-for-like comparison? Let's have a look at the figure. There we only see the number of Factor VIII units, which is -- I think it's what we've come across before, roughly 70 units of activity per one bottle,

but are we comparing like with like looking at this and going back to the 1983 return?

A. Probably. I mean, one of the uncertainties about cryoprecipitate is always exactly how many units are in a bag. A bag is -- a single bag of cryoprecipitate is the cryoprecipitate from a single unit of donor blood, and then a dose of cryoprecipitate would be assembled from, say, 10, sometimes a few more, bags for adults, perhaps up to 20 bags, and that would fit with 50 units per bag. 50 units per bag was probably the standard used by the National Blood Transfusion Service at that time. So they would expect their bags, you know, on testing to contain within plus or minus a couple of standard deviations of 50 units.

So if a bag only contained 30 units they wouldn't issue it. So they had a standard. So we probably took that standard from them of 50 units per bag.

SIR BRIAN LANGSTAFF: Thank you.

A. I mean -- yes, sorry. So I think they are comparing like with like.

MS RICHARDS: If we just go back then to the '83 return or forward to the '83 return.

HCDO0000143_003, please, Soumik.

We can see here perhaps the most significant

change from 1976 is the use of significant quantities of commercial concentrate.

A. Oh, vastly and, of course, this was the pattern all across the haemophilia world. I mean, we may even -- St George's may have even been slightly slow to replace cryoprecipitate with concentrate. But the massive increase in concentrate -- and basically, looking at that, haemophilia -- I mean, cryoprecipitate essentially ceasing to be used, because 200 units is a less than a single dose.

Q. Then if we just go to the next page of this document, Soumik, please, just to complete the picture for '83, as we have a full return for that year, this is patients with antibodies, haemophilia A patients with Factor VIII antibodies, one patient treated during the year, and we can see that's with both Armour Factor VIII and FEIBA.

Then if we go to the next page, please, Soumik, we have the figures for the haemophilia B patients treated during that year.

We can see there three patients with haemophilia B treated during that year, and exclusively NHS Factor IX concentrate both at hospital and for home treatment?

A. That's how I remember it.

started. What can you recall about it?

A. Well, I think it had grown, and I think that was shown by the 1983 returns, that in terms of the usage of Factor VIII concentrate, that it was sort of fairly evenly balanced between home treatment and on-demand treatment in hospital. I mean, it was acknowledged that home treatment was a far better model for treating haemophilia because the doses -- the required doses of factor were given earlier.

So there are two forms of prophylaxis. One is -- sorry, there are two forms of home treatment. It obviously is a model for prophylactic treatment but at the time that I started, prophylactic treatment was used in some patients, who were mostly in children or young people, and was still a minority thing. So most people on home therapy kept it in order to administer themselves doses in the event of a bleed, they perceived they were having a bleed. So that's called on demand. So the majority of the home treatment was on demand. To give home treatment you needed a patient or a relative, in some cases it was their parents that injected them, who was training in venepuncture and intravenous administration. So some people were never really interested in it because they didn't feel able to do it, they weren't able to do

Q. Now -- we can take the document down, thank you, Soumik.

We're going to come on in a moment to ask you in a little more detail about the approach to treatment and the kind of decisions that were taken as to which products to use. First of all, however, is this right, that in the period up until the time you took over as director in the summer of 1985, decisions as to which treatments to use and which particular products to use were the responsibility of Professor Flute?

A. Yes, 100 per cent.

Q. Your statement would suggest that you had little involvement in the process, in part because you were in training and also because you were circulating, rotating around a number of different hospitals?

A. That's correct. I'd only just seen my first bottle of Factor VIII ever just before starting in 1976 at St George's, and I had essentially no idea of the commercial world of Factor VIII purchase. So, no, he did all that.

Q. Now, in that period of time, late 70s and the first half of the 80s, what was the home treatment, home therapy programme at St George's? I think you have referred to it as having been piecemeal when you

that, or their veins did not allow it.

So that was the sense it was piecemeal. It wasn't for -- not everybody wanted it and we could certainly only afford a certain amount of it. The moment you start giving home treatment, your treatment requirements go up. The reason being that, of course, a patient will -- patients don't like going to hospital having intravenous injections, and they would surely delay going until it was absolutely imperative, which means the bleed has already reached a certain point, which has probably done damage to the joint, which will become permanent, whereas with home treatment the patient -- there aren't the barriers of travelling and waiting in hospital, the patient can administer the product as soon as they get sometimes quite early feelings that come with an incipient bleed in the joint. So an experienced patient will recognise the very earliest features of an oncoming bleed in a joint and be able to treat when perhaps the volume of blood in the joint is still very low. So that's why home treatment is absolutely a better form of treatment.

Q. Now, you told us in your statement your understanding of Professor Flute's approach to treatment, and I'm going to go through different categories of patient.

You say in your statement you were aware of Professor Flute's decisions only insofar as he explained them to junior staff. To what extent did he explain his thinking to staff? You obviously got a broad idea of what products he generally used for different types of patients but to what extent did you know why?

A. He would occasionally share parts of his decision-making. Professor Flute was an extremely genial and pleasant man but he'd come from a tradition, almost like semi-military tradition, in fact, I believe he was still a colonel in the Territorial Army, responsible for blood transfusion within the Territorial Army, and there was something of the senior officer about him, in that we would -- we were let -- on a need-to-know basis in terms of our training of the running of the department he would let us know. But we were not privy to many of the reasons for his decisions.

He did, however, as I've said, promote the idea that, in his opinion, it was not a good idea to have a multitude of providers, which I think you can see from the returns, that once he settled on a supplier he would stick with that supplier, in that case Armour. So I have read other evidence which suggests

that people felt that they shouldn't put all their eggs in one basket, that you might run out. He didn't work according to that principle. His principle was that he wanted very much all his eggs in one basket because -- I don't know. I can't say what his reasons for this were. They could have just been convenience, i.e. you only have to deal with one set of commercial operatives from a company. But anyway, that was very much his view. He told us about that and it's expressed in the annual returns.

Q. Now, haemophilia B patients were, as I understand your statement, and from your recollection, consistently treated with NHS Factor IX concentrate, which you recall being the Oxford concentrate prepared at Dr Bidwell's laboratory?

A. Yes. Dr Bidwell -- amazing. I mean, completely self-sufficient production of Factor IX. Of course, you don't need as many units of Factor IX nationally but that was -- and what's more, she managed to keep up the supply for what was required.

So, yes, I'm glad to see that we were restricted to that. And then when the concentrate came in to the NHS -- sorry, to the -- BPL Factor IX, that also we didn't need much in the way of commercial Factor IX.

Q. Now, severe haemophiliacs, you've said in your statement that, as far as you can recall, Professor Flute's preference was to treat children and younger adults who had severe haemophilia A with the NHS Elstree product, if it was available, because he considered it less likely to transmit non-A, non-B hepatitis; is that correct?

A. That was my understanding at the time, yes.

I mean, he was perfectly aware of the occurrence of what I think he probably still called serum hepatitis until late 70s, and made that decision, yes.

Q. Can you recall any discussions with Professor Flute about why he considered the Elstree concentrate less likely to transmit non-A, non-B hepatitis? Were there discussions about relative pool sizes or donor attributes, for example?

A. I'm afraid I do not recall any specific mention of that issue.

Q. Your statement says that unfortunately there was never enough Elstree product so older adults were usually given commercial concentrate, the Armour Factor VIII as we see reflected in the returns, and that in fact younger patients would also end up receiving Armour Factor VIII because it was a regular event that there

was insufficient Elstree product; is that right?

A. Yes, that's true.

Q. Did children also end up receiving Armour because there wasn't enough BPL product available?

A. I'm afraid I can't say with any certainty, but I would have thought it was inevitable.

Q. Can you recall anything -- again, I'm talking really about the period in the late 70s and the first half of the 80s here, before you took over as director, but can you recall anything about what the arrangements were for obtaining the Elstree product or the Armour product? Was it all done via the Blood Transfusion Centre in Tooting or was it done directly with BPL or the pharmaceutical company?

A. The commercial Factor VIII was purchased from the pharmaceutical companies with direct contracts. The BPL product was accessed through the National Blood Transfusion Service. Now here my knowledge is not complete but my understanding was that during the early years it was managed through BPL. It was essentially free product, although nothing from BPL is truly free, but the fact is that it was -- the region -- right, so the South West Thames NBTS Centre was also at Tooting, on the St George's site, and the amount of BPL product it received to pass to the

haemophilia centres in the region was linked to the amount of plasma the NBTS Tooting contributed to the national plasma -- the BPL product pools.

Whether that or actual total product production by BPL was the limiting factor on supplies -- I think probably their overall production was more a limiting factor than any particular shortfall of the NBTS centre. But, yes, that was -- if you like, there was a double constraint on the amount of BPL product that was available to us in that regard.

Q. Dr Winter told us about his experience of particular difficulties obtaining sufficient quantities of NHS product from Tooting, and he identified a particular problem being that the Tooting Regional Transfusion Centre covered two very large regional health authority areas: the South East Thames and the South West Thames, and his evidence described a service under pressure, unable to meet demand.

Is that something you have any recollection of yourself?

A. As far as I recall, that was true, yes. That was true. Yes, very much so.

In addition, of course, they had within their catchment area the Royal Marsden Hospital, which was a very large consumer of blood products such as

A. In strict terms, no. However, Professor Flute did communicate to us that he told everyone that was going to receive concentrate that they would be likely to get a brief period where their liver function was affected, that there was a form of hepatitis was almost inevitable -- as it was -- very soon after first exposure to commercial pooled product. He would tell them about this, but he would tell them about it, and us, in a reassuring way: everybody goes through this, it doesn't seem to cause any problem, people don't get very sick with it, sometimes you don't even have jaundice sort of thing.

So they were informed, but I would say that neither Professor Flute nor the patients were what we now call fully informed about that, validly informed.

Q. I'll come on to ask you in a little while about hepatitis in a little more detail.

In terms of patients with mild haemophilia, what can you recall being the approach to their treatment? Again, I'm talking in the period under Professor Flute's directorship up until 1985.

A. Well, by mild haemophilia you mean -- you know, the technical definition is anyone with greater than 5 per cent, if you like, of residual Factor VIII, but it also goes up to people who are on the edge of

platelet transfusions. So yes, I think they were never -- they were always short. They were never replete.

Q. Now, going back to the treatment policies towards severe haemophiliacs, those with haemophilia A, you describe in your statement there having been when you arrived a small number of individuals on cryoprecipitate, and you say that Professor Flute had -- I'm paraphrasing your statement here -- been content for that to be the case because it was cheaper to treat with cryoprecipitate than it was with concentrate.

A. Well, essentially cryoprecipitate was free at point of use. I mean, obviously in the NHS structure as a whole it wasn't free but to the end user it was free, whereas from the very start the commercial concentrate was regarded, certainly by other aspects of the hospital, as one of the most expensive therapeutic products on the entire field. So, yes, it was much more a hit on one's budgets to buy the commercial Factor VIII.

Q. Do you know what, if anything, patients were told by Professor Flute about the comparative risks of concentrate versus cryoprecipitate or NHS concentrate versus commercial concentrate?

normal, in fact may probably be normal, just a few points off. I think his position was they didn't need treatment at all.

When desmopressin came in, which was about 1982/3 I think, then he commenced to use it with some enthusiasm, because he saw it as a way -- firstly, in terms of treating individuals with von Willebrand's disease, it covered a lot of the conditions that you would need to treat them for, and this was certainly true of mild haemophilia as well. So we were definitely using desmopressin when I was a senior registrar. In fact, my colleague and I reported a case of an elderly gentleman who actually died after receiving desmopressin from a myocardial infarction, and this was published in -- and got us a bit of criticism from Mannucci for exaggerating it.

But, I mean, that was highly unusual. And, after that, we learnt to be cautious with certain types of individual, giving them desmopressin.

Q. We've heard from other clinicians in some centres that they were able to use desmopressin from the late 70s. Your recollection is that it was a little later for St George's?

A. During my period as a senior registrar it was in full use at St George's. So when he started it I'm afraid

I can't say.
Q. If, for whatever reason, desmopressin was not available or not suitable for a patient with mild haemophilia, and leaving aside the requirements potentially for major surgery, what was the next product of choice for a mild haemophiliac? Was it cryoprecipitate or was it concentrate?
A. Well, by definition, if you were going to treat mild haemophilia, it would usually be for a surgical operation. A surgical operation -- it obviously depends on the nature of the operation but if it's major surgery you need to maintain Factor VIII around 100 per cent maybe for a week to allow the initial wound healing to happen. It's very difficult to achieve that with desmopressin because after -- after a second -- desmopressin raises the von Willebrand factor in Factor VIII for about 24 hours. If you need it longer than that, a second dose of desmopressin is often less effective than the first and, after a second dose, you begin to run into the other problem with desmopressin, which is that it is an analogue of a pituitary hormone which conserves sodium -- sorry, which conserves water, and therefore people can get very dilute plasma and low sodium, which can be fatal. So you can't maintain someone at 100 per cent of

Factor VIII for a week with desmopressin. So you have to use some other form.

I think it would be very rare but that in the event of major surgery someone with mild haemophilia would usually receive BPL factor. I would think that would be done. He would classify them as a rare user and therefore do everything he could do give them entirely BPL product.
Q. Now, what about patients with moderate haemophilia A? What was the approach to treating them?
A. Well, people with moderate haemophilia A are very heterogenous, so to have just 1.5 per cent, if you like, no essential difference to severe haemophilia, certainly in terms of bleeding around surgery. You may get less spontaneous bleeding and not need prophylaxis and not need home therapy, but if you have a surgery you would be in exactly the same position as someone with severe haemophilia.

I think internationally it's been shown, where surveys have been done, that in general, over a lifetime, people with moderate haemophilia end up having the same ballpark of treatments with factor. So I think it was more likely that if -- in the case of the surgery they would receive a Factor VIII concentrate and, again, I imagine that he would

attempt to use BPL in those patients. But I can't -- knowing the shortage of BPL, I'm pretty sure that there might have been exposure to commercial concentrate in that period.
Q. You describe in your statement drawbacks of cryoprecipitate, and you've put it this way in your statement:

"The majority of patients receiving cryoprecipitate would, after cumulative exposures, experience severe febrile transfusion reactions."

Now, Dr Bevan, we've heard other clinicians describe reactions to cryoprecipitate, but I don't think we've heard it put quite as strongly as that, that the majority of patients would respond in that way. Bearing in mind there were, I think, only five of six patients receiving cryoprecipitate when you arrived, and that number diminished down to -- I think you describe one or two and then none in your statement, what is the factual basis for your understanding that the majority of patients would experience such reactions?
A. Right. We only had eight patients, so a majority would just be three or four of them, I think. So as far as I remember it was widespread, but my memory is such that, obviously, such reactions were very

striking and much more likely to stick in my memory than, say, the person who didn't have them. Then -- again, this is probably quite a widespread perception -- with a small number of patients, the people who needed cryoprecipitate on a regular basis, who were severe haemophiliacs who had no other product, would receive -- decided to have no other product. They were the frequent attenders. So it may be the majority of attendances I remember that this was an issue. Maybe not everyone got the most severe form. Maybe most -- maybe on many occasions you could suppress the symptoms of the reaction with hydrocortisone and Piriton but the ones that stuck in my memory, and therefore after so many years come to dominate my entire picture are two individuals, fully-grown adults, one of them almost middle-aged, and sitting suffering in the bed with the bed shaking and rattling, because it was an old-fashioned, steel-framed bed, with the power of this rigors they were getting, and that was despite going up to the limit of safe treatment with Piriton and hydrocortisone.

So it was -- you know, it was a very prominent thing in my memory.
Q. The reactions that you describe, and describe as

being, in the ones that certainly stick in your memory, unpleasant reactions, were they nonetheless temporary reactions?

A. They were temporary, although when the body has a reaction like that, there is a kind of cytokine -- a brief cytokine storm, so there is an after-effect that may last for several hours. For a start, the amount of Piriton they get will almost certainly have sedated them and made it impossible for them to drive home, for example, so they would need to rest up for a couple of hours after this, you know, a cup of tea. So, yes, they would recover but I think that for one of those patients, definitely, he developed an almost phobic response in that he would delay coming until the bleed was really quite advanced.

So, yes, that's how I remember cryoprecipitate.

Q. Now, cryoprecipitate wasn't, I think from your statement, used for home therapy at all at St George's.

A. No.

Q. Were you aware at the time that it was used for home therapy, or had been used for home therapy, with apparent success in some centres, Royal Free and Birmingham are two that the Inquiry is aware of.

A. Well, as a haemophilia director, I perhaps wasn't

aware of the practice in the UK. I was aware that in America, where many homes had domestic freezers, that cryoprecipitate could be used. I still think that it would pose considerable practical difficulties for the patient to administer cryoprecipitate. First of all, there's the business of subsampling bags, this is in the British system. So I think part of the American facility of using cryoprecipitate in home therapy was that their formulation of cryoprecipitate was somewhat different. They had, for example, freeze-dried cryoprecipitate, they had liquid cryoprecipitate, they had various forms which were, if you like, more convenient to use.

The British form, where you needed to subsample to get a dose from -- so, for example, you've seen that the broad number of units in a single bag of cryoprecipitate was 50. Therefore, a dose for an adult, it has to be maybe 2,000 units. So you have to give 20 or more bags, and subsampling these into a single bag is fine when you can infuse it through a drip in hospital, but setting up drips on yourself is not a straightforward thing. So the home user would have to draw it up into a very large-barrelled syringe, 50 ml syringe, and give it in several doses -- I mean, very, very inconvenient and complex.

We know that -- so I'm -- I'm interested that some centres found that practicable.

I remember reading about Katharine Dormandy's approach that she used to transport the cryo, even if the patients did not have home freezers, they used to keep it with solid carbon dioxide cardice. I mean, a hazardous substance likely to administer serious cold burns if you mishandle it. So complex and with many pitfalls but, nonetheless, I can see they did it. I didn't know at the time they were doing it.

Q. Is this correct -- please say if it's not -- that, in terms of the treatment of children at St George's, during -- again, I'm talking about the period up until 1985, cryoprecipitate was not, as far as you can recall, used for children at all?

A. No, because all those problems about volume and reactions, if you like, more prominent, more prohibitory in children and, I think, also with children, quite rightly, you have huge input from the parents and if the parents -- parents, given the option of a concentrate versus cryo, would always go for -- because they reduced volume of injection down to about 30mls with the early concentrates, it was an enormous step, because now an injection could be given through -- I mean, establishing intravenous

access in a child is difficult, can be difficult and is -- you know, you want to use it and get out of there as soon as possible. You don't want to trust to an intravenous cannula being able sit in position for perhaps 20 minutes or half-an-hour, while you slowly administer viscous cryo.

So there were all sorts of reasons why the children got concentrate.

Q. You have said in your statement parents wouldn't have allowed children to have cryoprecipitate, and one can quite understand the convenience of concentrate over cryoprecipitate for a parent, but would you accept that a parent's choice in those circumstances might depend upon what they were told about relative risks, and we'll come on to talk about the risks of AIDS a little later, Dr Bevan, but a parent might well wish to opt for a safe but inconvenient product over a riskier but more convenient one.

A. Yes, I can't say what parents were told about that either by Professor Flute or by their paediatric consultant. Yes, I mean, I think here, at that time the only risk we knew about was non-A, non-B hepatitis. We thought that the Hep B situation was covered by testing. Accordingly, cryoprecipitate was not free from risk of transmitting non-A, non-B

hepatitis. In fact, you may see later when it comes to the Hep C look-back at St George's, my main two patients, where one was one that received NHS cryoprecipitate entirely during treatment for a condition called TTP. Another was a patient who received platelet transfusions from the BTS.

So cryoprecipitate could not be considered free from non-A, non-B. Yes, because of the pool size it was less but, again, you have to consider that if for a dose of cryo you have to subsample donations of cryoprecipitate from ten bags, that's ten donors. It builds up, and over a year someone entirely on cryoprecipitate would experience exposure to the plasma of perhaps 100 donors. So non-A, non-B was in the British population, in the donor population, and being transmitted by these products -- much lower risk but the risk was not zero.

Q. In relation to those patients, the handful of patients who'd remained on cryoprecipitate, you have said in your statement they negotiated a change to concentrate within a year or two, or Professor Flute had negotiated a change to concentrate within a year or two of your arrival. Do you know what those patients were told about relative risks of cryoprecipitate versus concentrate?

A. No. No, I don't know.

MS RICHARDS: Sir, I note the time and I am going to move to a slightly different topic, so perhaps this might be a convenient moment for a break.

SIR BRIAN LANGSTAFF: Yes, we will take a break. We normally have a half-hour break in the morning to allow people at home watching, and you giving evidence, to have a cup of coffee or whatever and that's what we do. What you mustn't do, you may have heard me say this on other occasions to other witnesses, I don't know, you mustn't discuss your evidence, either the evidence you have given or that which you are likely to give, you think, with anyone, whoever they are, that includes your daughter if she was interested, but you can talk about anything else you like. I look forward to seeing you back at, shall we say, quarter to 12.

A. Quarter to 12, thank you very much. No, I won't talk to anybody.

(11.18 am)

(A short break)

(11.44 am)

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: Dr Bevan --

A. Sorry -- yes, I'm here.

Q. I wanted to ask you next about your knowledge of hepatitis risks, in particular non-A, non-B hepatitis.

You have said in your statement that as a trainee you knew that blood and blood products could be infective, and you have said also this in your statement:

"Like any British doctor trained during the 1970s, I was well aware of the hepatitis B outbreak that killed patients, nurses at renal units in Scotland."

What can you recall learning, whether as part of your general medical training or your junior medical work, about hepatitis and risks from blood and blood products?

A. Well, of course one learnt about hepatitis during courses on liver disease and in general medicine, and one met patients with chronic hepatitis, cirrhosis, and other, and one was aware of phenomena of autoimmune hepatitis. And, among this, one was also aware of serum hepatitis, which had been recognised for a very long time, exposure to blood products.

Hepatitis B was obviously the most clear-cut and dramatic of those situations, and partly this was because it could be an acutely devastating disease, so that the outbreak at Glasgow, and also I know now that

there was one at Guy's, was, you know, very dramatic, a lot of very sick people, some people died of acute hepatic necrosis and then, in addition, you had the remarkable serendipitous discovery of so-called Australia antigen, which could actually just as well be called haemophilia antibody because the antigen was identified by its reaction with sera from haemophilia patients, and therefore, that one could actually screen blood for this.

So by the time I took up haematology I was aware that one of the major risks of blood-transmitted infection had been modified to the point of excluded by good serological testing of donor blood but that obviously there were other causes of transfusion-transmitted hepatitis which were not Australia antigen positive and therefore could not be screened for and then, as I said, it very quickly became clear to me as a registrar that patients with haemophilia were being probably given this by the product they received. So, sorry, where did you -- have I answered your question?

Q. You have. Just dealing with -- you have referred to the outbreak in Scotland with the devastating consequences it had. Had you been aware in the 70s of the outbreak at Guy's Hospital? I know we've supplied

you with an article that refers to it but is that something you can recall being aware about at the time?

A. I think I was. The one at Glasgow was very prominent, and for the most superficial of reasons: that serving doctor was one of the first of many to write a novel about it, called The Houseman's Tale, which was published while I was a house officer in Darlington, which was an extremely -- how can I put -- almost crazy in terms of the workload, and so I was desperate for some kind of relaxation, so I -- because there was this book called The Houseman's Tale and I read it. I think it is quite a scurrilous view of the Glasgow outbreak because it invoked sexual transmission as the main -- which is almost certainly not true. So -- but nonetheless, that's the way in which things achieve prominence in your mind. So I then took care to actually familiarise myself with the true nature of the Glasgow outbreak.

But the Guy's outbreak I probably did know about, but it was, like, in second place, although it was a much bigger outbreak in fact.

Q. Do you recall reading about or learning about at the time the outbreak at Bournemouth that was reported by Dr Craske in 1975 in The Lancet?

I mean, the inevitable bit was probably correct in terms of commercial blood product exposure or even any pooled donor product exposure on a regular basis.

But classically it happened during the very first few exposures of a child, for example, or a young person to any kind of commercial concentrate.

And that was the way I think it was explained to them: that this is inevitable, it's just a disturbance in liver transaminases, so-called transaminitis. There's no jaundice, so it can't be -- I mean, completely unacceptable -- what's the right word -- assumptions, as it turned out, and probably even in principle, to assume that something is harmless.

Q. You have said in your statement that you've got a recollection in 1979 of attending a UKHCDO meeting and hearing a talk from Dr Craske which effectively led to your understanding that non-A, non-B hepatitis was something to be taken seriously?

A. Absolutely right. I mean, I'll have to apologise again for memory, which as we saw in the case of cryoprecipitate, is not a quantitative thing, it's not going to -- images stand out, and Dr Craske was quite a recognisable speaker at the podium. He had a huge shock of white hair and he was -- you know, you knew

A. No, I wasn't aware of that one.

Q. Now, you said in your statement that you knew before 1979 that most severe haemophiliacs were being infected with serum hepatitis, and do I correctly understand your statement as reflecting your understanding that by this time serum hepatitis was essentially the same as non-A, non-B hepatitis, because testing for hepatitis B was now available?

A. Yes, and hepatitis A had its own clear-cut clinical features. So I don't think I can say with any confidence which year the designation "non-A, non-B" very first appeared or became common currency, but I guess it was the late 1970s, yes.

Q. So there came a point in your practice and in the dealings and interactions you had with others where the term "serum hepatitis" effectively became replaced by "non-A, non-B hepatitis"?

A. Yes.

Q. You have said also in your statement that up until 1979 this infection was presented to trainees by their mentors as inevitable and harmless. Can you elaborate upon that.

A. Well, once again, I think I've unaccountably generalised that statement. It was mentioned to me by my mentor as generally harmless and inevitable.

when you were being talked to by Dr Craske. And so I just remember that and thinking, yes, you know, this authority is taking it seriously and we all should.

Q. Just so that we can give a probable date to that, I'm just going to put up on screen the minutes of the November '79 UKHCDO meeting.

Soumik, it's HCDO0000015_068.

We can see from the top of the page:

"Minutes of the tenth meeting of UK Haemophilia Centre Directors held in Oxford ... 20th and 21st November, 1979."

Then we can see among the list of attendees as being present both days, yours is the, I think, fourth name down: "Dr ... Bevan, St George's Hospital"?

A. Yes.

Q. I think this is right, Dr Bevan, you were effectively attending in Professor Flute's stead, and you had done so also the previous year in 1978?

A. Yes. I think this was a mixture between his encouragement of my attending of events such as the haemostasis club and the actual deputation in that he couldn't go himself, so he wanted the Centre always represented there. So I was the point person to do that.

Q. If we go on, please, Soumik, to page 18 I think -- no,

sorry, if we go back -- it's page 18 if you look at the pagination at the top. So go back perhaps three pages, Soumik. My apologies. That's it.

It doesn't necessarily give the flavour of everything that was being said by Dr Craske but we can see here that on day 1 of the two-day meeting there was a report by Dr Craske of the Hepatitis Working Party, and we can see that there's a discussion halfway down that long paragraph saying:

"... it was important for the incidence of chronic hepatitis in haemophilic patients to be assessed. There was much discussion regarding the incidence of chronic hepatitis in haemophilia patients, the possible value of liver biopsies ..."

And then there's a discussion of liver biopsies and a discussion of the possibilities of obtaining samples post-mortem, discussion of attack rates.

"Dr Craske commented ..."

This is towards the bottom of the page, Dr Bevan.

"... that most patients thought to have developed chronic liver disease had not previously had an overt attack of hepatitis. There were various possible causes of hepatitis ..."

If we go over the page.

"... and one should keep an open mind about it. There were two types of non-A, non-B hepatitis."

And then a discussion about forms for reporting cases of chronic hepatitis.

So is it fair to say this is probably the occasion that you have a memory of?

A. Yes. Yes, it is almost certainly.

Q. So is this a fair way of putting it, that from at least late 1979 onwards you, as a relatively junior doctor still at that stage, understood that non-A, non-B hepatitis could be serious or, put another way, it wasn't something that was inconsequential or benign and harmless?

A. It certainly wasn't inconsequential. I mean, one of the difficulties was the distinction that was being made at that time between what was called chronic active and chronic persistent hepatitis.

So chronic hepatitis could be of the type which was, at that time, classified as chronic persistent, which was thought to be not progressive towards cirrhosis, whereas chronic active was regarded as potentially progressive towards cirrhosis.

So for a time that belief that non-A, non-B hepatitis had a harmless element or in some cases it was harmless was based on the fact that the finding on

liver biopsy was of the chronic persistent type of hepatitis. So there was still some -- there wasn't the absolutely clear-cut role of the hepatitis C virus, which of course it eventually became, where we understand that there is no innocent type of chronic hepatitis associated with it.

Q. We can take the document down, Soumik.

Can you recall whether -- post your hearing that talk from Dr Craske in November 1979, can you recall whether you had any further discussions with Professor Flute about how non-A, non-B hepatitis should be regarded?

A. I do not recall any such discussions. I kind of understood that when he was being deputised that he would go through the minutes, and he would have been aware of that. And then of course there was Eric Preston's paper on biopsy which was very close to that.

Q. That was, in fact, the next matter I was going to ask you about. I'm not going to turn to it unless you want to look at it in detail, Dr Bevan. We have looked at it on a number of occasions in the Inquiry. It is 1978, Professor Preston's publication, liver biopsy results, including findings of chronic active hepatitis. Did you read that at the time as far as

you can recall?

A. I wish I could claim that I read it in detail at the time. I think the implications of it were clear from its publication, not least because, of course, at UKHCDO meetings a fair amount of stuff takes place on the podium but other stuff takes place in conversation with peers. So some of the younger -- some of the people of my similar age and stage as I was, like -- there were members of the Sheffield team, Makris, for example, who were involved, and it was clear from conversations that this was highly significant finding.

I mean, there was no way -- I mean, Professor Flute was of the generation of haemophilia doctors where I think wild horses would not have driven him to do a liver biopsy on a patient because he was part of the group that felt it was completely impermissible.

But I think that that was a prominent finding and that was well appreciated at the time and I think by me as well.

Q. Do you recall whether you saw the December 1975 World in Action documentary which talked about hepatitis risks and blood donation practices in the States?

A. I don't think I saw that documentary.

Q. Do you consider that, as a matter of principle, patients should have been told about the risks of non-A, non-B hepatitis and that they could potentially have serious consequences, at least from 1979 onwards?
A. I think that's unarguable. I don't think anybody would claim that they should not know that since we knew it by then.
Q. But I think from your earlier answers that -- again, please correct me if I'm wrong -- you don't know whether Professor Flute's advice to patients changed at all about non-A, non-B hepatitis?
A. I'm afraid I have no knowledge of that. I would hope it did but I can't say yes or no.
Q. What was your practice from the point in time at which you became the responsible consultant for the haemophilia patients at St George's, so summer of 1985, in the sort of years that followed in the second half of the 1980s, prior to the availability of the hepatitis C test, what was your practice in terms of the information you'd provide to patients about non-A, non-B hepatitis?
A. As far as I can recall, and I would certainly hope, my practice was to inform them of the risk of non-A, non-B hepatitis and what was known about it at the time. Yes.

Q. Did --
A. I think in this I was informed also by -- I tried to say, the HIV or the AIDS epidemic changed everything, and one of the things it changed was I became used to working with a counsellor and she was -- if you like, she became interested, as well, in Hep C. So from then on my practice moved towards complete disclosure of risks, I think, at the outset. We still regarded consent to treatment with concentrate as categorical, that is not to be renewed on every exposure, necessarily, but I did put people in the picture.
Q. Moving to the question of AIDS, again, you've said in your statement that you recall reading -- I think you've put it as late 1982 -- an MMWR report of AIDS in haemophiliacs in the United States; is that right?
A. Yes, I think I do. I mean, the MMWR is not something that British haematologists would normally consult, but the fact is it was published as a supplement. A kind of digest of MMWR findings were published in the Journal of the American Medical Association, as far as I remember, and this was a journal I did read, it was one of my kind of chronic reading lists, so I had read that and I was aware of it and I was alarmed by it, as you'd expect.
Q. You put it this way in your statement, having read

that, that you knew that:

"People with haemophilia were at risk of blood-borne infection because of their exposure to pooled plasma from many donors, so the association, as I understand it between blood product usage and AIDS seemed quite likely to me."

A. Yes, at that time, I think I remember CADIC describing it as, you know, the person with haemophilia exposed to multi-donor products being the canary in the coal mine for any blood-borne infection, and this would be not just information that led to me regarding them as risk but also, you know, quite good information suggesting that you were looking at a blood-borne virus or a blood-borne infectious agent, I should say.
Q. Again, we know and you will have seen this in some of the material supplied to you for the purposes of your evidence, Dr Bevan, that there were also in December 1982 reports of AIDS or AIDS-type symptoms in patients who had been transfused with platelets, there's the San Francisco baby case --
A. Yes.
Q. -- do you recall becoming aware of that as well?
A. Yes, I think those early publications on AIDS in the New England Journal and others, that were top-line reading, I think, for all of us.

Q. I'll come on to such discussions as you had with Professor Flute on the issue but, before we do that, can you recall what, if any, discussions were had around this time, late 1982, first few months of 1983, with others, other doctors in the hospitals in which you worked, for example, the Royal Marsden?
A. No. By then -- so where are we talking about now? 1982/3, I think my relationship with the Royal Marsden had essentially ended. I had no more attachments there. I think -- and the Royal Marsden is a rather enclosed cancer world, and I'm not sure -- so no, I don't recall having any discussions with them at that time, even on the issue of Kaposi's sarcoma. I don't recall discussing them, yes.
Q. Can you recall, for the first half of 1983 where were you in the rotation that you were undertaking, the senior registrar rotation? Were you at St James' Hospital or were you predominantly at St George's at that time?
A. I think I was at St James'. I was attached to St James' Hospital but, unfortunately, my precise CV seems to have got lost in my loss of electronic documents post-retirement. So I can't say for sure but I think it was St James', because I think that would fit it with my recollection that the first few

months of my consultant appointment were at St James', that I kind of continued that relationship.

Q. Can you recall when you became aware for the first time of the first haemophiliac patient in the UK thought to have AIDS, the Cardiff AIDS patient?

A. I cannot remember that with any certainty. You are undoubtedly going to ask me about the conversation at the teaching session we had with Professor Flute. I've got a feeling that we hadn't had a British case then, and that was part of his response, but I can't remember for sure, sorry.

Q. Can you describe for us that conversation that you recall you and, I think, Dr Richard Lee, another trainee at the time, having with Professor Flute?

A. Well, I can recall that we were assembled at the St George's base and we were, in fact, sitting in the haemostasis laboratory, and because Richard was there as well -- he was a colleague of mine, Dr Richard Lee, similarly a lecturer, and we were both preparing for the MRCPath, and I think we probably attended a teaching session on haemostasis in the laboratory and, therefore, we had a moment where Professor Flute took us through what we'd learnt.

As part of that discussion, I can't remember -- I think it was more or less raised it jointly with

him, had he read this, did he not think that this was a transfusion-transmitted condition, from which all our haemophiliacs would be at risk of, particularly those who were receiving American concentrate, and I just remember his response. I can actually, as I said, in the narrative way remember these things. I remember the fact it was a sunny day and he was sitting by the window and he was, in his usual way, kind of gruffly, jovially said he didn't regard this as in any way a proven infection.

At that time, he was an editor for the British Journal of Haematology and he said he'd seen recent submissions of papers showing similar disorders among T cell subsets in a bone marrow disorder known as myelodysplasia, nothing to do with haemophilia and not treated with similar blood products, but did get a lot of red cell transfusions, sometimes platelet transfusions, and he said that, as far as he was concerned, the findings in the American group were just typical of people who had received any kind of transfusion therapy on a regular basis, that it was, if you like, an immune system adjustment to being exposed to other people's blood and their HLA antigens and other foreign antigens in that material.

So he went into it in some detail and then, as

a second part of the explanation, he explained that in no way would he take any action in terms of changing infusion practice in haemophilia, unless there was official firm guidance from the UKHCDO so to do, and at that, as was a bit typical of Colonel Flute, the discussion was over.

Q. In terms of that second reason, and the way you've put it in your statement is this, he explained that it was essential in times of uncertainty, particularly for smaller centres to stick closely to the current guidance from UKHCDO, which at that time was not to discontinue US concentrate or revert to cryoprecipitate, and he gave additional weight to UKHCDO being supported by The Haemophilia Society in this opinion.

As far as you can recall, was your understanding that that was a view personal to him or did you understand it to be, in fact, the position of UKHCDO, that smaller centres should fall in line with UKHCDO's recommendations?

A. Definitely. I mean, I don't know whether there were any real dissenting voices at UKHCDO. There may have been warning voices but I don't think anybody actually dissented from the general view. Of course, this was informed by the structure of medical negligence

thinking at the time, which was based on the Bolam test. So, by and large, I don't have to tell you about the Bolam test, but if you were following the advice of an authoritative group of clinicians in exactly the same field, if you're following their advice to the letter, essentially, it was very difficult to convict anyone of negligence. Whereas, if you had gone off, away from their advice, you would have become vulnerable to claims of negligence. So if anything happened, if anything bad happened as a result of switching people off their concentrate then you would be in open view, sort of thing.

So I can understand why he was emphasising that we didn't have the power as a small centre to go off on our own track.

Q. In relation to the first of his reasons, and acknowledging that you and Dr Lee were the junior trainees at this point and that Professor Flute was, as you described, the colonel in the Territorial Army, did you and Dr Lee express a different view that you can recall? Were you impressed by his reasoning?

A. I don't think we chose to quarrel with him. Unfortunately, I cannot claim that we quarrelled with this. You will have to ask Richard whether he felt we were sufficiently -- or we just dropped it at that

point. I would draw a distinction here, of course, that this Dr Lee is not the same as Dr Christine Lee, who was also actually a trainee in the department under the part-time women's scheme.

Q. Yes.

A. This was Richard Lee.

Q. Yes and we have a statement from Dr Richard Lee I think, in any event.

Given that to your mind, at least in the first -- in early 1983, there was a likely association between the use of blood products and the development of AIDS or AIDS symptoms in haemophiliacs, would you agree as a matter of principle that patients should have been told of that possible or likely risk at the time?

A. Well, I think they should have done but obviously if I was coming from the same position as Professor Flute, I would have thought that it was necessary to have a further degree of proof before you confronted the patients with it, yes.

Q. Do you know what, if any, information or advice was given to patients as a matter of fact? It may seem from Professor Flute's words to you and Dr Lee that he may not have given patients warnings but do you have any knowledge yourself of that?

A. I really have to say I don't recall any evidence that he raised this question with his patients. That would be slightly reinforced by my own conversations with them when I actually did -- when I shared the news of their seropositivity with them.

Q. Is this correct, that as far as you know, there was no change of treatment policy at St George's in response to the risk of AIDS until the switch to heat-treated products in early '85?

A. As far as I know, that's the case.

Q. There were various communications from UKHCDO to centre directors in 1983. As well as the annual meeting there were some letters March and June of 1983 on. I'm not going to take time going over them with you because, as I think from your earlier evidence, you were predominantly at St James' at that time, but was that material that you routinely saw? Did Professor Flute share with you and Dr Lee and other trainees information received from UKHCDO?

A. I cannot recall having that information shared. Of course, you know, I followed the evolution of the subject through the medical literature, but from UKHCDO I cannot recall explicitly being shown their conclusions.

Q. Now, we'll pick matters up now in 1985 and the move to

heat-treated product.

Soumik, could we have CBLA0002049, please.

We can see this is a letter from Professor Flute, February 1985, to Dr Snape at BPL, and he is asking for a supply of heat-treated Factor VIII concentrates for patients named in an attached list. Two categories of patients. First category, those who had not received treatment in the past year, and few may do so in the year to come. And then category 2, patients who had all received treatment during 1984. Then it says this:

"Their HTLV-III antibody status is under active investigation."

Is this right, that you understand that reference to the "active investigation" to be to the fact that samples had been sent to Dr Tedder for testing by this time?

A. Yes.

Q. Do you know whether prior to this letter in February 1985 there had been a switch to commercial heat-treated concentrates at all or were patients still being treated with unheated concentrate in early '85?

A. This is obviously quite a crucial thing, which unfortunately I cannot recall. I did visit

St George's once or twice after hearing with the IBI to see if I knew any places where records of treatment documentation were kept. Because it was all noted down in kind of Dickensian ledgers exactly what -- and I was not able to access patient histories which would have letters and other clues in them about what exactly was being used during that time.

My feeling is that during 1985, certainly by July 1985 I would hope that none of the factor we were giving was non-heat-treated but I cannot be certain of that. There may have been some residual non-heated material that was used at some time during 1985. So I apologise for not remembering that.

Q. Your recollection in your statement from -- your approach from the middle of 1985, when you took over onwards, was that for the most part over the years that followed you were using BPL 8Y and BPL 9A, and you have said --

A. Well, 9A is easy to say because I think we've always -- as you can see from past returns, the Christmas disease patients nearly all got BPL product of one form or another -- sorry, before that the Bidwell product and we never had to go to commercial 9.

When it comes to Factor VIII, I cannot avoid

a suspicion that there were some unheat-treated batches used up until the middle of 1985, but quite honestly, whether through wishful thinking or not, I do not think we gave, from my attendance, any non-heated product from July '85 onward.

Q. You have said in your statement you don't have a memory of using commercial concentrates from when you took over in mid-1985 onwards but it could have happened due to shortages of heat-treated --

A. Well, we definitely used commercial concentrate, but my feeling was it was heat-treated.

Q. We can take the document down, Soumik.

Now if we come to the question of the testing and informing patients of their test results, your understanding is that Professor Flute had sent samples in the early part of 1985 to Dr Tedder at the Middlesex Hospital. And is this right, that was not on stored samples because St George's didn't maintain a bank of stored samples? Is that right?

A. I cannot say for certain that none of them were stored samples but I know that we had no bank of stored samples. So I guess it was -- when I said he would have started sending them to Richard Tedder's lab in -- when he wrote that letter to Dr Snape in December 1984, and that process of sending samples to

the Middlesex may well have occupied several months of 1985 before all the samples he could get were there.

I believe that the agreement by Professor Tedder to test samples for British haemophiliacs put considerable load -- so he wasn't able to test them all at once. There was a kind of a queue and a backlog, which was eventually resolved. And as far as I remember -- again, one's memory is slightly suspect on this -- I received all the results simultaneously very soon after starting as director, which was -- to say it was a wake-up call was too trivial.

Q. Before we come to that, do you know whether the patients whose samples were sent off to Dr Tedder were informed that they were being tested for HTLV-III?

A. No, unfortunately I -- I can certainly say that I have no idea. I do not know whether they were informed of the purpose of those samples. I think knowing -- knowing the patients and Professor Flute, I think it's likely that most of them were but, on the other hand, I had certain evidence from when I eventually came to tell parents of children that that may not have been the case with children. So I cannot say either one way or the other whether they were informed or not

informed.

Q. As you have referred to, the task of telling patients the results of the HTLV-III testing fell to you in the summer of 1985, when you took over from Professor Flute. And I think your recollection in your statement was that the test results arrived shortly after you took over.

A. That's my memory of it.

Q. Do you know whether the likely infection of some of his patients with HIV was a factor in Professor Flute's departure?

A. No, I can't say. I can't say.

Q. You didn't have access to records for the purpose of making your statement but your recollection, as set out in your statement, was that there were between 15 and 18 patients who were infected with HIV: one patient with moderate haemophilia A; one patient with haemophilia B; and the remainder, patients with severe haemophilia A, of whom three to four were children.

A. That is the limit of my memory. That may not have been precisely right but I think that's as I remember it.

Q. Could you explain to us how you went about the process of informing patients of their positive results.

A. Well, as I said, because of my training at the

Royal Marsden, which had a very formalised view of how to give patients bad news of all types, and in terms of a cancer hospital sometimes the worst conceivable news, I used the processes that I'd learnt there, which -- or the principles -- were that the patient was informed by the consultant in charge of their case. The patient was informed in confidence. But then, obviously, they could bring a close family member or other supporter with them, that if there were other people present this was cleared with the patient beforehand and their potential role was also introduced. That basically you told the truth. You didn't hedge, you didn't euphamise it, you told them the truth. And then you began, after a period, to talk about, in cancer terms, of course, the possibility of treatment, of what was going to happen, and the percentages.

Unfortunately, one could see, with the HIV situation, one could not say there was any treatment apart from we would treat any infections that arose as a result.

So I think I obeyed those principles. I think I did it confidentially, usually in clinic rooms. Later, when we were given by the health authority funding for a counsellor, who to my terrible shame

I still can't remember the name, but she was a very good supporter in further information and in transmitting things like safe sex recommendations to our patients and so forth. So sometimes she -- from a later point she was present.

Obviously, I wasn't able to tell everybody instantaneously. But that's as I recall it. I think I told them the truth. But of course there was a great deal of uncertainty then at that time. It wasn't like giving a diagnosis of cancer where you knew the epidemiology and the outcome chances.

Q. In terms of your general approach, I'm just going to read if I may, Dr Bevan, the way you have put it in your statement so that those who are listening who may not have read your statement can understand. You said in your statement:

"The Royal Marsden Hospital ethos is to be utterly honest with patients with bad news, including the worst news. Only complete honesty can be the basis for valid patient consent to treatment including palliative treatment. In addition to imbuing trainees with this principle, the Royal Marsden Hospital also gave us invaluable training in giving bad news. Part of that training was that bad news had to be given verbally, in person, in confidence, by the responsible

consultant."

That, as far as you can recall, was your approach to informing patients?

A. I hope and think that I did that.

Q. Can you recall what, if any, arrangements were made for the testing of partners?

A. I think this was introduced subsequently and we did offer to test partners in principle, and indeed I think most partners got tested. I mean, not all people with haemophilia have partners but I think we did do that testing. We certainly offered it.

Q. Can you recall whether any partners tested positive for HTLV-III?

A. I think one partner tested positive. And I think there were other factors which might have led to that, which I'm not sure I ... you know, both had other practices which might have involved transmission.

No, mostly we found where people did have firm partners, the partner was usually negative. And so, through later months and years, we pursued a -- sperm washing so that they could have -- they could try for children. And I think at least one couple did have children subsequently, safely, after interventions like that.

Q. What was your approach to telling the parents of

children and children themselves in relation to the three or four children who'd been infected?

A. I mean, obviously I won't have to say this was the most difficult situation or the most painful situation. I think I'm -- I'm pretty sure I pursued the same thing in terms of telling the parent. Family structure in haemophilia is often a single mother. Tragically at that time, not so often now but in those days, often the fathers somehow used to disappear from the scene and the mother was left as sole carer for the child, and so nearly all -- I seem to remember that those discussions -- thankfully I didn't have a huge number of affected children but those conversations were held almost entirely with the mothers. But I think I was honest with the mother.

Then whether one informed the child depended on the age of the child. And I think here one generally followed the kind of Gillick competent, Fraser competent model, after the mother had had the chance to think about it, because obviously I'd be very guided very much by the mother in what I'd tell the child, and we'd tell them together. I can remember one child that we spoke to together in that way.

Then, in later years, obviously, as the children grew up, they came into the knowledge one way

or the other.

Q. What was your practice, the centre's practice, in relation to GPs being given this information?

A. I think that the approach I took was to get the guidance from the patient on this: did they want their GP to know? I certainly applied no blanket provision that I would automatically -- you know, I would on principle let all the GPs know. I would discuss that with the patients first.

The same thing, even more so, went to non-medical things, like schools. That was, again, a difficult -- I'm not sure anyone ever solved that issue, protecting a child from victimisation at school. And I think sometimes people tried with the best intentions and it didn't work -- you know, they weren't safe from victimisation at school.

Later, when we had the counsellor, we used to plan the possibility of a school visit where the school nurse and headteacher team would be cautiously informed. As far as I know none of my patients were overtly victimised at school, but I can't say for sure. It was a very, very difficult situation to control.

Q. I'll just ask you more generally about the decision-making structures that were in existence to

look at risks of transfusion-transmitted infections in the late 70s and first half of the 80s. You've described in your statement the only St George's body that you were aware of was the Blood Transfusion Committee, but you said that as far as you understood it they were preoccupied with ensuring the prompt and plentiful supply of blood for surgery, and safety was seen as secondary to the maintenance of supply. Is that correct?

A. That's the way I see it. I mean, it may be a caricature of the way the blood transfusion -- but I think it's fair to say that the blood transfusion system -- the supply was like nine tenths of the law. The one fear they had was running out of blood for transfusion. So, as you'll see from future action, they were, for a while, very unwilling to -- or very, very conflicted about introducing, for example, hep CV testing, hepatitis C antibody testing on donor blood, because they thought it might actually dissuade donors and cut the donor number below critical point. And this has always been a huge issue for them. So that blood transfusion system was obsessed with the availability of blood, the non-wastage of blood.

So I can remember the director of the NBTS, when he appeared to talk to clinicians under his

jurisdiction, the talk would always be about, "You're wasting blood, you're ordering too much blood", you know, "We'll run out". They were obsessed with it, quite frankly. And one can understand why. Since the Blood Transfusion Service was started, running out of blood has been the dominant -- so yes, the Blood Transfusion Committee was committed to supply of blood. And they may have discussed safety but I was never an active participant. Because it was a blood bank thing, Dr John Parker-Williams usually covered that committee, so I can't say -- but I don't think, either from the minutes or anything else, that HIV and non-A, non-B was ever discussed at the Blood Transfusion Committee.

Q. In terms of the South West Thames region more generally, you have said in your statement you think it probable that there were meetings held within the region by the Blood Transfusion Service or at Tooting to consider transfusion safety but it wasn't something you or your colleagues were party to or provided with information from?

A. To the extent of my memory, no.

Q. On a national basis, is this right, to the best of your recollection, that in terms of recommendations or guidance, it was really just UKHCDO and no other

source of national recommendation or guidance to you?

A. I'm trying to map this against the early development of AIDS treatment units, like again at the Middlesex, whose process -- whose -- what's the right word? Anyway, their practice began to impact to a greater and greater degree on the rest of us. So at George's I was extraordinarily lucky to be on the site of one of the first AIDS treatment units that was developing under Professor Griffin and Dr Wansborough-Jones, and others whose clinical ward was adjacent to the haematology ward and so -- and we knew this -- them very well.

So they rapidly developed counselling and began to develop their own practices, and we tended to follow them. So I think I also had internal advice from the AIDS treatment unit, its clinicians and counsellors and nurses, which helped us along.

Q. Do you think, from your perspective, as first of all senior registrar and then as the consultant who took over, that it would have been advantageous to have national advice from Chief Medical Officer or Department of Health and Social Security?

A. I think that would have been helpful if it had been a programme, it might have come through UKHCDO. It would be likely to be expressed at a fairly high

level, sort of, towards UKHCDO. I think that the role of the Chief Medical Officer -- I can't even recall who the Chief Medical Officer was, but I don't think there was an activist Chief Medical Officer in the same way as my colleague and friend Sally Davies became an activist to appear in public to promote certain things to warn other things. I think they were a much more bureaucratic person in those days, much less likely to go into the public domain in a big way. So, yes, presumably it would have added impetus to the actions of UKHCDO if direction was coming from the higher place but I'm not sure. I don't think it happened.

Q. Can I ask you to move forward a few years now to the early 1990s and the arrangements for testing patients for hepatitis C. What were the arrangements that you made at St George's for the testing of your bleeding disorder patients for hepatitis C, once the test became available?

A. As far as I recall, and this may not be 100 per cent reliable, we were able to do such testing internally with St George's virology department, rather than refer them outside. So that's my view. We were able to test them internally, more or less as the test became available. So I know that Professor Savidge

felt that some of the commercial tests were more valid, more sensitive, more reliable than others and he -- so he went outside to people like Professor Tedder's laboratory. But I think we got ours internally. I don't think we had to refer them outside.

Q. Was there, for the hepatitis C testing, a process of pre-test counselling undertaken?

A. Yes, I think I can firmly say that, because then we had the counsellor and we'd learnt the lessons from the HIV setting about how to do this. So, again, the patients were told. I must admit that my recollections of those interviews were completely different with many of my more experienced patients saying, basically, I've got enough to worry about with HIV, without dealing with this situation. Since it doesn't seem to be affecting me it goes on the back burner, sort of thing. So their approach was, yes, it was distress at this too but also the fact that this seemed to be less of an immediate danger to them, which I think is true.

So I think we told everybody correctly. I hope we did. We should have done.

Q. Did you, as far as you can recall, follow the same process of talking to them in person, the news being

delivered by you?

A. Yes. By then, I would have my counsellor alongside me. Yes, I think we'd refined it by then.

Q. Again, I'm conscious you don't have access to records or data about the numbers of patients infected with hepatitis C. The estimate, I think your statement gives, was 70 per cent of patients, at least of those seen frequently, were infected. Is that consistent with your recollection?

A. Of the severe haemophilia group, I think that's probably roughly right. Unfortunately, I can't claim exactitude on that.

Q. Can you recall whether there was any particular features of the treatment, whether it was 30 per cent or a different percentage who were not infected, that would explain why their outcome was different?

A. Well, some of our patients by then had actually received only heat-treated product. So this would be true of the children up to about the age of 12, maybe, that they'd only required -- only received heat-treated product. So, while accepting that during the early phase of heat-treated product some of the heat treatments were not 100 per cent effective against HCV, they seemed to be -- in effect, those who had only received heat-treated product were negative.

Q. Can you recall what information you gave your patients on telling them of the hepatitis C result about the possible long-term consequences?

A. I told them -- I'm pretty sure that I told them about the findings of Sheffield that there was a risk of chronic hepatitis. I probably wasn't informed enough in those days. I hadn't worked with hepatologists enough to understand that once there was cirrhosis there was an in-built chance of hepatic cancer. To me, cirrhosis was, if you like, the worst case at that time. I think I was a bit naive.

The fact is also that none of my HCV seropositive patients had clinical liver disease at that time. So I don't think -- none of them had cirrhosis that we could diagnose without biopsy. I still largely did not press biopsy upon them and I'm pretty sure my patients wouldn't have accepted it. By that time I'd had an unacceptable experience with one person that we had tried to do a liver biopsy and, in fact, the operator had hit their spleen -- we managed to salvage the situation but it was very sticky for a while.

So I had no great desire to do -- their liver function tests seemed okay. They might have a mild transaminitis, they had no symptoms, they had no

varices, they had no clinical signs of liver disease. I referred them, or I discussed referring them, to our hepatologist gastrointestinal specialists, and they would agree to be referred. The specialists were a little bit -- as I can say, "Do they have any symptoms? Do they have any signs of liver disease? If so, why am I seeing them?" Sort of thing. "I have clinics full of people with established cirrhosis." But eventually they did see them.

Again, as I pointed out, I think we had an ultrasound doctor at that time who reckoned he could diagnose cirrhosis on ultrasound, probably an illusion and so we put them through that and none of them appeared to have it. So, in the absence of any clinical evidence of actual liver disease, there was not much activity, and I think the majority of patients thought of it as a minor problem compared to their HIV seropositivity, if indeed they had it.

Q. In terms of the monitoring of the hepatitis C positive patients for the years that followed, in the 1990s and the early 2000s, what were the routine arrangements for monitoring and what was the point at which referral to a hepatologist or treatment with interferon and other early therapies became contemplated?

A. Right, I think that yearly or six-monthly we tested the transaminases and the other liver function tests, I assume albumin or a gamma GT. So some of those enzymes are very, very sensitive to hepatocellular inflammation. Others like albumin content would only fall during late liver disease. So you have got a bit of a spread there between tests, which are either find something that doesn't have any major implication or too late to act on. But if the liver function test became more disturbed, then I would refer them to -- then they would attend the hepatologist.

Sorry, when it came to interferon, right, I do recall some patients of mine having treatment with human cellular interferon, like the most crude version of the drug, which comparatively had very severe side effects, and both the patients who were put on that drug couldn't tolerate it after about the second month of treatment. So one doesn't really know if they ever responded to it. That's at St George's Hospital.

So I'm still trying to think if anybody at St George's progressed to varices or overt cirrhosis during my tenure. I just can't remember it. I can't remember it.

Q. Would decisions about interferon --

A. Sorry, I've misled you there. There was one patient

a very complicated patient who died and he was co-infected with HIV and Hep C, and at the coroner's inquest -- in any case, the coroner decided to classify it as an HCV infected -- occasioned death. So it would be wrong to say I had no problem when I had a coroner's associated death. I think it was more complicated than that and the coroner took family views, but I should not go any further in that respect.

So yes, I did have one patient with a degree of cirrhosis and I think another patient with hepatic varices. So, yes, by the time I left, some of the longer-term patients had developed overt liver disease and were under the care of hepatologists.

Q. Were decisions on prescribing interferon, whether it was the early version you've described or pegylated interferon, interferon and ribavirin, were those your decisions or was that something which would be dealt with by the hepatologist?

A. By then I'd come to the understanding that I, unlike some of my colleagues like Mark Winter, was never going to be a HIV or hepatitis doctor, and that I used the true experts on site to manage those aspects. Of course, they would discuss things with me if they wanted a change in treatment or there was a clotting

aspect to it but I let the experts decide.

Q. I think, in relation to the treatment of patients with in HIV, you said in your statement that there was no need for you or your colleagues at the haemophilia centre to become *ad hoc* HIV specialists, because you had the on-site infectious diseases specialist unit that you referred to?

A. Yes, I had opinion leaders and clinical scientists who were advanced in the field to help me out at St George's, just as later I did at Guy's and St Thomas'.

Q. In the early years, the pre-treatment years for HIV, you have described the care of patients in these terms in your statement:

"This care became a desperate holding operation as patients progressively succumbed to the onslaught of multiple opportunistic infections. We lost four patients quite quickly, including one who was 13 years old. I had seen similar organisms cause disease in immuno-suppressed leukaemia patients but never in concert like this, rapidly invading multiple organs, despite high dose antimicrobial therapy. The sense of helplessness in the face of a new disease that was outpacing the chasing clinicians was terrifying."

A. I think it was the most terrifying phase of my life,

of my professional life, because of this feeling that it was running out of your control. I mean, even in -- you know, in cancer situations where people have become profoundly immune suppressed, you felt a certain degree of trust in the drug regimes, whether they were antibiotic, anti-fungal, antiviral, that you used, and by and large they worked to a useful degree. But in the HIV it was -- it seemed to be running out of control. The moment that you -- while you might get the front line immune suppressed opportunistic infections under some kind of control with pentamidine inhalations, you name it, then along would come bizarre versions of Hodgekins Disease or lymphoma in the brain or elsewhere, that would -- eventually you would not be able to treat.

Now, in retrospect, what happened was there was an early cohort of patients who succumbed to this very quickly and then there was another cohort that seemed to have some residual resistance to this complex and then, as I said, I had one patient who never even developed a T cell abnormality, who presumably was genetically in some way immune.

But that first cohort, it contained most of the older patients. So anybody over 60 was at severe risk of relatively early succumbing but we also had these

very young patients who might have had some kind of pre-disposition to get severe disease. Very, very, very alarming.

To me, it brings great sympathy to the contemplating the intensive care doctors trying to deal with the first wave of Covid pneumonias, where clearly it was something different from what they'd ever seen before and they have learnt how to manage it and I think probably the HIV doctors did as well.

Q. I wanted to ask you next, Dr Bevan, about some of the reflections you have set out in your witness statement, paragraph 50. I don't know if you have a hard copy of your statement on hand or I can put it up on the screen?

A. I don't.

Q. It's WITN4106001, please, Soumik. If we go to page 22, please. If we look at the bottom paragraph of this page and the first two paragraphs of the next page first of all, you say this -- I will read it aloud because it will be easier for some of those following and watching to hear rather than read:

"To my current acknowledge (from hearsay, largely informed by subsequent written sources such as Starr's revealing book 'Blood') during the 1970s and early 1980s plasma fractionation companies in the USA

bid for large pools of frozen plasma assembled from up to 40,000 donors, traded on the North American plasma 'spot' market (Toronto, Canada) by 'plasma brokers'. The companies and brokers who participated in this market maintained a state of wilful ignorance of the provenance of this plasma, which was widely known to have contained donations from US prison populations, so-called 'skid row' blood donation facilities buying blood for cash from street people (including substance abusers) and even donations forced from Central American villagers at gunpoint by paramilitaries. They performed screening for hepatitis B on the plasma pools but otherwise fractionated them into Factor VIII concentrate."

Then you say this:

"I therefore consider by far the dominant contribution to the scale of infection of patients with bleeding disorders in the USA and UK to have been made by the commercial fractionators who made and sold infected Factor VIII concentrate, because they knowingly abandoned any control over the safety of their raw material. Another significant contribution to the scale of infection was made by the acts of plasma market makers and brokers involved in the sale of plasma."

Just pausing there, and before I ask you about UKHCDO and the approach of doctors about which you may have more direct personal knowledge, do I correctly understand that what you have set out there is your view, now informed by the reading of material such as the Starr book that you have described? It's not based upon your own knowledge at the time or direct knowledge?

A. No, no, it's not based on anything I knew outside that history, as very persuasively demonstrated in the Starr book. Then, obviously, subsequently dealt with at some length, insofar as they are in the public domain, the legal arguments of various plaintiffs, particularly in America, American haemophilia groups against the companies involved. I must say that -- yes, sorry.

So, insofar as it can be backed up -- the thing about paramilitaries, I think, is in Starr alone. I've never seen any other reference to that. But the plasma market occupying the Canadian aspects -- the plasma brokers who traded large pools of plasma on that market, I think that's all been -- wherever I've seen it, it's been confirmed that it was taking place, but I have no personal knowledge at all.

SIR BRIAN LANGSTAFF: We do have some material which has

been offered to the Inquiry which would tend to support the Central American reference which is set out here.

A. I mean, that's obviously absolutely horrible to contemplate.

SIR BRIAN LANGSTAFF: Yes.

MS RICHARDS: You then continued in your statement by talking about the approach of UKHCDO and the generation of haematologists that dominated UKHCDO at the time. I want to ask you a little more about that, because obviously that's something about which you may have more direct knowledge and experience.

I'll just, again, read out the next few paragraphs, if I may, for the benefit of those listening:

"The AIDS epidemic was a turning point that utterly transformed medical practice in ways analogous to the effect of a World War. The decisions and policies of the generation of haematologists that dominated the UKHCDO and haemophilia treatment in the UK up to this point -- pre-AIDS -- were conditioned by the long period when haemophilia treatment was of limited availability and effectiveness.

"Their attitude and reactions were dominated by determination never to withhold treatment and never to

run short -- let alone out -- of treatment. This unwillingness to countenance the loss of effective treatment was shared by the Haemophilia Society.

"The UKHCDO also took a position in many ways typical of British public health governance: Not to risk over-reaction, not to act prematurely, not to alarm the public, 'the evidence is not yet conclusive', 'we don't yet have proof' -- responses still evident during the early phase of the current Covid-19 pandemic."

Could we just continue down the page, Soumik.

You then refer in the next paragraph to Factor VIII companies pulling the wool over the eyes of doctors. I'll come back to that, if I may. I'll skip that for the moment. You then say this:

"However, taking all these things into account, the UKHCDO continued to hold the line, well into 1983, that the evidence of an infectious cause of AIDS was inconclusive, and that action would be premature, long after that position became obviously untenable. However, by then the scale of HIV infection in people with bleeding disorders in the UK was fully established."

And obviously that's a matter that the Inquiry will have to determine in due course.

Obviously, whether that is correct or not is a matter for the chair but is that the sense of what you were trying to convey?

A. Yes, because they'd grown up during a period -- I mean, they had been trained, they'd had their early care when the majority -- in a time when, you know, the median survival of people with severe haemophilia had really stayed stuck very much in the Carol Birch area of mid-teens to early 20s, that young people with haemophilia essentially lost the use of their joints or many of their key joints, knee joints, ankles, elbows by the age of 20, and there were patients confined to wheelchairs by the scale of arthropathy that had been established.

Now, the introduction of cryoprecipitate in 1963 by Judith Pool changed the survivorship but, because of its complexities in giving prophylactic treatment, didn't really change the scale of joint damage. So it may have delayed it by five to ten years but the end result was still severe joint disease in haemophilia. So they saw all the downsides of not having prompt and convenient treatment, and they'd just been given, if you like, within the last ten years, this supply of treatment of concentrate that could -- they knew had the capacity to eradicate

Just pausing there, I will come on to hepatitis C perhaps after the lunch break, first of all, are those observations you stand by?

A. I stand by those observations.

Q. The observations you set out there remain your view?

A. Every clinician is a creature of their generation. So I may well have attitudes that future generations will find equally -- not inexplicable, equally hidebound or non-responsive. So those doctors were in many ways admirable doctors, far more distinguished clinical scientists than I ever was. I would feel embarrassed confronting them with it but the fact is I think that they held the line to the point where it almost became like denial, a denial problem, into 1983.

I think to continue to propose that there was no conclusive evidence that AIDS was caused by an infectious agent was simply, in retrospect of course, untenable. So I still feel that way, yes.

Q. The sense that this part of your statement gives is an observation by you that the generation of haemophilia doctors, as you describe, those who dominated UKHCDO, were so focused on not withholding treatment and wanting to maintain treatment at all costs that it may have been that insufficient weight was given to counterbalancing concerns about safety.

those problems of haemophilia. So their attitude was conditioned by their experience of the disease. It may still be the case that if one had withdrawn commercial factor or tried to substitute by widespread reintroduction of cryoprecipitate, we would still now be looking at patients in wheelchairs who wouldn't have been there otherwise.

So I can understand the attitude they took but I still see it as a kind of denial of the reality.

MS RICHARDS: Sir, I have a handful more questions on this topic and then a handful of other topics to cover, but I note the time and it may be a convenient point at which to break.

SIR BRIAN LANGSTAFF: We'll take a break. We'll come back at 2.05. Same rules apply. So 2.05.

(1.03 pm)

(Luncheon Adjournment)

(2.13 pm)

MS RICHARDS: Dr Bevan, can you see and hear me?

A. Yes, I'm not hearing you too good. The thing is not yet charged up properly.

SIR BRIAN LANGSTAFF: Do you want some more minutes or are you all right?

A. I can hear you clearly. I've got vision. Sorry, it lost all its power during the lunch break, like many

of us.

SIR BRIAN LANGSTAFF: Well, I thought the idea of a lunch break was to refuel but ...

Let's start up and see how we go. If we run out, we'll just take a break.

MS RICHARDS: Dr Bevan, I was asking you about some observations in your witness statement and I'm just going to pick up on that again.

Soumik, could we have back on screen WITN4106001, please, and go to page 23.

If we pick it up in the bottom half of the page, you refer in the third paragraph of what's on screen to some Factor VIII companies pulling the wool over the eyes of medical opinion leaders:

"Armour ... [taking] visiting UK haemophilia doctors around their plasma-collection facilities where fresh-faced college students underwent plasmapheresis to provide a relatively safe source of product. However, Armour did not reveal to their visitors the massive supplementation by pools bought on the Canadian spot market. The eminent haemophilia doctor Peter Jones published a brave *Mea Culpa* admitting to having been deceived in this way."

Is that something of which you have personal knowledge or discussed with colleagues or Dr Jones or

is that based upon what you'd read?

A. That's based upon his article, which came out at the time. I myself have visited the Armour -- later, the CSL bearing Revlon -- I forget which phase of their ownership it was -- their Knoxville University apheresis centre, which is indeed reassuring, but I was additionally reassured by the fact it was taking part after heat treatment had been introduced, and they went into great detail about the complex donor surveillance, donor selection criteria they were now applying. So even though I saw the fresh-faced college students giving plasma, they were actually also getting proper antiviral testing before giving plasma. In fact, they had really what I would see as a rock-solid process whereby their plasma is held and not used until they've passed several sequential safety tests.

So I may have had the wool pulled over my eyes. It was still a company trip but by then it had been rendered safe, and in fact, as you know, subsequent to that no infections have been transmitted through plasma-derived products, although we avoid them upon principle now. So I know that that was the policy of the companies. I know they have relatively safe plasmapheresis collection facilities, but

unfortunately they were also supplementing it with plasma, the safety of which they had absolutely no control over.

Q. For the sake of completeness, Dr Bevan, what was the year of your visit?

A. Oh, gosh, I can't remember. It was something like '89, something like that.

Q. Then picking up with your observations in relation to hepatitis C, so the bottom two paragraphs, you said this:

"In the case of HCV, by comparison with AIDS, there was ample warning. Every haemophilia treater in the US, the UK, and elsewhere knew that their patients were acquiring an infection from [Factor] VIII concentrate, and that this infection was marked by a significant rise in liver transaminase enzymes, i.e. it was a hepatitis, likely to be a viral hepatitis.

"For circumstantial reasons, including a lack of symptoms during the acute phase, the absence of jaundice and cases of acute liver necrosis, the lack of a known pathogen and a blood test to demonstrate antibodies to it, the disease was widely considered to be non-serious. The progressive development of chronic hepatitis and cirrhosis remained silent

because of the historic 'rule' that liver biopsy in haemophilia was hazardous and absolutely contraindicated. In the absence of evidence from liver biopsies, the assumption was made that this viral hepatitis was an inconvenience, but essentially harmless."

Go over the page, please, Soumik, to the top of the next page.

You say this:

"Such an assumption is the kind that doctors should not make. The overt, potentially fatal, acute severity of Hepatitis B was regarded as a distinguishing between the two viral illnesses ..."

SIR BRIAN LANGSTAFF: Just a question there, did you mean -- the way it's come out on the typing is "a distinguishing"; did you mean "a distinction"?

A. Yes, "a distinction", or "distinguishing" without the "a".

MS RICHARDS: "... between the two viral illnesses, when attention should have been given to the likelihood that they were similar. I feel guilt on account of accepting this myth of harmlessness when it was first expounded to me, even though I was just a junior trainee with zero clout.

"Accordingly, I think that those who formulated

the advice promulgated by UKHCDO were late to recognise the reality of transfusion-transmitted HIV infection, and so may have made a minor contribution to the scale of HIV infection in patients with bleeding disorders.

"The community of haemophilia specialists made a somewhat larger historical contribution (again much smaller than that of the companies) to the scale of the HCV infection -- a much older disorder -- by assuming that it was relatively harmless condition for much of the 1970s. However, it should be pointed out that throughout that time there were opponents of this view, and that it was members of the same community (including Dr Craske, Professor Eric Preston, Dr Mike Makris, and Professor Christine Lee) and the same organisation (UKHCDO) who thoroughly corrected this assumption during the 1980s."

Dr Bevan, just going back to the paragraph at the top of that page, I'm paraphrasing but is this the right way to understand what you are saying there, that in a sense the wrong question was asked or considered in relation to hepatitis B and non-A, non-B hepatitis? The distinction between the two in the acute phase was somehow regarded as the key criterion rather than consideration of whether in the longer

term the two illnesses or viruses might lead to similar consequences?

A. Yes, I think probably that might have been clarified if after "similar" I'd added "in the long-term", because as we know hepatitis B can also cause chronic hepatitis cirrhosis. So I meant in the long-term that they'd be similar.

Q. Is there anything else by way of addition or explanation that you have to add to the observations that you've set out there?

A. No, except -- again, hindsight bias is not something any of us can avoid. It's like an inherent part of the human brain. But I'm still rather amazed by the fact that that assumption, that they were looking aft a harmless phenomenon, was sustained. It just doesn't seem to make any sense to me. Doctors are usually accused of over-exaggerating dangers rather than the reverse. I think that's probably our role.

So, again, one must avoid anachronism here in that concepts like that of -- what's the term I used, I used it later -- the precautionary principle did not to my knowledge exist then, certainly not in medical practice or common parlance. The idea that you would actually take action in respect to perceived dangers, even if those perceived dangers were relatively remote

or not defined. So, as I later discuss, the approach to vCJD for example, from the outset, has been based on the precautionary principle that, no matter what inconvenience/problems it may cause in everyday life, you have to proceed on the assumption that certain people are going to be transmitters of the disease.

But that concept of precautionary principle was certainly -- it may have been published by philosophers but it had not yet appeared in medical practice. Like many other subsequent developments, like the concept of clinical governance, et cetera. That's all.

Q. We can take the statement down.

Dr Bevan, amongst the materials that have been provided to you in advance of your evidence was a letter from Dr Spence Galbraith, who was a public health doctor, epidemiologist, who in May of 1983 was advising the DHSS precisely along precautionary lines, suggesting that there should be a suspension of the importation of US concentrates. We can look at the document if you want but it has been provided to you. I hope you had the opportunity to look at it?

A. I recall it, yes.

Q. Was that something which ever came to your attention at the time?

A. No, not in 1983.

Q. I'm going to move on now to deal with various other topics touched on by your statement, Dr Bevan. The first is in relation to the national tendering process that you describe in your statement as being implemented from 2005 onwards, which, as you put it in your statement, eliminated directors from the direct purchasing of blood products.

What were the advantages and any disadvantages of that system from your perspective?

A. From my perspective there were no disadvantages of the introduction of centralised purchasing. It was all good. I mean, first of all, it achieved, in world terms, a quite unique reduction in costs, reduction of price per unit. Secondly, it lifted what I would call an ethical weight, moral weight from the shoulders of haemophilia directors, who were no longer as -- obviously, the sole determinants of which products they used. I mean, I was particularly glad that by the time I took over the directorship at Guy's and St Thomas', when the product budget was of the order of GBP 25 million a year, that I no longer, if you like, had such very large amounts of money in my gift. I'm sure I would have been, you know, the subject of a lot more attention if it had been.

So I was -- it seemed to me that the mechanism for the national contract involved quite sufficient elements of a degree of choice over which product you had, and that you were able to communicate your preferred product. By then I think most of us felt that the recombinant products that were introduced were completely identical in functional terms, whether they were -- you know, as you know, some of the recombinant products for the B domain of Factor VIII deleted and some people thought that that was a risk of inhibitor generation, it doesn't seem to be the case, so basically a certain degree -- where it was required, a certain degree of user choice was incorporated within the national contract structure.

So I think it was an overall great benefit.

Q. Do you know of any reason why such a system which would have meant individual directors were no longer having to take decisions that varied enormously from centre to centre and across the country, why such a system couldn't have been introduced earlier?

A. I mean, it was -- the organisation of the purchases with relation to haemophilia services, the funding of Factor VIII, had previously been dispersed and chaotic between various health authorities. There was -- haemophilia was not on the specialist commissioning --

again, "commissioning" as such. Haemophilia needed to be under the aegis of a specialised commissioning function before proper attention could be paid to the funding of the subject.

There was no -- until the commissioning side of the subject was properly formulated, I don't see that they could have run a centralised purchasing -- so it required other developments before it could be put effectively into use.

Q. Those other developments reflecting reorganisation of the way in which NHS bodies dealt with one another?

A. Well, specifically the way in which they dealt with commissioning in haemophilia care, which became a separate item on specialised commissioning field.

Q. Moving from that into prior to 2005, when decisions were still either for individual directors or for regional consortia, we've provided you with a couple of examples of letters that were sent to you by Cutter, I think you described them in your statement sales pitches, letters talking about the particular Koate treatment and discussion of price and the like.

How common was it for you to receive approaches from pharmaceutical companies once you took over as director and what form did those approaches customarily take?

A. I mean, that was perhaps slightly unusual in that -- I can't remember. I mean, I explained that I can't remember that correspondence at all. It was at a time when, you know, I had quite wide responsibilities to a large number of patient groups and disease categories, and it was at the periphery of my knowledge. I used to generally discount communications from drug reps.

Now that's, with all due respect, because I've known some very, you know, correct drug reps, who know a lot about their subject, but I would normally consign such messages fairly rapidly to kind of the round file, as it's come to be ... So I do not recall that interaction at all. In fact, what she appears to be offering me is to do with the technique of heat treatment of the product.

So, if you like, because there was some -- at that time it was still uncertain, I think, which was the best heat treatment protocol for non-A, non-B hepatitis, Hep C, whereas it was quite clear that all the heat treatment techniques got rid of the HIV virus. There was a point to it but unfortunately I didn't recognise it at the time and I didn't recall it.

In terms of approaches, if you like, from the

competitors to the people who were supplying us, I would expect them at least once every six months from each company, usually, as I said, not based on something specific like this, which is the degree of heat treatment.

I think that's all I can say on that since my memory has failed me on that one.

Q. Some witnesses have described pharmaceutical companies providing some form of funding to centres, whether it be for training or education or facilities and products. Was the centre at St George's, to your knowledge, ever in receipt of funding along those lines from pharmaceutical companies, or donations from pharmaceutical companies?

A. No, direct donations to departments, as far as I'm concerned, never happened at St George's or, indeed, at Guy's and St Thomas', because that would be a very crude and overt way of doing it. The companies, of course, provided sponsorship for the attendance of medical staff, including the director, and often several members of the medical staff if you had them, to major international conferences, the sort of conference to which haemophilia directors really should be going, World Federation of Haemophilia, International Society of Thrombosis and Haemostasis,

sometimes American Society of Haematology meetings, where there would be substantial sessions on haemophilia, on blood-transmitted infections -- I mean, where you are likely to see state of the art research discussed and also to be able to discuss with peers in other countries various approaches.

So I think it's -- doctors needed to go to those affairs. They were extremely expensive to attend and register for. So simply getting a registration fee to ASH or World Federation of Haemophilia would cost of the order of £600, £700 and then you would have to -- usually, they were held in major centres where there was vast amounts of hotel accommodation, because these conferences were often 30 or 40,000 delegates from around the world, and that was expensive and the travel was expensive, because a lot of the conferences were in the US.

No way could any NHS clinician fund that out of any NHS funds. They simply weren't available for such things and very few had private means sufficient to do that. So, in a way, we all took advantage of that system.

Now, it may be that the companies could have put people up at motels, and so on. Normally, they chose 4 star or even more star hotels. As for having

said that, I did stay at a motel once in Seattle, because there simply weren't enough major hotel beds in the centre and I was some way down the list.

Basically, yes, the companies provided that and during attendance at such a conference the companies would often take you out for a meal and, usually, these were quite expensive restaurants. So, yes, to one's shame, one participated.

Companies would sometimes provide -- with the World Federation of Haemophilia, companies also provided support to patients and family members and members of organisations like Haemophilia Society to attend those, because the World Federation of Haemophilia is an open meeting for patients and their representatives, as well as medics and nurses, counsellors, the whole gamut of the multidisciplinary team and they supported those as well.

When it came to the patient organisations, I'm sure the companies supported The Haemophilia Society. They tried to set up an organisation, which I don't think was ever particularly -- I say this with due respect -- took off, called The Haemophilia Alliance which was on the basis of things like the renal -- I think there's a Renal Alliance, which is partly funded by dialysis machine constructers, and so on.

So drug companies have often funded the setup of such organisations which involve patients and doctors, if you like pressure groups for improved services.

So those are -- and the third thing is that companies at one stage, knowing that you needed to train patients and their carers to self-inject and knowing that some places didn't have haemophilia nurses to do this, offered nurse specialists that they would entirely fund to teach your patients how to administer the product. That was proposed to me once at George's and it was regarded as internally impossible or unwanted, by what then -- subsequently has become the trust, then was just the hospital.

So they did offer that. They would provide refrigerators for people to keep their product in at home. They would provide carrier bags and cold store equipment for patients who needed to keep it at home. They would provide booklets and educational facilities for patients, if you like, a range of activities which would seem to be completely blameless or to have no ulterior motive really.

Q. The motive of the pharmaceutical company and, for example, funding the hotel and the meals and the transport, and so on, was presumably at the very least, in large measure, to influence the clinician to

choose the products of that pharmaceutical company.

A. I've been thinking about this. Yes, it would but, at the same time, it was mostly after the fact. So, by and large, patients -- patients -- directors and other staff were taken, were supported by companies they already had a relationship with. So it may well have been a *quid pro quo* but it was after the event, in most cases. I know of no-one who's -- if you like, there was a bidding war -- no, I mean, the company's motive is always profit, always.

Q. What, if any, systems or processes were in place, whether within St George's or in the NHS more widely, to your knowledge, that might have protected against at least unconscious bias, subconscious bias, as a result of those kind of interactions and dealings?

A. Yes, of course, and that's why it's much less -- what's the right word -- much less indulgent nowadays. I mean, various regulations have been put in place, sequential regulations by the ABPI and other international pharmacy governance agencies to steadily reduce the monetary value of any such support.

However, I believe the basic elements which are registration fees, hotel costs and travel costs are still being supported.

Q. Let me move to ask you briefly about vCJD. You have

touched upon the difference of approach as a matter of principle and the application of a more precautionary approach, and I just wanted to ask you about one document you refer to in your statement. Soumik could we have on screen, please, WITN1194004, please. If we go to the next page.

You'll see, Dr Bevan, this is a letter from you and your paediatric colleague and haemophilia nurse specialist, September 2004, and it says this:

"You may have heard -- from The Haemophilia Society, in newspapers or on television -- that some batches of clotting factors (manufactured in the UK by BPL), were made from 'pools' that included plasma donated by individuals who later developed ... (vCJD). These newly identified batches are in addition to some that were similarly affected a while ago.

"So far, only a few batches of clotting factor, used between 1994 and 1997, are known to contain this material. However, new cases of vCJD, in people who were once plasma donors, might occur in the future, so all clotting factors made from 'UK pooled plasma' between 1980-2001 have now been reclassified as being 'at-risk' of transmitting vCJD.

"Because in the past you received some clotting factors made from pooled UK plasma donations you may

have an 'additional risk' of acquiring vCJD. The risk is called 'additional' because anyone who ate UK beef products during those years is assumed to be at a low degree of risk of developing vCJD, so any risk from UK plasma products is 'in addition'."

Then you refer to an information pack:

"After you have read the information you will need to decide whether you want to know if you received any batch of clotting factor known to contain plasma from individuals who later developed vCJD. The haemophilia centre staff will help in any way possible, before or after your decision. Our preferred way would be to see you in person for confidential discussion of the issues involved."

I'm not going to go through the details of all the kind of national notification processes but this was a process in which, as I understand your statement, Dr Bevan, you and your colleagues decided to afford your patients the right to say if they wanted to have this information or not. Is that correct and can you just explain your thinking please?

A. Yes, that's correct. I don't think we were unique in this at all.

Okay, let me just get my head round this.

The problem was that here we're dealing with

something completely different from HCV or HIV, in that you're dealing with a huge area of uncertainty. So the uncertainty is expressed in the second paragraph, in that we can't say which batches -- that these are the only batches that have a risk of this type. Since vCJD has an incubation period of anything up to 40 years, I don't know what the current feeling is, then it was 20 to 30 years, now it is probably longer, basically any plasma product produced in the UK might contain such stuff and, of course, any plasma donated in the UK was subsequently excluded from any use in the manufacture of clotting factors.

So you're immediately transmitting a feeling of uncertainty to patients. Have you been exposed or have you not? We can't say at this point. We have to cover all bases.

Secondly, we have no idea of the actual degree of this risk of actually getting clinical vCJD. As it turns out, the risk seems to be vanishingly low because still no people with haemophilia in the UK have developed vCJD. I know there was one that had pathological prion extracted from their spleen but since the spleen is the organ in the body which tries to filter out junk from our circulation that might do us harm, that may mean that the body had in some way

neutralised it.

So, basically, what are you going to tell people? You have no test to test their blood. It's not like HIV or non-A, non-B. You can't test their blood and tell them whether they've been infected or not. There's no way of forestalling what might happen if they were infected, no known way still of treating prion disease, and so all you're doing is giving them a form of uncertainty, which is worse than the form of uncertainty -- that was my view. I knew that some patients felt this, that there was no point knowing this sort of information, that it could only possibly prove to be a source of long-term anxiety and blight in a way.

So we decided that, as well as explaining, as usual, you know, because we don't have a test but with the test you are supposed to explain the implications of having the test, with a view to them deciding not to have the test under certain circumstances, here we thought it was the information itself that the patient should decide they want to hear about or not.

In fact, after talking to our patients that this letter would have gone to, they divided, as far as I remember, fairly equally between people who had a very pronounced desire to know and people who had

an equally pronounced desire not to think about it ever again. There was no public health implication of this, in that -- you know, so basically, for all those reasons, we decided to offer them the option. As I said, I don't think we were the only centre to do this.

Q. The way you put it in your statement, Dr Bevan, is that you and your colleagues concluded individuals should be given the right to know or not to know, the right not to be passive recipients of the information?

A. Yes.

Q. We can take the letter down. Thank you, Soumik.

I next want to ask you about a letter you wrote to --

A. I mean, I would say I never had any feedback from patients suggesting they were offended by the letter or confused by it or otherwise wished they hadn't had it. Most people seemed to appreciate that we were giving them a degree of empowerment, however slight.

Q. I'm next going to ask you about a letter that you wrote to a newspaper. I think it was The Independent. You have discussed it in some detail in your statement but I just want to ask you about a couple of parts of it.

It's UHMB0000006_064, please, Soumik.

medico-legal burden of providing the safest possible products for their patients will find themselves constrained by a ruthless requirement to cut costs.

"In case haemophilia treaters feel disinclined to favour these products on the open market, a scandalous linkage has been arranged between the proportion of BPL products bought and the price that the hospital concerned will be charged for totally different blood products such as red cells and platelets. This smart move in effect places patients with leukaemia and other serious blood disorders in the position of hostages in a sordid commercial battle for Factor VIII orders.

"Such destruction of the ethos of the gift relationship in blood and plasma donation, previously exemplified to the highest degree by the Blood Transfusion Service and its Blood Products Laboratory at Elstree, surely illustrates the dark side of these invidious 'reforms'."

Dr Bevan, I wanted to ask you two questions. One is specifically about the linkage you refer to in the penultimate paragraph. But before we get to that, what was it broadly that triggered your writing to the paper in these terms?

A. What a firebrand, eh? How nice it was to be young ...

A. Oh dear.

Q. It's a letter written in April 1991, or published I think in April 1991, and you say this -- I'll just read it so that again those following can follow the evidence:

"The worst conceivable response to the HIV tragedy in British haemophiliacs is to throw this group of patients to the mercy of the markets, not only for provision of their health care, but also for the supply of Factor VIII on which their health and lives depend. That is what is happening, however, as part of the 'reform' of the National Health Service.

"Presumably, the Government feels that its obligations to the British haemophilia community have been paid off by the settlement of the recent legal action, but must be aware that a cost-cutting war among haemophilia treaters and Factor VIII manufacturers will reduce the safety of the blood supply, as illustrated by your article of 9 April.

"They should also be aware that the legalistic defences which saw them through will not work a second time, since they can never again claim to be surprised by the contamination of crude preparations of bulk plasma by unknown viruses or other infectious agents. The haemophilia treaters who will bear the ethical and

I think the main lesson of this letter is probably to take care before writing to newspapers. And I must admit when I saw it published in The Independent my heart dropped through my boots. They had edited it substantially but I can't even remember what they edited out of it. I don't think they changed the sense of it.

So what may have provoked this was anything from a manager giving me a hard time at St George's about the amount I was spending on Factor VIII, and telling me I had to stop or I had to stop treating patients, but the thing -- the centre of it is, I mean, BPL was finding its way as a commercial organisation or a pseudo-commercial organisation in the face of the Government reforms, you know, the Government reforms of the NHS, which obviously from that you can tell I'm no supporter of, and the intensification of budget pressure on treaters.

Of course, as haemophilia treaters, we were always way outside in terms of product cost per patient and therefore an easy target, particularly since, you know, we were accused of spending as much on treating 20 patients as the hospital spent on the entire paediatric ward and things like that, which was actually the way it was -- not just at the Royal Free

but also at George's I was getting similar stuff from the managers, newly empowered by the reforms.

One of those reforms meant that BPL had to try to find a commercial footing. So no longer were they allowed -- going to be allowed to provide free product based on plasma donations, as in the past, but they had to charge for it, and they were struggling with exactly how to do this while fulfilling their mission to supply patients with the blood products they needed.

One of their mechanisms that they proposed, and which I was directly attacking in this letter, was to say: well, we'll make the price of platelet transfusion, the platelet concentrates you need, to your hospital dependent on the amount of Factor VIII you order from us. So the more Factor VIII you order from us and buy from us under the new arrangements, the cheaper will be your platelets. And if you don't buy so much BPL from us, the cost of your platelets will go up.

I must admit, I found this linkage -- this is what I call the "scandalous linkage" -- it particularly hit me because I was responsible both for treating haemophiliacs with Factor VIII and for treating people with leukaemia and other conditions

Q. Again, for the benefit of those listening who may not have read your statement, on that issue you talk about the adoption of high purity Factor VIII. You've said this in your statement:

"I strongly agreed with those UK clinicians who considered that the adoption of high purity Factor VIII was an important step in future briefing Factor VIII safety, since HIV showed that novel organisms with hitherto unpredicted effects could suddenly invade the blood supply. It was no good to simply protect against known pathogens; in future they might not be enveloped viruses susceptible to heat or viruses at all. The official contention was that the HIV epidemic was an unforeseeable event due to a completely novel virus that couldn't be seen coming. My doubt about that excuse was that it simply would not do next time around."

A. No. Yes, that's right.

I mean, whether the partial purification by affinity chromatography, which is what we were talking about, I mean, that was a variety of commercial -- new versions of commercial Factor VIII. They were treated with heat appropriately and they were safe but they were also purified so that things of unpredictable chemical nature would tend to be avoided.

with platelets. So it sort of directly hit me that I was being sort of held to ransom over -- in fact, I think they dropped that idea pretty quickly. I do not claim any agency in that for this letter but I think I wasn't the only person to object to this linkage of blood product costs to how much BPL product you bought.

The fact I was actually keen to buy probably as much Factor VIII-wise possible for a long time didn't play any role in this. In fact, in the paragraph where I allude to, you know, they can't be surprised by the contamination of crude preparations of bulk plasma, I was at that time part of a group of haemophilia treaters who wanted to go to the so-called high purity Factor VIII, on the basis that if you construct a system which specifically extracts Factor VIII from plasma, you are likely to leave unwanted things behind, and I suppose you can say that my warning that there will be new agents with unpredicted characteristics which will invade the blood supply actually was manifested by the vCJD experience.

Even though I'm embarrassed by this in retrospect, I'm no longer -- I feel no actual huge difference from it now.

Of course, a few years later, you know, one was able to do that simply by moving to recombinant products, achieve the same degree of theoretical safety. Whether the high purity products actually did eliminate any infections is moot. We never knew.

Q. The next topic, Dr Bevan, is to ask you about your involvement in the HCV look-back exercise, and I wanted to ask you first about the national look-back in the 90s. I think we sent you a couple of examples of Blood Transfusion Service-generated letters about individual patients from 1996.

I'm not asking you about the details of individual patients but what can you recall from your perspective, as consultant and Haemophilia Centre Director, of your involvement in the national blood transfusion-led hepatitis C look-back in the mid-90s?

A. In the mid-90s I think we complied with it as well as we could, given the information we had. And it was a result of our look-back that resulted in the identification of the two cases that I was then written to by the blood transfusion lead, would I be prepared to counsel them, which of course I was because they were my patients, with -- but they didn't have haemophilia. I mean, a slight irony. And of course, that's what the look-back was intended to do,

not just pick up people with bleeding disorders but everybody who had been exposed.

So there it helped having a relatively small group of patients. The workload imposed on the department by the look-back in the mid-'90s I think was not -- we did it, I think. I don't think we fell short of it.

The later look-back -- anyway you may not be asking me questions about the later look-back.

Q. I will come to that in a moment but can you recall what the mechanics were or the process was that was asked of you at St George's in relation to the first look-back, the 1990s look-back?

A. It was just to record every example of a person given a blood product within that timescale in the hospital, which is obviously a large one and largely stems from the blood transfusion department as organised -- and anyone who'd every known my colleague Dr John Parker-Williams would know he was like the encyclopaedia about that. So, as far as I remember, I just, repeatedly -- I just, not for the first time, provided the list of my patients who had been exposed to see through the plasma for their haemophilia treatment, and the rest was done by John Parker-Williams and the blood bank, and I think

quite effectively.

Q. Then if we move to 2011 we look at HCDO0000510, please, Soumik, so these are the minutes of a meeting of the advisory committee and the annual general meeting of UKHCDO, October 2011, and you were in attendance, and if we just go to the bottom of page 3 please, Soumik, we can see the bottom of the page says:

"HCV Look-back exercise: the aim is to identify all patients affected with hepatitis C and to calculate the burden of disease for planning. There were 15,057 patients registered during the period of risk (mostly with mild bleeding disorders). 11,567 are still alive. The number of forms received is 3,266 [et cetera]."

Then it says in the next paragraph:

"It is generally that the burden being placed on Centres is too great."

Then there's a decision about what to do in relation to forms and collection of data.

What, if anything, can you recall about this look-back exercise in 2011?

A. I must admit, I found this look-back exercise somewhat amorphous because, as it says there, many patients had been treated -- because we were a reference centre,

referral centre, call it what you will, comprehensive care centre, now responsible for a large network, we were constantly -- we were referred patients for shared care, or many more so, and they would have been from other centres in the area, so Lewisham and others. There was uncertainty about whether -- you know, double reporting, patients deceased. In addition, of course, at St Thomas' I no longer had any contact with the -- direct involvement with the blood transfusion system at Guy's and St Thomas', so I didn't have any access to those but, thankfully, I did have a colleague, much regretted, Dr Thompson, who was able to devote a fair amount of his time to collecting it. So I think we did contribute data. It was much more difficult to be sure that one was complete of the data to the second look-back on having missed something.

Q. Can you recall roughly how many, if any, bleeding disorder patients, who may have been infected with hepatitis C were identified at St Thomas' as a result -- Guy's and St Thomas', as a result of this particular look-back exercise?

A. Who had never been recognised before?

Q. Mmm.

A. It must have been single figures but I'm afraid

I can't remember this and I don't have access to any records of it.

Q. I want to ask you next on a different topic but looking also at a set of UKHCDO minutes from 1989, so could we have HCDO0000015_035 please, Soumik. So this is a meeting of Haemophilia Centre Directors in October 1989 and, again, we can see that you're in attendance, and then if we go please to page 5, Soumik, halfway down the page under the heading "Litigation", there begins a fairly lengthy discussion about litigation. Sorry, I should have drawn your attention to the list of attendees. Dr Rejman from the Department of Health and a representative of the firm of solicitors, Cole & Cole, were also in attendance. We can see here there's a report from Dr Jones. In the second paragraph, it says:

"Dr Jones highlighted the damage being done to the doctor/patient relationship as the case dragged on ..."

Then we have a Mrs Simpson, partner in the firm of Cole & Cole, giving an outline of the progress of the defence to the patients' Statement of Claim. Then if we go over the page, we can see she provides various details about who's involved, about the progress of the litigation.

If we can look at the bottom half of the page, Soumik, a little closer, you'll see that long paragraph there talks about a questionnaire being produced and who the lawyers were involved, and then that long paragraph ends with this:

"Haemophilia Centre Directors were not defendants and the lawyers would like the Directors to co-operate fully and give as much help as possible."

Then in the next paragraph there's a question about individual directors and the solicitor emphasised that the Health Authorities were the defendants and not the directors. Then if we go over the page please, and we zoom in on the first half of that long paragraph in the middle of the page please, Soumik, we can see Dr Chisholm asks about the cost to patients and if directors could do anything to help patients. Mrs Simpson talks about the defence lawyers looking to strike out the claim, and then there's a long paragraph where Dr Rejman, representing the Department of Health, gives the Government's perspective:

"... no case for an out of court settlement ... compensation must be sought through the courts", et cetera, et cetera.

Now, it would appear from this discussion that

directors were, to some extent at least, being asked to assist in the defence of the litigation. They were certainly being given a fairly detailed account of the defendants', including the Government's, response. Can you recall whether at the time that struck you as odd or concerning that directors were being drawn into the litigation for the defendants in this way?

A. Okay. I kind of remember it because of Dr Rejman. It's somewhat -- I could say he presented the Government's position in a kind of hardline way that struck me as unsuitable, inappropriate. That's about the only thing I can remember of that.

Now, your question -- sorry, can I ask you to clarify? You're asking was I surprised that doctors were, what, talking about helping the plaintiffs or --

Q. No, the defendants, being -- as the doctors were not themselves individually being sued, did anything strike you at the time or does it strike you now as concerning about the fact that directors were, as it were, almost being assumed to be somehow on the defendants' side or there to assist the defendants in their defence of the litigation?

A. I mean, apart from the fact that, of course, the defendants are all paid employees of the National Health Service, I would have thought, yes, that was

a somewhat unwarranted assumption. I don't know quite how I can reply to that. I don't remember any strong feeling myself about things, just that this was the way things happened. One was pretty aware, I think, that cases of medical negligence were unlikely to be straightforward against doctors involved, unless people could be shown, for example -- as long as people were following the guidelines set down by the UKHCDO, for the aforesaid Bolam situation. I think -- obviously, I'm aware that Bolam is now defunct and different standards are applied, but I think when it comes to legal action about treatment, it would be unusual if the doctors who'd prescribed that treatment did not feel somehow in the focus of the litigation, and the assurance that, so far, no doctors were actually being individually sued would be regarded as not necessarily applying to the future.

That's all I can say on that. I did not feel particularly threatened by anything but I remember feeling somewhat out of sympathy with Dr Rejman's approach.

SIR BRIAN LANGSTAFF: Just one question about that, really addressed through you, Ms Richards. If we go back to the previous page -- thank you -- I think it's the previous page, again.

MS RICHARDS: The page before that, Soumik.

SIR BRIAN LANGSTAFF: 0005, thank you. What Mrs Barbara Simpson was saying. The underlying picture, apparently being painted, was that the assembled doctors were assumed to have some interest which coincided with those of the defendants in the litigation, and she appears to be asking the doctors present to assist, insofar as they could. I've always understood it as a general principle, when asking people who are not themselves at least currently being sued for what is expert opinion, that if it's offered it should be available -- if the doctor or other person is invited to give a comment, as opposed to make a report -- should be available to both parties, so that both parties can see what the individual has to say and the impartiality is not compromised.

Do you know whether any enquiry has been made of Barbara Simpson as to the basis of the request she was making?

MS RICHARDS: I don't off the top of my head, sir. We can certainly find out.

SIR BRIAN LANGSTAFF: Because it might be a matter of importance. One has to take into account that it's at a time, perhaps before Mr Justice Cresswell set out in The Ikarian Reefer the general principles of how

experts should behave, et cetera, but it was well known that if individuals were suing doctors who had been involved in their treatment that they ought to be freely available to go to other doctors who would be under no sort of pressure one way or the other to say anything to the would-be plaintiff other than what they really thought, and the defendant similarly.

MS RICHARDS: Yes.

SIR BRIAN LANGSTAFF: That's a comment by me, really, doctor. It's just arising out of this particular document, which we have seen before and I haven't asked that question before. I felt prompted to ask it at the moment.

A. Okay.

MS RICHARDS: Before we leave that, Dr Bevan, was there any further comment you had?

A. Sorry, is it fair to say then that I -- apart from a general air of concern, I didn't get any feeling that we were being directed not to provide evidence for the plaintiffs.

SIR BRIAN LANGSTAFF: That's helpful to know at any rate. Thank you very much. That's some reassurance --

A. I mean, I subsequently became much more acquainted with clinical negligence through my work as an expert witness in various cases, so even through the later

knowledge I have, I wouldn't have seen any direction there that one was not to provide information to the plaintiffs or their representatives. Sorry.

MS RICHARDS: No, no.

Sir, that concludes the questions I had for Dr Bevan, but I had a handful questions from CPs, Core Participants, over lunch and obviously we should afford them the opportunity to suggest any further questions arising out of Dr Bevan's evidence today. So I was wondering if we could take a break now for perhaps 30 minutes and that will give the legal representatives of Core Participants the opportunity to email to me and to Mr Boukraa any further questions they would like us to consider asking Dr Bevan.

SIR BRIAN LANGSTAFF: Yes, indeed.

You may have seen if you watched any of the previous proceedings, Dr Bevan, that at this stage we take a break so that Ms Richards can field any of the questions which others may wish you to be asked, and as appropriate we'll ask questions when we return.

So we'll take a break now until quarter to 4.

A. Excellent.

(3.12 pm)

(A short break)

(3.44 pm)

MS RICHARDS: Dr Bevan, just a handful of questions for you that I have been asked to ask.

The first is in relation to dissemination of minutes by UKHCDO. You referred in your evidence this morning, when we were discussing the meetings you'd attended in '78/'79 on Professor Flute's behalf, your understanding was Professor Flute would go through the minutes of the meeting in due course when he received them.

Can I just check with you your understanding of what minutes were circulated by UKHCDO. Our understanding based on evidence so far has been that minutes of Reference Centre Director meetings were not generally circulated beyond the Reference Centre Directors. Is that your understanding?

A. That's my understanding, including the Reference Centre Director meetings I attended after taking up post at Guy's and St Thomas'.

Q. The minutes of the AGMs that were attended by or to which all Haemophilia Centre Directors were invited which took place annually, are those the minutes there you were referring to which you understood were circulated to all directors?

A. Yes.

Q. Thank you.

Secondly, I asked you about contributions or sponsorship from pharmaceutical companies. As a matter of process, were those sponsorships or contributions that you were discussing in your evidence this afternoon declared to NHS Employers at the time and, if so, were they ever questioned or were any concerns or objections ever expressed by your employer?

A. Definitely at Guy's and St Thomas' any such contributions were declared to the Trust and one had to clear them -- one's attendance at the conference and support with the line manager in the general management team.

At George's I think, once again, after line managers came in, one was supposed to clear it with them. But the formal requirement for it being declared was much more -- much less prominent, let's put it that way. So I think they were probably very likely declared before about -- before 1995 or so, possibly.

Q. So they were very likely or unlikely declared?

A. No, they were -- I think they were probably under-declared. I'm sorry, I'll modify that. Before 1990. After the internal market came in, everything got a bit more corporate.

Q. Did you ever have your line manager saying, "No, you shouldn't accept this", or "You shouldn't go"?
A. No. And then I think the UKHCDO introduced registration of such events and I think it was pretty widely complied with. But of course that's not quite the same thing.
Q. Thirdly, we talked about the precautionary principle, and you said that the precautionary principle wasn't something that was generally recognised or applied to medical practice at the relevant time, and we were talking about the late 70s/first half of the 80s. In your view, should it have been? Should that have been a key part of medical practice at the time?
A. That really refers to my whole feelings about a degree on anachronism. There are many things that, if they had been applied to the situation at that time, such as the current principles of clinical governance, of patient autonomy -- in a way, yes, they all would have been better, but they weren't -- I mean, they didn't exist. So it's a kind of strange question in a way.
Q. Okay.
A. I think there are many things that we -- as I've said before, a lot of aspects of medical practice, not just clinical practice but organisational practice, ethical practice, changed as a result of the HIV epidemic.

of her within a year of that.
Q. The final question I've been asked to raise with you as about transfusion practice and your general experience as a haematologist more widely. And I think it might be most useful if I ask you to look at a document and then ask you the question.

Soumik, could we have on screen, please, NHBT0015055_001.

This is a medical report you prepared I think for the purposes of a possible legal claim in August 1991. I'm not going to ask you anything about the individual patient or the individual circumstances of the case but just about a general observation you made at page 3.

So if we can go to page 3, and it's the bottom half of the page, please, Soumik.

If we look at the penultimate paragraph there is, Dr Bevan, you say this:

"The risk of acquiring any viral infection, specifically viral hepatitis, from blood product transfusion is proportional to the total number of donor units to which the recipient is exposed. It is therefore good clinical practice to restrict this exposure as far as possible without jeopardising a good outcome."

And of course you could look at all those new introductions and say, "Oh, they would have been much better prior to the end, they would have achieved a lot if they had been in place prior to the AIDS epidemic", but the fact is they weren't. We needed the stress and horror of the HIV epidemic to learn those things.
Q. The next question is just in relation to the HIV counselling. You referred to having a counsellor. Can you recall how long it took, approximately, after 1985 for you to have the funding at St George's to have the services of a counsellor, or was that something that was attached to the infectious diseases unit?
A. No, they had their own counsellors and we had ours, and she was a great help and I find it to be appalling that her name has just gone from my memory. And no doubt the patients remember her.

I've tried to think of myself, my -- I think time has become compressed in retrospect, and it may well have been a year or so after getting those initial HIV results before we got the counsellor. My feeling is that within a year or two we had her, because she was founded by the Wandsworth Health Authority as a special grant. So I think we got hold

That's a statement of principle that you made about good clinical practice, and the question I've been asked to ask you is about whether you were aware, as part of your wider experience as a haematologist or your knowledge of the Blood Transfusion Committee at St George's, of whether there was any particular trend or practice of over-transfusing patients?
A. Right, okay. So here, although I use the word "blood product transfusion", I'm really talking about red cell units, which obviously can only come from a single donor, and therefore the larger the number of red cell units transfused into someone, the more donors they've been exposed to. Over-transfusion is indeed a possible problem in hospital practice, usually because in an emergency situation people, for the best motives, assume the person has lost more blood than they actually have.

I think in modern practice over-transfusion is much less likely because of -- in critical operations like cardiac bypass, there is real-time monitoring of blood volume and other monitoring measures which would mean that over-transfusion was far less likely now. But I think, yes, over-transfusion could occur. Is that -- does that answer your question?
Q. Yes, that's the question I've been asked to ask you,

and I thought it might be useful to do so by reference to the observation you've made in that report.

A. Yes, that's about a pulmonary bypass patient who was transfused a large amount, and I'm just saying that ... as you can see from the thing below, I'm not saying that there was over-transfusion in this case --

Q. No, and I wasn't asking --

A. Given the complexity of the situation, the volume seemed to be comparatively modest or appropriate.

Q. We can take that back down, thank you, Soumik.

Sir, those are the questions I have for Dr Bevan, or those were the questions from CPs that I'm proposing to ask. Before I ask Dr Bevan if he has anything further to add, are there any questions you have, sir?

SIR BRIAN LANGSTAFF: Do we have to ask -- is it, Ms Shibilka?

MS RICHARDS: She has no questions.

Questions by SIR BRIAN LANGSTAFF

SIR BRIAN LANGSTAFF: Yes, I do.

Very early in your evidence this morning you said -- something of an aside, but this. You said "nothing from BPL is truly free". You'd just been talking about how BPL product was free, and then you added that. What did you mean?

SIR BRIAN LANGSTAFF: I understand it. I wouldn't say perfectly but I understand it I hope.

The next question really arises out of your comment about the patients who were informed that they had hepatitis C, and they're indicating to you they thought it wasn't one of the most serious problems they had because it was -- any particular risk was long-term rather than immediate compared to the HIV from which they might very well be suffering. That was very much greater.

Just to put their view as to how serious it was into some sort of context, did you ever know just how many of your cohort that you were treating for haemophilia actually took interferon when it was available?

A. I would hope very much because later on in South Thames, under the approval of the Pan-Thames Haemophilia Consortium and its subsequent equivalents, we formed a network of centres so that the link between, say, the George's centre and St Thomas' centre became more formalised, and most of the patients with hepatitis C at St George's, including one or two I remember very well, came to St Thomas' to the liver clinic there. The reason being that the liver clinic at St Thomas' had, you know, a typical

A. Well, I meant the presumption that it -- the manufacture or the production of such a product involved costs, costs to the NHS. So somebody's paying for it. I think it may not -- when it comes over to the clinical side, in terms of the haemophilia centre, we do not pay for it. It's, if you like, free at the point of use.

SIR BRIAN LANGSTAFF: Yes.

A. But everybody must recognise that there is a cost. The trouble is that the NHS has never been very good at ascertaining, if you like, system-wide costs, as opposed to the costs that appear on someone's budget at the end usage.

This can sometimes be a problem, for example, if you have a new drug that can radically simplify and reduce the costs of, say, anti-coagulation in thousands of people. That drug may not be used because it's expensive at the point of use, whereas the costs involved in using the old method are not quantified properly, whereas the cost of a commercial product that appears on an invoice on your budget is real. The true cost of the thing has never been collected and displayed in the same way. I've probably overcomplicated my answer there. I apologise.

piece of Professor Savidge's financial acumen, acquired a device that measured the elasticity of the liver by sound waves. My ageing brain has temporarily lost the name of the thing but basically it's a way of accurately deciding whether someone has cirrhosis or not without liver biopsies.

SIR BRIAN LANGSTAFF: So some form of fibro scanner.

A. Fibro scanner, that's the word I was looking for. Thank you very much. So they had a FibroScan and a FibroScan clinic run by one of the nurse specialists there which gave a very good running account of whether people had cirrhosis. So I'm pretty sure that all the people who acquired HCV at St George's eventually came to St Thomas' to attend that clinic. So I think everyone there was then treated with not just interferon but ribavirin and the newer drugs and are currently on programmes where they've access to single drug therapy and the modern forms of drug therapy and EPSI, which have transformed the outlook in the pre-cirrhotic population. So I've no doubt they are being properly looked after.

SIR BRIAN LANGSTAFF: I suppose it might be said that their view of how serious hepatitis C was, in the light of what they've been told, wasn't perhaps quite so sanguine if the knowledge which presumably they

were given of the side effects of interferon and ribavirin meant that they were prepared to undergo it. That's a comment. Would you like to comment on it?

A. I understand what you're saying. I think the fact is that their position was very much that right now, in the face of HIV, I haven't got time to worry about this and I'm finding the HIV treatment enough to be -- without adding these other agents to it. In fact, my colleague Dr Mark Wansborough-Jones, who looked after my patients with both conditions, found it very difficult to persuade dually infected patients to add Hep C treatment of its early form of interferon or interferon and ribavirin, because the patients knew about the weight of side effects from those early regimes.

In fact, so that feeling of the comparison between the two was the reason why I think he found it difficult to persuade our patients to receive anti-HCV treatment.

SIR BRIAN LANGSTAFF: So it wasn't a case of being dismissive of the risk, it was a case of this is all just too much all at once.

A. I think so and that they would deal with that risk when the time came.

SIR BRIAN LANGSTAFF: Thank you.

A. I mean, by now, my haemophiliac patients, you know, they were -- how can I put it -- much more directly experienced in all this stuff than I was. I took my lessons from them by this stage. When I introduced the idea of vCJD to these somewhat battered guys, their response was perhaps even more dismissive. But, as you know, some haemophiliacs found the vCJD just like the absolute limit of what they could tolerate, a third experience. But, by now, the person -- I know that my patients understand the whole context in great depth, more depth than I could ever understand.

SIR BRIAN LANGSTAFF: The last question -- series of questions which I have to ask, really arises out of drawing the strands of two or three things that you said together and can I introduce it by taking you back to paragraph 50 of your witness statement. Soumik, that's 4106001 and it's paragraph 50. It's the third page of that, so it's page probably 0021 or 021 would be the number, it is page 24 internally. Thank you. Let's move on. Page 24 internally, page 24.

Here you're talking about the approach, the dismissive approach that some doctors took to the risk of non-A, non-B hepatitis, and you comment that the overt, potentially fatal, acute severity of

hepatitis B was regarded as distinguishing between the two viral illnesses when attention should have been given to the likelihood that they were similar, and you added, having reflected on that in the course of your evidence, in the long-term.

A. Yes, they clearly weren't quite similar in the short-term.

SIR BRIAN LANGSTAFF: You told us earlier that serum hepatitis became known as hepatitis C, non-A, non-B first and then hepatitis C. Is it your understanding that before hepatitis B was identified, it too was seen as part of what was a composite whole known as serum hepatitis?

A. I think my practice in medicine and indeed my time as medical student didn't go back far enough to be aware of any such stage where all the hepatitides were lumped together -- sorry, apart from, I suppose, hepatitis A --

SIR BRIAN LANGSTAFF: Let me put the question a different way. The Inquiry has heard that ever since the War, if not earlier, it was known that blood could transmit hepatitis.

A. Yes.

SIR BRIAN LANGSTAFF: Was it -- again, I'm asking for your understanding, if you can't comment because of your

relative youth compared to some in the field, but was it your understanding that that, let us call it, serum hepatitis, that that was known to have long-term consequences in some cases?

A. I mean, hepatitis B was distinguished from other types of viral hepatitis before I became a medical student. So it would have been involved in a study of, if you like, history, medical history, which I was not able to do.

SIR BRIAN LANGSTAFF: The reason I asked you is because you have described non-A, non-B as not a new disease but rather an old one, well known.

A. I think serum hepatitis has been known of since serum was used as passive immunisation, you know, after Pasteur. So that goes back a long time. I know that some of the -- much of early serotherapy used horse therapy, horse serum and rabbit serum, but nonetheless I imagine that it came from those days, of the use of serum as a passive immunisation treatment. So indeed it was anciently recognised.

SIR BRIAN LANGSTAFF: If ancient --

A. To say that hepatitis B was once only serum hepatitis, if you like, it's not quite true because I think hepatitis B --

SIR BRIAN LANGSTAFF: That isn't what I'm asking. I think

it's very helpful that you should say so.

What I was really asking was -- serum hepatitis as it was identified after Pasteur, was it known to have, in some cases, serious long-term consequences?

A. I'm unaware of that. I know of no reports of that in the medical literature.

SIR BRIAN LANGSTAFF: I won't take that any further. That's all that I have to ask. Thank you very much.

MS RICHARDS: Dr Bevan, is there anything further that you would like to add?

A. Not really, except to say that the heroism, resilience, resourcefulness of my patients and their families and the ability, in haemophilia care, to know individuals from basically their infancy through to adulthood and beyond, has been an enormous privilege, and their responses to these concurrent epidemics should never be forgotten.

I mean, the fact that I eventually managed to get into a position where I could do research meant I did research entirely on post human blood transfusion protocols, including recombinant factors with extended half lives, and indeed drugs which don't involve Factor VIII at all but which otherwise changed the haemostatic balance in the patient to achieve control of haemophilia, and some of those are coming

to fruition now and I'm very glad to see it. So hopefully we have moved on into a new world. But for the patients who were affected and their families it will always be there. My sympathies are with them entirely.

MS RICHARDS: Thank you, Dr Bevan.

Sir.

SIR BRIAN LANGSTAFF: I'd just like to thank you hugely for the evidence which you've given. It has been, in ways that you may not appreciate, though I hope you do, really very valuable indeed for us to hear evidence given with such honesty, practical, frank, straightforward and, in particular, you have been very careful not to say what you don't know and to avoid inventing it and told us what you do think in ways that listening, as I do, may well be seen to have at least the conviction of my knowing that you believe what you have had to say. I recognise that you have been shaken a little bit by some of the memories which come back. You have given us an insight into how memory truly works, by finding the colourful episodes in one's past which may colour the rest of our recollection but certainly give rise to a focal point from which true memory can expand and be given. So thank you for all that which, as I say, has been

hugely helpful.

A. Thank you very much in turn. Thank you.

MS RICHARDS: Sir, that's today's evidence and tomorrow we have a presentation on the Manchester Haemophilia Centre, that is to say the reference centre at Manchester Royal Infirmary.

SIR BRIAN LANGSTAFF: So we start at ten o'clock.

MS RICHARDS: We start at 10.00, tomorrow, sir.

SIR BRIAN LANGSTAFF: So ten o'clock tomorrow. Thank you very much.

(4.12 pm)

(Adjourned until 10.00 am the following day)

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