Wednesday, 18 November 2020

(10.00 am)

SIR BRIAN LANGSTAFF: Good morning, Dr Mitchell.

THE WITNESS: Good morning.

SIR BRIAN LANGSTAFF: Now, let me explain, before you are given the oath to swear, what our setup is, so that you understand, so that those who are present in the hearing room understand, and those who are watching remotely understand.

You are, as I understand it, at home?

THE WITNESS: Yes, I am.

SIR BRIAN LANGSTAFF: And your legal representative, your solicitor, is watching remotely.

THE WITNESS: Yes.

SIR BRIAN LANGSTAFF: There are two members of the Inquiry staff at your house but not in it.

THE WITNESS: That's true.

SIR BRIAN LANGSTAFF: I think your wife is in the house.

THE WITNESS: She's downstairs, yes.

SIR BRIAN LANGSTAFF: Now, that's your position. What you need to know is that you are talking to a room in which there are four members of the Inquiry legal team, there are four members of the Inquiry staff, and there is a technician whose job it is to make sure that the right documents are displayed at the right

time whenever they become relevant. That's the extent of the number of people in a very large room. You will understand immediately that we're all properly socially distanced.

THE WITNESS: Yes.

SIR BRIAN LANGSTAFF: Although it would have been my preference to have had you here so that you could see us, we could see you, and there would be that sense of immediacy and presence, those who would have been here, had it not been for the virus, if I can call it that, the coronavirus, they are watching remotely. They have you visually available to them, and they have a sound feed. They will at the end of the day and during the day for most a transcript of what you are saying so that there is a permanent record of it. That will be checked at the end of the day so that we know that it's accurate and corresponds to what you actually said.

Those are the arrangements. We take a break normally halfway through the morning for lunch and halfway through the afternoon to enable you to get a break and some refreshment if you want, and for those who are watching to do exactly the same as well as those here. So that's the setup. I'm going to ask you now to take the oath. Mary, one of our members of

staff, will ask you.

VIVIAN ERIC MITCHELL (affirmed)

Questioned by MS RICHARDS

MS RICHARDS: Good morning, Dr Mitchell. Can you see and hear me?

A. Yes, I can.

Q. I'm going to start just by asking you to help us with an overview of your career. Your statement tells us that you undertook your general medical rotation in Sheffield hospitals from 1970 to 1973; is that right?

A. That's correct.

Q. Then between 1973 and 1975 you were working in Wales. Could you just give us an overview of where you worked and what kind of work and training you were undertaking there?

A. I was a registrar for two years. Most of it was at the University Hospital of Wales in Heath Park in the north of Cardiff. Six months of it was the Llandough Hospital which is on the western outskirts of Cardiff in Penarth.

As I come from a medical background as opposed to a pathology one, they put me through the various laboratories, so I did a lot of laboratory haematology; first of all in blood bank, then in coagulation and in the general laboratory and, in

fact, that led to my being on call as an MLSO for six months. They were quite keen on that.

I also did three or four months clinical work with Jack Whittaker concerned with malignant and non-malignant haematological disorders on the ward. I spent about two to three months in coagulation with Professor Bloom.

Q. Can you recall anything in relation to the two to three months you spent with Professor Bloom? Can you recall anything about the approach to treatment or the policies in relation to treatment at that time?

A. Not really, no. I think we were using some concentrate, but I believe we were using some Factor IX concentrate. Even then, some of the -- a lot of the time was spent in the laboratory learning coagulation techniques. It's an area they felt I was lacking in because of my background.

Q. Did you have any involvement in decision-making relating to choices of products or treatment plans for patients?

A. Not at all.

Q. You then moved to the Sheffield Royal Infirmary where you worked from 1975 to 1978 as a senior registrar in haematology.

A. Yes.

Q. I think it was during this time that you undertook your MRCPath exams?
A. Yes. Towards the end of that time, yes.
Q. You had six months at the Northern General Hospital. Briefly what did that entail?
A. General malignant haematology. It's not a haemophilia centre. There are two consultants, and we had in-patients, out-patients, and, as I say, it was general malignant haematology and laboratory work.
Q. Then you had a secondment during that time to the Blood Transfusion Centre in Sheffield. Was that under Dr Wagstaff?
A. Yes, it was. Yes.
Q. What did that entail?
A. We rotated through the various departments in the Blood Transfusion Centre. We did -- there were a lot of exercises. There was a lot of technical work in the MRCPath in those days. You were expected to be quite proficient in blood transfusion coagulation and other laboratory techniques. So one of the senior MLSOs would set up an exercise for me to do in the afternoon. I also did some sessions for them when they were short, going out on to the blood transfusion sessions, and, in those days, there was always a doctor present at those sessions. And I did --

I fielded some of the telephone calls and so on from people asking for blood and blood products.
Q. Do you recall during that secondment any discussions or any training in relation to pool sizes or risks of viral transmission?
A. No. Obviously, we knew about testing for hepatitis B, which had been in place for some years. I don't remember discussion about pool sizes. Obviously, the only product -- I mean, they made fresh frozen plasma and cryoprecipitate there, but plasma for concentrates would be sent off to BPL.
Q. Then the majority of this period, 1975 to 1978, is it right you were working with Professor Preston in Sheffield in the haematology -- in the haemophilia centre?
A. Well, with Professor Preston and Professor Blackburn, of course. Professor Blackburn was actually head of department at that time, yes.
Q. What, if anything, can you recall about the approach to treatment taken by Professor Blackburn and Dr Preston as he would then have been?
A. Most of my time even then was involved with patients with malignant blood disorders. It's what the -- to a large extent what the senior registrars did. I don't think I even attended the haemophilia review

clinics.

The patients with haemophilia were treated on a ward -- well, in a room adjacent to one of the wards where we had adult patients. They were treated I think with -- largely with concentrate. I don't think it was a specific concentrate. I think there were several concentrates in use. I'm sure we used cryoprecipitate as well, but I can't remember how the patients were divided up.
Q. You had some involvement in the Sheffield study which was reported in The Lancet in 1978. I'm just going to put that on screen.

Soumik, it's PRSE0003622. If we zoom in on the right-hand column, please, top half of the page.

We've looked at this already within the Inquiry, Dr Mitchell, on a number of occasions, but we can see it's The Lancet, 16 September, 1978. It's the article entitled "Percutaneous liver biopsy and chronic liver disease in haemophiliacs" and there are a number of names there recorded including Dr Triger, Professor Preston, Professor Blackburn, and we see your name there, VE Mitchell. Your capacity or your role at the time was senior registrar?
A. Yes.
Q. Can you recall what your involvement in the study was?

A. Basically looking after the patients. So I admitted them on a Monday, clerked them in, worked out their dosage according to a protocol that Professor Preston had provided. Dr Triger came and talked to them on the Tuesday, did the liver biopsy -- and he was a considerable expert in hepatology -- and then they were treated for several days and then discharged on the Friday. So it's really looking after the patients whilst they were in hospital.
Q. I'm not going to go through the detail of the article because we've looked at it on a number of occasions, but what you have said in your witness statement is that you understood from this work that, at least in some patients, liver disease was significant and progressive. Is that right?
A. Yes, that's true. I mean, Professor Underwood -- we had meetings with Professor Underwood where he demonstrated the histopathology and some of the -- at that time, some of the pathology, quite persistent hepatitis, for example, was regarded as non-progressive, but there were some patients who showed progressive disease, including I believe two of the mild -- patients with mild haemophilia, yes.
Q. You were also involved, your statement tells us, in an early study of the use of DDAVP in haemophilia. We

don't, I'm afraid, have any specific documentation in relation to that, although you have given us a reference in your statement.

What, if anything, can you recall about that DDAVP study?

A. I think the use of DDAVP in mild haemophilia had been reported possibly the year before or the same year by Professor Mannucci and I think Professor Preston thought it was a good idea to actually establish our own study, that it would work in our hands and to see how successful it was. And, of course, it was important to do -- because it doesn't work in every patient as well as you would like it to, by doing it once you would actually know whether it would work in that patient at future times.

So I think it largely confirmed the findings of Professor Mannucci. But it meant that Professor Preston and Sheffield were using DDAVP at a very early stage. I read a review by Professor Mannucci, and he wrote a lot of those, saying that he thought the take-up of DDAVP to treat haemophilia in the rest of Europe had been very slow. Well, that wasn't true of Sheffield.

Q. You then between 1978 and 1979 were a research fellow at Sheffield university.

A. Yes, that's true.

Q. Then in November 1979, you took up a post as consultant haematologist in Leicester and director of the haemophilia centre.

A. I'm not sure they characterised me as director of the haemophilia centre, but I was made responsible for haemostasis, including haemophilia.

Q. You remained in that post until your retirement in November 2003.

A. Well, I retired in March 2003, but then was asked back for six months.

Q. I just wanted to ask you a little about the facilities in Leicester before you arrived, which we can pick up from an article that I understand you wrote in The Bulletin.

Soumik, it's HCDO0000276_061. No, that's not correct, I think, sorry. HCDO0000276_043. Then if we could go, please, to page 4, I think.

This is an article which I understand to have been written by you, and in the left-hand column you describe the lack of services in Leicestershire in, I think, the early part of the 1970s.

Then if we go down to where it says "no centre", please, Soumik.

If we could see the bottom half of the page, you

say this:

"There weren't haematologists. There was no centre."

Then I think it says:

"The Blood Transfusion Service would not allow even cryoprecipitate to be stored in Leicestershire."

Then you've described patients having to leave Leicestershire to seek treatment elsewhere, or travel long distances to obtain treatment and then how, in 1973, Dr Wood was appointed as the first consultant haematologist. In 1975, he was joined by Dr Hutchinson, and they were able with the support of Professor Blackburn to establish Leicester as a haemophilia centre.

Then you go on to describe how towards the end of 1980, so a year or so into your appointment, a new Haematology Department opened with a purpose-built haemophilia centre. Is that an accurate summary?

A. Yes. That's fair enough, yes.

Q. So by the time you arrived, there were two consultants in post but you, as I understand it, undertook a range of haematology duties, but you took particular responsibility for haemostasis and the care of patients with bleeding disorders?

A. Yes. We were -- I mean, even by the standards of the

day, we were very understaffed from a consultant point of view. There were only three of us, and there were three major hospitals. Most of my work, in fact, was in malignant haematology, laboratory haematology and I was made responsible -- as well as taking referrals from the infirmary, I was made personally responsible for one of these other hospitals, Glenfield Hospital, which if it had been 20 miles away would have had two consultant haematologists, but because it was only four miles away, it was served, if you like, from the LRI.

We're very large from a laboratory point of view, with three departments, three blood banks and over 70 MLSO staff. But we were very short on consultants. So my colleagues had wanted somebody to take over a section and, in fact, first of all, they advertised for a paediatric haematologist, so it was almost fortuitous that I came along to do haemostasis. And it was ten years before we got a fourth consultant, which I think then was expected --

Q. When you arrived, there was no haemophilia nurse but a nurse was appointed in early 1981?

A. Yes.

Q. She was, I think your statement tells us, the first in the Trent region and, your understanding is, one of

the first in the UK to have a specialist nursing role?
A. I don't think there were many in the UK at that time. I think -- I heard Charlie Hay say, I think, that he didn't know about haemophilia nurses until 1987, when he came across them at a haemophilia seminar. So it wasn't all that common then. She was a great boon.
Q. Your statement tells us I think she was involved in matters such as home and school visits, training patients and their parents for home therapy, liaising with the local Haemophilia Society, and then we'll come on at a later stage to her role in relation to HIV and HCV testing.

We're just going to look at an annual return from 1976, so before you arrived, but just to get an idea of numbers of patients being treated at that time. It's HCDO0000063_004, I think, or it might be 83, sorry.

We can see here this is a return from 1976, and we get a sense of the number of patients. Total number of haemophilic patients treated during the year: 20. Total number of Christmas disease patients treated during the year: 4. And then we can see usage of cryoprecipitate. This form doesn't distinguish between hospital and home treatment. And then in terms of concentrates, Armour Factor VIII being used

and Immuno, Kryobulin -- not, apparently, any NHS concentrates in 1976. And then NHS Factor IX concentrates being used for the care of patients with haemophilia B.

So that's 1976. When you arrived in late 1979, what, if anything, can you recall about the approach to treatment at that stage? What did you find?
A. If I could comment on this form a little, the thing that surprises me here, that with 20 patients with haemophilia A, they're only using about 180,000 units, which is a tiny, tiny amount of treatment, and would work out at about 9,000 units per patient per year. So it may be that this isn't a whole year or that the haemophilia -- the treatment of haemophilia had just started, if you like, just got underway.

When I arrived, there had been three intervening years, of course, and home treatment was already established, and I believe all the patients on home treatment were on commercial concentrate. There was NHS Factor VIII concentrate being used in the centre at that time but I don't think there was a great deal of it initially.
Q. You have said in your witness statement that the treatment policy which you adopted in Leicester was explicitly based on the reduction of risk and based on

restricting the use of large donor pool concentrates whenever possible. Can you just elaborate a little upon your thinking, please.
A. I was convinced by the Sheffield work and the Sheffield report that there was a connection between the use of multi-donor factor concentrates and the development of liver disease, and I was further convinced that in some patients this could be progressive and, although there was doubt about the pathogenesis, the way in which the liver disease had occurred, it didn't really seem to matter. Whatever the pathogenesis was, the way to protect patients was to try to reduce, as far as possible, their exposure to multi-donor factor concentrates.

I came up with a policy which seemed to me, rightly or wrongly, to be a reasonable approach at that time.
Q. We'll go through the different elements of the policy in a moment. What you've said in your statement is that you essentially had to formulate your own policy. Was that because of an absence of any kind of national or regional guidance?
A. As far as I'm aware, yes. I wasn't aware of any. I must say, I was, to a large extent, professionally isolated from a haemostasis point of view. You know,

I was a long way away from Sheffield, 70 miles from the reference centre. The reference centre didn't really play much of a role in guiding policy in Leicester, and there was nobody else other than myself and the sister who was really interested in haemostasis and haemophilia care. So I was professionally isolated, I suppose.
Q. Now the elements of your policy, first of all, in relation to patients with mild or moderate haemophilia and von Willebrand's disease, your approach was to use DDAVP and tranexamic acid wherever possible; is that right?
A. Yes. Although in moderate haemophilia it may well not be sufficient.
Q. Did you have any difficulty obtaining sufficient supplies of DDAVP or tranexamic acid?
A. No.
Q. And in relation to DDAVP, did you use it on its own without tranexamic acid or were they always used in combination?
A. I don't remember but I think certainly with a dental extraction or something like that, mucosal bleeding, they would have been used jointly. I'm not sure whether we always used them jointly but I think quite often we did.

Q. Do you recall whether there were any particular or frequent difficulties with the use of DDAVP or was it generally a successful mode of treatment for patients in those categories?

A. I mean, there were precautions you had to take. It could result in fluid retention, for example. There's the tachyphylaxis, so that the response diminishes over time. You have to do a trial to make sure that the -- because the response varied from patient to patient, so if you were aiming at an operative procedure then you would need to do a trial first, to make sure that particular patient responded as hoped. But we used it -- well, we used it fairly often, I think.

Q. Again, for these cohorts of patients, so patients with the mild or moderate haemophilia and von Willebrand's, if you weren't able to use DDAVP, with or without tranexamic acid, your policy was to use cryoprecipitate?

A. Where possible, where feasible. Obviously, if someone was having a major operation with mild haemophilia -- I mean, I think the Inquiry has mentioned the mild haemophiliac from outside of Leicester who required open heart surgery -- then DDAVP, we could use DDAVP to cover his catheterisation but we couldn't use DDAVP

to cover his open heart surgery.

Q. And in relation to that kind of surgery, could you use cryoprecipitate or were you then required to use concentrates?

A. I'd use concentrate.

Q. We will come on to that particular instance at a later stage.

So DDAVP and cryo generally for mild to moderate patients and von Willebrand's and then, with children who had severe haemophilia, your policy was to treat them with cryoprecipitate until such time as they went on to home treatment; is that correct?

A. That's correct.

Q. Do you recall roughly typically at what age a child would start on home treatment or was there --

A. I'm trying to think of that and honestly I can't. I think we may have been later than some other centres, so I think it may have been at round about 10 or something like that.

Q. I think you have said in your statement that the decision as to when to convert to home treatment would depend upon parents' wishes, frequency of bleeds and ease of venous access?

A. Yes, and how well the people, the parents, got on with the training that the sister was giving them.

Q. Did you have any difficulty obtaining sufficient quantities of cryoprecipitate for use in the way in which you have described?

A. No, I don't remember that we did.

Q. Did you experience significant issues with allergic or other reactions to cryoprecipitate?

A. Certainly it was known. I'm sure it may have happened. I don't remember it being a major problem but it's certainly an unwanted effect that is known. I've seen it more often with fresh frozen plasma in fact, but yes, it does happen.

Q. Did the patients who were being treated with cryoprecipitate, whether they were adults with mild or moderate haemophilia or the parents of children being treated with cryoprecipitate, did they have any issues or protest about the fact that they would need to attend hospitals for bleeds to be treated with cryoprecipitate?

A. Not often. I can remember one mother who was very keen for her child to go on to home treatment and who I believe wrote to The Haemophilia Society about it, who then forwarded her letter to me. But she was actually having -- she was a single mother and she was having considerable difficulty with the procedure, with the venapuncture, with her son, and we got her on

to home treatment as quickly as we could.

But by and large, no. I suppose we were lucky, in a way, that -- we're in Leicester, in the middle of the county. Most of our patients were actually from Leicestershire, so nobody was further away than 20 miles and, in fact, most of them, because of the way the population is figured, I mean, you have Leicester with 300,000 and two-thirds of the rest of the population live in villages and towns surrounding Leicester. So most of our patients didn't have to travel far to get to the centre and that probably helped.

Q. Do you recall whether you told your patients that the basis for your approach to their treatment was one of safety and reduction of risk?

A. I'm sure we did. I don't specifically remember saying that to the people receiving cryoprecipitate.

Q. Then, in relation to adults with severe haemophilia, and I'm talking here about haemophilia A for present purposes, your approach, as I understand it from your statement, was as much as possible to treat adult severely affected patients with NHS factor concentrates?

A. Yes.

Q. But as I understand your statement, there were

insufficient supplies of NHS factor concentrates and therefore you also had to use, within the centre, commercial concentrates?

A. Yes.

Q. You obtained cryoprecipitate I think from the Regional Transfusion Centre. The NHS factor concentrates, were they supplied to you directly from BPL?

A. No, I believe they also came from Longley Lane. Yes, from Sheffield.

Q. Do you recall anything about how the system for allocating NHS concentrates worked within the Trent region?

A. I think it was decided by the director, Dr Bill Wagstaff. I certainly spoke to him to try to get our allocation increased and I think he did do so. I mean, obviously there was a tradition that most of this went to Sheffield, but even for their purposes it was insufficient for them to treat the majority of their patients.

Q. And your statement says that you would certainly have used more NHS product if it were available?

A. Absolutely.

Q. So the second element of your policy in relation to the treatment of adults with severe haemophilia A was, if you were using commercial concentrate, to adhere to

one single concentrate as much as possible.

A. As much as possible one batch of one commercial concentrate, yes. That was our policy.

Q. When you arrived, I understand that Koate, which was produced by Cutter, was the commercial concentrate most often used in Leicester and you essentially continued its use; is that right?

A. Well, that's what I remembered. The things you've sent me suggest that there were -- Humanate and possibly others were also in use at -- certainly two or three years before then. So I'm not sure. My memory was I would have continued with whatever intermediate purity product was in use then. But if -- I mean, there are documents which are missing, aren't there? And I don't really know what happened between '76 and '80.

Q. You say in your statement that you would buy as much as possible of a batch from a single commercial supplier, and you say, in this way, patients had been treated for as long as 18 months using 100,000 units or more of the same batch.

How did that reserving batches or batch dedication policy work in practice?

A. Well, we would hope to only have one batch of one product in the hospital, except obviously at the times

when we were changing over. And the sister made up the home treatment packs, which are kept, you know, in the cold room of the blood transfusion laboratory labelled for the patient so that when they arrived she would be able to hand this over to them, to sign it out to them. I suppose that was it, really. We would try just to have one batch of one product so that people couldn't make mistakes out-of-hours.

Q. As far as you can recall, did you experience any difficulties in obtaining sufficient supplies of the one product that you seem to have predominantly used at least, the Koate?

A. I would have said no but I know you have a document which suggests that we had to resort to BPL product at one stage with one patient.

Q. Yes. We'll just look at that for the sake of completeness.

WITN1167004, I think.

So this is an extract from a patient's UKHCDO records and I appreciate you won't have had any access to any other records relating to this individual patient or others, but this shows predominant usage of Cutter's Factor VIII Koate but some usage, in 1980 and '81, of Humanate and, indeed, of Factor VIII in 1981, and also of the BPL, the NHS concentrate, in 1980 and

1984.

So that would suggest, if these records are accurate, that you weren't always able to achieve compliance with your single concentrate policy?

A. I don't think that's quite the case. I think what it means is that -- in my first year, for instance, I think it was fairly frantic and I was predominantly doing malignant haematology and other haematology work, so -- and there was no centre, there was no sister. I think it probably took us a year or so to *(unclear audio)*. Although I had the policy, I think it took us a year or so to fully implement it. But from this it would look like it was implemented with this patient from 1981 onwards.

The thing that more concerns me is the fact that the patient was given BPL Factor VIII in 1984, and I'm not clear of the -- for the reason that that happened. If it had been the end of '84 I would have thought that perhaps we were -- with increased access to NHS Factor VIII, we were using that before the patient switched on to heat-treated commercial concentrate. But unless these are out of order, it seems to be in the first half of 1984 that he was, for some reason, given BPL Factor VIII.

I mean, I think that's the bit that's out of the

policy rather than the early treatments.
Q. Thank you.
To what extent was it part of the approach to treatment at Leicester to give lifestyle advice to patients, to try to avoid bleeds and thus avoid the need for treatment?
A. I think it was standard that we would tell people. We wanted, particularly the boys and young men, to live as normal a life as possible. I mean, they are normal people. But we would obviously have to advise them against contact sports like rugby and so on and -- but it was very important that they did exercise, that they kept their muscles healthy, because that protects the joints. I mean, swimming was the particular sport that we would advocate, so we did try to get them to avoid injury but we also wanted them to live a full and happy life. So we had to be balanced about it.
Q. Then your policy in relation to the treatment of patients with haemophilia B was, is this correct, to use NHS Factor IX concentrates?
A. Yes.
Q. I know there are a couple of instances of usage of commercial Factor IX concentrates but we will come on to that at a later stage.
A. Just one I think.

Q. Generally speaking, it was NHS Factor IX.
A. Yes.
Q. We'll look at the 1983 returns.
So this is HCDO00001550,_02, please, Soumik. And if we go to the second page, please --
A. That page is interesting, because it says "registered at Oxford", "registered at Oxford", I think there are several other mentions of that, and that does show that those patients were travelling to Oxford for their treatment before treatment was available in Leicester. I mean, it will be people at Oxford who have written the "registered at Oxford" on the returns.
Q. Then if we go to the second page so we can see here this is the annual return for 1983. Total number of haemophilia A patients treated during the year: 31. And total number of von Willebrand's patients: 6. Then we can see there is the usage of cryoprecipitate in hospital for the treatment of haemophilia A patients: 388 bags, 27,001 060 units, presumably, is the calculation there. And then NHS factor concentrates being used in hospital: 152,455. And then at home: 57,850. And Cutter, Koate: 128,050 in hospital, 423,870 for home treatment.
And then down the bottom of the page we've got

DDAVP, and then to the right-hand columns we've got von Willebrand's disease, cryoprecipitate.
So this would suggest that certainly by 1983 you were using a sole commercial product, Koate --
A. Yes.
Q. -- in particular for home treatment, with a much smaller amount of NHS concentrates being used for home treatment?
A. I think when I arrived, the majority of patients on home treatment were on commercial concentrate, and I didn't really have the ability to switch them over to NHS with the amount of NHS we were receiving. So that was continued.
Q. Then if we go on to page 4, I think it should be, Soumik, this is the annual return in relation to patients with haemophilia B.
We can see that you treated eight patients with haemophilia B during that year and one carrier of haemophilia B. And the treatment is NHS Factor IX concentrate, used both in hospital and for home treatment. And then "Other Materials ... FFP", fresh frozen plasma, and that's been used for the carrier of haemophilia B for in-patient treatment?
A. Yes.
Q. Then if we go to -- no, I think we will come on to

a later return at a later stage.
In terms of the home treatment programme, were all the patients who were on home treatment patients with either severe haemophilia A or patients with haemophilia B?
A. They were always severe haemophilia A or B, yes.
Q. So no patients with the mild or moderate. And was there any home treatment programme for von Willebrand's patients?
A. No.
Q. How and when, as far as you can recall, did you become aware of the association between the use of factor concentrates and AIDS?
A. I'm not at all sure. 1983/84.
Q. In terms of information that you might have had, what journals did you generally read at that time?
A. I received the BMJ as a member. I subscribed to New England Journal of Medicine. I received the British Journal of Haematology as a member. But I must say that, of course, I had to keep abreast of -- right across the field of haematology, so -- I heard someone, I think it was Mark, say the British Journal of Haematology didn't have much haemophilia in it but an awful lot of haematology. So I was not concentrating on the haemophilia literature alone.

Q. We know that there were publications, for example, in January of 1983, in the New England Journal of Medicine, which talked about the occurrence of AIDS in haemophiliacs in the States. Is it likely that you would have read those at the time?
A. Perfectly possible, yes.
Q. We'll go to one document that you, I think, would have received at the time.
Soumik, it's HCDO0000517_001.
You'll see, Dr Mitchell, this is a letter dated 22 March 1983.
If we go to the second page for a moment, please, Soumik.
We'll see that it's authored by Dr Craske, Dr Rizza and Professor Bloom, and it's been sent out on behalf of the UKHCDO. So if we go back to the first page, it's:
"Dear Director ..."
It's headed "(AIDS)", it refers to discussions in the Hepatitis Working Party and a recent meeting of Reference Centre Directors. And then it invites directors to essentially report any possible cases of AIDS to the authors of the letter.
Do you recall, as a matter of fact, this letter at all?

A. Not as a matter of fact, no, but if it went to all haemophilia directors, I would have received it.
Q. That's certainly our understanding, Dr Mitchell. That was its purpose.
A. Yes.
Q. Just looking at the first paragraph, which refers to discussions in the Hepatitis Working Party and a meeting of the Reference Centre Directors, did you at the time, as a director but not a Reference Centre Director and not a member of the Hepatitis Working Party, did you receive the reports or minutes of those working parties or Reference Centre Director meetings?
A. No.
Q. Then if we go, please, Soumik, to HCDO0000517_002.
This is a report from Dr Craske dated 1 March 1983 which we understand may have accompanied this letter. Again, I'm not sure whether -- have you got any actual recollection of seeing this report at the time?
A. No, but I'd seen similar things, I think, about Kaposi's sarcoma and Pneumocystis carinii, yes, so I may well have had ...
Q. Then if we go to page 3, we can see, at the bottom half of the page, under the heading "Aetiology", there's a discussion by Dr Craske of various theories.

He refers to the possibility of drugs such as amyl nitrate and then discounts that. He refers to cytomegalovirus and then discounts that as seeming unlikely.
And then we go over the page to his point 3. He refers to the likelihood of an infectious agent with a similar epidemiology to that of hepatitis B. And then he goes on to say:
"If (3) is the most likely cause, then it is possible that such an agent might be present in the plasma pools ..."
If we go to the last page, please -- I'm sorry, the page before that, my apologies, Soumik -- we can see the last paragraph says:
"It is thought likely that batches of factor VIII concentrate which might contain the AIDS agent came into use since January 1st 1980 in the USA."
And then goes on to talk about the setting up of a reporting system reporting cases of AIDS.
And then just to complete the picture, there's one further document.
Soumik, its HCDO0000273_078.
This is headed "Acquired Immune Sufficiency Syndrome Survey", "Spectrum of Disease Presentation in

the Acquired Immune Deficiency Syndrome (AIDS)", and it says:
"Please complete and return to Miss RJD Spooner at Oxford Haemophilia Centre a report form AIDS/3 for all patients with blood coagulation defects seen by your Centre who fulfil any of the following criteria."
Then on that page and over the page there's a list of symptoms and signs and abnormalities to look out for. I won't go through the detail of it with you, Dr Mitchell, but is it fair to assume that by March of 1983 you would have had at least the knowledge that's set out in these documents?
A. Yes, I think so, although many of the clinical conditions there are very rare. As I understood it, the presentation was more likely to be candidiasis or pneumocystis pneumonia, but, yes, I presume I received these documents.
Q. Now did you, as far as you can recall, provide your patients with any information at this time, spring of 1983 onwards, about possible risks of AIDS from use of factor concentrates?
A. I think both I and the sister will have talked to the patients about this. I think many of them were already aware because of reports in the media that there was this association.

Q. So you think you would have done. Can you remember, and I appreciate I'm asking you about matters of many years ago, but can you remember as a matter of fact whether it became your routine practice to do so or whether it was only if it was raised by a patient?
A. No, I can't, no.
Q. Now, as I understand your statement, your approach to treatment of patients didn't alter because the policy, you say in your statement, that you had in place to try to reduce the risk of liver disease was equally applicable to HIV and was, therefore, continued?
A. I mean, both were my idea how to try and reduce transmission of an agent, whether that was a virus or not. I mean, the argument about pathogenesis is largely irrelevant, really. If the harm is being done by the concentrates, then you try to reduce exposure to concentrates. And I suppose I felt that it was very important to carry on treating patients but I would do all I could to try to reduce the exposure of the patient.
Q. Can you recall whether you gave any active consideration at the time to the suspension of home treatment, for example, on a temporary basis?
A. And substituting what?
Q. And patients coming into the hospital to be treated

with cryoprecipitate.
A. Yes. I don't think I gave it active consideration. I mean, one of the problems was that many of the patients in Leicester had received inadequate treatment. There was a more severe -- many of them had more severe joint problems than I was familiar with seeing in Sheffield. Some of them almost resembled a situation I saw in Karachi and Lahore many years later. So there were many patients who had very severe haemophilia arthropathy, and the idea of returning them to inadequate treatment, or what I felt was inadequate treatment, would not have appealed to me.

You could compare that with the situation in the early 1990s when I had lads with severe haemophilia who were competing with local swimming clubs, and one of whom was working weekends as a lifeguard. I mean, these were muscled young men, you know, with -- who were fit and healthy and living normal lives. I think returning to inadequate treatment would have -- would not have been something I would seriously have considered.
Q. Do you recall whether you gave any consideration to perhaps using porcine product, Hyate:C, for some patients or some bleeds other than for the use of

inhibitors?
A. I did use it for inhibitors. I do not remember considering it for the treatment of people of -- haemophilia A patients without that. It did have some disadvantages, and I understand that many patients became resistant to it with continued use.
Q. We've heard some evidence from -- in relation to some centres that possibly in 1984 an approach was taken to defer non-urgent surgery because of the risk of AIDS. Do you recall whether that was something that was considered locally in Leicester?
A. I don't think we did any surgery at that time. I think we were trying to do that, yes.
Q. Now, there came a point in time, I understand from your statement, probably in early 1985 when patients were transferred to heat-treated product. And we'll just look at a couple of documents in relation to that.

Soumik, could we have, first of all, CBLA0002067.

We can see that this is a letter from you to Dr Snape at BPL. It's dated 25 February 1985, and it is in relation to obtaining supplies of heated Factor VIII concentrate for some patients who were regular users of NHS product. You then go on to say:

"We have several children who at present only receive cryoprecipitate but are in the severely affected category and might be expected to go on to home treatment in the next year or so."

You then tell us:

"There are 39 patients with mild to moderate severity haemophilia who might require treatment with Factor VIII concentrate in certain circumstances, and another patient with severe von Willebrand's who might be a potential user of NHS factor heat-treated concentrates."

And then if we look at the handwritten PS, it says:

"I have not included our severely affected adults at present receiving commercial heat-treated product."

So it would appear that, certainly by 25 February 1985, you were receiving commercial heat-treated product. I think you, again, were using the Koate heat-treated product --
A. That's true, yes.
Q. -- for severe haemophiliacs who were already being treated with commercial concentrates; is that right?
A. Yes.
Q. Then for the cohort described in the first paragraph

of this statement -- so patients who had been treated with NHS product, and you were trying to get the heat-treated NHS product -- at this point in time, were they still receiving treatment with unheated NHS product, as far as you recall?

A. Yes.

Q. Do you know how long it took for you to receive sufficient supplies of heated NHS concentrate to be able to treat this group of patients with it?

A. I can't remember exactly when we started to receive NHS heat-treated concentrate. I should think it was that summer.

Q. Then if we look at one further document. It's CGRA0000559, please, Soumik. If we go to the second page.

I should say, I don't think we have a date for this, but it appears to be an internal Cutter document, in any event. It's giving details about Koate and Koate HT sales, so the heat-treated Koate. If we just look at the bottom half of the page, "Koate returned material". It says this:

"The December figures show returned Koate from only the two centres, but the following centres have subsequently returned or are in the process of returning material."

And then we can see Leicester is there identified. And then underneath that table, it says:

"All the centres which returned Koate in December and those subsequently have replaced with Koate HT."

So it looks from this as though, in early 1985, you were seeking to return your unheated Koate to Cutters and to receive heat-treated Koate in return. Does that accord with your recollection?

A. I don't remember it specifically, but certainly it looks as if that's what we and many other centres were doing, and it makes sense, I think.

Q. Do you recall whether you took any steps in relation to your patients who were on home treatment and who might have supplies of Koate -- unheated Koate at home?

Did you take any steps to ask them to bring that in so that they could have it exchanged for heat-treated product?

A. I don't remember whether the sister did that, but we certainly seemed to be returning quite a large amount of product compared with some of the other centres there, so it may well be that we did take back material from the home treaters.

Q. Then in relation to obtaining heat-treated products,

your statement suggests that you had to get permission to increase the centre's spending, but it was given, and the delay was not major.

A. That's my understanding. It was ordered by Mr Godfrey. He was the chief pharmacist. They called him the unit pharmacist because the LRI was just one unit in the Trust. He was always very helpful. But in the case of a major and continuing expenditure like this, he would have to pass it upwards, and sometimes I got involved in discussions with the Medical Director and the Chief Executive too.

This became an increasing problem later on, but I don't think on this occasion we had a great delay. It wasn't something the unit pharmacist could do on his own.

Q. Then in relation to Factor IX concentrate for your haemophilia B patients, your statement says that the NHS Factor IX became available, I think you suggest, from the autumn of 1985. Prior to that, you used non-heat-treated NHS Factor IX in preference to commercial products because you didn't consider the commercial products to be safer. Is that correct?

A. I wasn't convinced of the safety of the first lot of commercial heat-treated concentrate. I was a great believer in the British voluntary donor system. And

also the viricidal methods to be used by BPL were much stronger; much more, I thought, likely to be effective. And I also wasn't keen to change all my patients on to intermediate purity heat-treated products and then move them back on to NHS products a few months later because I was always trying not to expose people to large donor pools. So those were, I think -- that was my thinking.

Q. Then could we have on screen, please, Soumik, BAYP0000007_045, please.

This is an internal Cutter memo dated 4 July 1985. We'll just go to the second page, please, Soumik.

Under the heading "Leicester", it says this:

"The problems we encountered at Leicester during the last three months are almost over. These problems were lack of stock and not being able to reserve batches for them and pressure on Dr Mitchell to use Profilate HT on six virgin haemophiliacs. Our supplies to Leicester are back to normal. We are now able to reserve small batches for their patients. And despite all pressure from Barry Barber or Dr Mitchell, four out of the six virgin haemophiliacs are now using Koate HT. The other two patients continue to use cryoprecipitate."

What, if anything, can you recall about the events that seem to be described here?

A. I don't know whether this is correct. I'm not sure that -- I'm not sure that we had six patients -- we transferred six virgin haemophiliacs, as he calls them. They won't have been virgin haemophiliacs at all; they would have been patients who had been treated for many years with cryoprecipitate, so they weren't previously untreated patients. And I don't know whether we transferred four of those to Koate HT.

It may have been that we discussed it with the parents and said, "Do you want to wait until the BPL product (which I would have preferred as a product if it had been available), or do you want to transfer over to commercial HT?" So I can't say whether this is correct or not.

I don't think everything that's -- well, certainly, as I've shown later, not everything in these internal memos was correct.

Q. I think your statement, looking at this, suggests that it might mean that you had six patients to transfer from cryoprecipitate to heat-treated concentrate and that you might have been keeping them on cryoprecipitate longer to wait for the heat-treated Koate to become available. Is that a possibility?

A. That is a possibility, yes. I think I did certainly suggest that we did that, but whether we put them on to Koate HT or NHS product, I'm not sure. Certainly, our NHS usage increased considerably.

Q. Then we'll just look at the return for 1986, to complete the picture in terms of product usage.

Soumik, it's HCDO0000333_002.

So we can see this is the annual return for 1986. 38 haemophilia A patients treated in 1986; 7 von Willebrand's disease patients treated in 1986. We can see there that for the haemophilia A patients still using cryoprecipitate in hospital -- there is then an increase in the amount of NHS concentrate being used, so 271,000-odd in hospital; 240,000-odd units for home treatment. And then there is only one commercial concentrate identified, that's Koate; 174,570 hospital, and then 472,710 home treatment. Then we can see towards the bottom of the page you are using the porcine product. That would be, as you have earlier referred, for a patient or patients with the inhibitors?

A. Yes.

Q. Then DDAVP tranexamic acid. Then there's a reference to topical thrombin, I think. What was that for?

A. Sometimes in babies and toddlers, toddlers

particularly, they fall. Their newly-emerging teeth go into their lips, and they get a continuous ooze if they have severe haemophilia. At that time, it was sometimes -- people used to soak gauze swab in topical thrombin and just gently compress that against the lip, and it would mean that that mucosal bleed would stop without the need for any intravenous treatment. It's always good for small children to come to hospital without having somebody stick a needle in them. It made it less stressful and perhaps less reluctant to come again on a different occasion.

We didn't use it very much, but it did have a place. Later on, it was stopped.

Q. Then if we go to the fourth page, please, of this document, we can see this is the 1986 return for haemophilia B. Seven patients treated in 1986. And we can see there the usage is predominantly NHS Factor IX concentrate, both in hospital and at home. There is the reference to the use of commercial Factor IX, and we will come on to that later for the patient to whom that related. And then tranexamic acid is also referred to for haemophilia B patients.

By this time, 1986, is it correct to understand that all the concentrates, whether it's NHS Factor VIII, NHS Factor IX, or the commercial

concentrates would have been heat-treated concentrates?

A. Yes, yes, indeed. Sorry, I think when you're looking at cryoprecipitate and FFP, what this doesn't give you is the number of patients who were treated with it. In my BMJ letter, for example, I think I say that -- patients treated with cryoprecipitate, 28, or fresh frozen plasma, 3. So although the number of bags is few, because these are patients who required infrequent treatment, the number of patients treated with cryoprecipitate or FFP was actually -- well, 31 out of 76. So almost -- well, something like 40 per cent of the patients were receiving single donor treatment.

Q. Dr Mitchell, we're going to come on to the BMJ article next, in fact, but what I was going to suggest -- because we haven't looked at it in a hearing before, what I was going to suggest is we take a break now.

Sir, if that's convenient to you. It is 11.10.

SIR BRIAN LANGSTAFF: Yes, it is.

MS RICHARDS: And then we will look at the BMJ letter in full, as we have not previously looked at it.

SIR BRIAN LANGSTAFF: As I mentioned at the outset, we take a break in the morning. It will be half-an-hour long, so we will come back at 20 to 12.

MS RICHARDS: Sir, could you give Dr Mitchell the usual warning?

SIR BRIAN LANGSTAFF: Yes, I will.

There is only your wife to talk to at home but you mustn't talk to her or, for that matter, to anyone about the evidence you've given or you think you may yet be asked to give. You can talk about anything else you like but not about your evidence. That applies at any break.

A. Yes.

SIR BRIAN LANGSTAFF: Thank you very much. See you at 11.40.

(11.12 am)

(A short break)

(11.40 am)

MS RICHARDS: Dr Mitchell, we're going to look at the BMJ letter that you were referring to before the break.

Soumik, it's PRSE0001555. If we could zoom in on it, it's the middle column.

Dr Mitchell, I'm actually going to read it aloud because I think, for those who are following the Inquiry, it's not necessarily going to be easy to read the letter and, as I said, we haven't looked at it in hearings before.

So it's a letter from you published in the

British Medical Journal, 20 July 1985, and it's in response to a letter from Professor Bloom, and it says this:

"Professor Bloom and his co-authors state that cryoprecipitate should no longer be used. This recommendation by the Reference Centre Directors will have a major and, we believe, unfortunate effect on treatment policy in many haemophilia centres. One implication is that patients with von Willebrand's disease and haemophilia A of mild or moderate severity will have to be treated with large donor pool Factor VIII concentrates, albeit heat-treated, when desmopressin is not appropriate. Initially, because of concern about chronic liver disease in haemophiliacs and more recently with HTLV-III also in mind, we have for the past five years tried to restrict the exposure of our patients to large donor pool concentrates. Cryoprecipitate has played a major part in this policy, being used in the treatment of patients with von Willebrand's disease and those with mild to moderate haemophilia. Children with severe haemophilia are also treated with cryoprecipitate until they go on to home treatment.

Even so, we used 1 million units of Factor VIII concentrate in 1984; 60 per cent in the form of

commercial concentrate. This exposure is limited by buying as much as possible of a batch from a single commercial supplier. In this way, patients have been treated for as long as 18 months using 100,000 units or more of the same batch."

Then could we have the rest of that column, please, Soumik. Thank you.

"This policy has resulted in a low prevalence of HTLV-III antibody in our patients. We recently tested 76 patients, including 27 children, who have received blood products at the centre during the past five years. Seven of the 28 who had received commercial concentrate were HTLV-III antibody positive; 25 per cent. There were no positive results from patients treated with NHS Factor VIII concentrate only (5), NHS Factor IX concentrate (12), cryoprecipitate (28) or fresh frozen plasma (3). The 7 positive patients all have severe haemophilia A and constitute 37 per cent (7 of 19) of this most at risk group. All are adults aged 23 to 54 years. None have clinical features of HTLV-III infection.

"All patients with mild or moderate haemophilia A, Christmas disease, von Willebrand's disease and factor X deficiency were HTLV-III antibody negative. Three severe adult haemophiliac patients

were positive for HTLV-III antibody on transfer to the centre in recent months, bringing the total number of our positive patients to 10.

"Recurrent treatment with blood products is hazardous. Apart from the danger of HTLV-III infection, the severity and progressive nature of chronic liver disease in haemophilia has recently been re-emphasised. Cirrhosis of the liver has been reported in mildly affected, infrequently transfused haemophiliacs and in children. Although the pathogenesis of chronic liver disease in haemophilia is not completely understood, it is undoubtedly related to treatment with large donor pool concentrates, all of which contain non-A, non-B hepatitis viruses. We would agree that only heat-treated concentrate should be used, since this may protect the recipients from HTLV-III infection, but heat treatment has not so far been shown to eradicate hepatitis viruses.

"The best approach seems to us to be a treatment policy which is designing to reduce as much as possible all the risks associated with blood products and which is tailored to the needs of each individual patient. HTLV-III antibody testing of all blood donations is expected to start in September 1985

(W Wagstaff, personal communication). During the intervening two to three months, we believe it is preferable to continue using cryoprecipitate, rather than treat patients with large donor pool concentrates which otherwise they might never need receive.

"Adoption of the proposal by Shore et al that cryoprecipitate should be prepared only from the plasma of female donors would decrease the risks of HTLV-III infection during the interim. This policy could be extended to fresh frozen plasma and platelet rich plasma, and plasma from male donors could be used for preparing NHS heat-treated Factor VIII and IX concentrate. Desmopressin and antifibrinolytic therapy should be used when possible to avoid treatment with blood products."

So that was the letter you sent, Dr Mitchell, to the BMJ in July 1985 and, obviously, it sets out the policy which you have been describing to us.

Can we just look again at the figures. You explained in that letter that there were 7 patients who were infected with HIV. That was the information you had at the time. And those were 7 out of 28 who had received commercial products, and they were all patients with severe haemophilia A.

A. Yes.

Q. None of the patients who had received any NHS Factor VIII seroconverted to HIV?

A. No. Can I point out, perhaps, that the way we've divided it up there, it's the patients -- the 28 who received commercial concentrate are patients who received commercial concentrate at any time. So that may well include some patients with mild or moderate haemophilia who were treated before my policy came into effect.

The patients with NHS Factor VIII concentrate, that small group, have only ever received Factor VIII concentrate. So the two groups are slightly different in that respect; one group is more all-embracing. So some of those 28, at the time of this letter, may actually have been transferred over on to NHS concentrate, but they had a history of having had commercial concentrate.

Q. Your witness statement tells us that in fact there were eight patients at the centre who were infected with HIV in consequence of their treatment there. So there was an eighth patient who was not referred to in the BMJ letter because that test result came in at a later stage in 1985?

A. Yes, that's true.

Q. But all 8 were severe haemophiliacs. None mild or

moderate, none with von Willebrand, none with haemophilia B, and no children?

A. Yes, that's right.

Q. There is a reference in one of the internal Cutter documents that we've got which refers to a 17-year-old testing positive for HTLV-III in 1985. Do you know whether that's the eighth case or not? I don't want you to say anything that would identify any individual.

A. He was actually 18, but yes.

Q. Do you recall whether that eighth patient was a patient who had received only commercial concentrates?

A. I don't recall that, no. He certainly had received commercial concentrate.

Q. That figure of 8 does not, as I think your letter to the BMJ makes clear, include some adult patients who transferred to Leicester but were already infected with HIV and had already been tested and diagnosed with HIV?

A. Yes. The letter's about the Leicester cohort, if you like. So I didn't include -- we were a growing centre. Having started off from nothing at all, we were a growing centre, and we were getting people joining us, some of whom lived nearby, in fact.

Q. Your statement explains that work was not undertaken to establish precisely when patients seroconverted.

Do I correctly understand you did not have a bank of stored samples to test?

A. We did not store samples, no.

Q. Your statement also says that one partner of a patient tested positive for HIV.

A. Yes.

Q. Can I just ask you a little more about the process for testing patients for HTLV-III.

Can you recall approximately when that process was undertaken and what the arrangements were?

A. We had a letter from the UKHCDO saying that testing was available. I approached our consultant virologist, Dr Flower, who is on this letter, and she said, "I can do that for you." Only she chose to do it -- rather than do it through Dr Tedder, she sent it to the virus reference laboratory. She wanted to send it as a cohort and, therefore, the sister contacted the patients. They came up with a time convenient to them. She explained what was happening and what she was doing, took the sample, and they were sent off as a block.

Q. Then do you have any recollection as to how long it took for the results to come back?

A. Longer than I would have liked, but I think it must have been two or three months, something like that, before Dr Flower approached me with the results.
Q. What were then the arrangements for informing patients of their test results?
A. They were all seen personally by me, often with the haemophilia sister present.
Q. What information, as far as you can recall, did you provide to patients at that time. So in 1985 when you are telling them that they are HTLV-III positive, what else did you tell them?
A. It's very difficult because it was very uncertain at the time. It wasn't even certain that the positive antibody test meant continuing infection, although I think most of us feared that it did. So I would have told them that they were positive, they'd been exposed to this virus, that it wasn't inevitable that they would develop AIDS, because that's what we understood at the time, and that we would carefully monitor their progress in the future. I don't know whether I gave general advice at that time because we didn't know an awful lot about the virus or its natural history.
Q. Was advice given in relation to sexual transmission?
A. It certainly was. I can't remember whether it was at

the same meeting or a subsequent meeting, but it certainly -- gave them advice generally about sexual transmission and also about making sure that they cleared up any blood with domestic bleach and covered grazes and so on. We gave them general advice on how to look after themselves and others.
Q. What, if any, arrangements were made to offer tests for family members?
A. I said in the statement that I didn't think we'd done this, but I've been thinking about it, and we must have done because I do remember meeting the person who was affected, and that can only have happened if, in fact, we did offer testing to relatives and sexual partners. So we must have done that, and my statement I think is in error.
Q. One of the regrets you've expressed in the statement was the absence of any form of psychological support or formal counselling for patients.

What, if anything, was available in terms of such support?
A. Very little. The hospital itself didn't have a clinical psychologist at that time. We had a social worker for a time. She was a paediatric social worker, but she was willing to see adults, but she was then withdrawn. I can't remember if she was there at

the particular time we're talking about, '84/'85. Most of the counselling was done either by myself or, in large part, by the haemophilia sister.
Q. What were the arrangements that were made for the ongoing monitoring of this cohort of patients who were HTLV-III positive and, in due course, for their treatment?
A. We saw them regularly -- I think something like every three months. Although, of course, they could always come to us if they did become unwell. We were able to monitor their T4:T8 ratios. They were all in good health at that time.

When treatment became available, I think that one or two of them may have received AZT from -- whilst they were in the centre, but after that when treatment became more advanced and more complicated and really outside my level of expertise, we referred them to Professor Karl Nicholson and Dr Martin Wiselka, the infectious diseases consultants who were looking after HIV patients from other sources as well.
Q. Was that an automatic referral, or did patients have to request it?
A. No, they didn't request it. We offered it.
Q. In terms of the arrangements for testing -- before I ask you about the arrangements for testing for HCV,

can I just ask you about information provided to patients about non-A, non-B hepatitis.

I have asked you earlier about what information you thought you might have provided to patients about the risks of AIDS. What, if anything, can you recall telling patients in the 1980s, prior to any test for hepatitis C being available, about the risks of non-A, non-B hepatitis or the risks of liver disease?
A. We would talk to patients about their liver function tests. They would know that they were having these blood tests, that they were being done on a regular basis. And we would talk to them, and we would say that -- talk to them that there is a possibility of viral transmission, and there is evidence that -- I think rather than saying non-A, non-B, I've never found that patients really like to have their condition described to them in such -- it was the same with non-Hodgkins lymphoma which I was dealing with in my other role. It's not an easy thing for patients to have.

So, I would say that there was evidence that there was inflammation of the liver, that we didn't know how severe that was, and that we were monitoring the situation. We had little to offer, and we would give them advice about alcohol and so on.

Q. I'm just going to ask you to look at a couple of documents.

Soumik, could we have WITN1167005, please.

So we can see here, this is -- again, it's an extract from some UKHCDO records, and it identifies chronic non-A, non-B hepatitis in 1982 and identifies, in fact, particular products and batches.

Then if we could go please, Soumik, to WITN1167006.

This is "Hepatitis Survey" -- this happens to be for the same patient as the document we've previously looked at, but I'm not asking you about the individual patient, Dr Mitchell.

We can see "Hepatitis Survey". It's a form to be completed and sent to Miss Spooner at the Oxford Haemophilia Centre immediately a patient is suspected on clinical or laboratory grounds of having contracted hepatitis. Then we can see it identifies a type of therapeutic material received during the six months prior to development of hepatitis Koate or Factor VIII. Then there are details of the symptoms and signs there set out, which include jaundice, discoloured urine, et cetera and, if we just go to the bottom of the page, we can see the date, 1982.

Were these forms forms that you were

routinely -- you or the sister routinely filling out in relation to patients and sending off to Oxford?

A. I presume so. I presume so. Yes. I don't remember the forms particularly. They were obviously for patients who'd had clinical hepatitis. And clinical hepatitis was, in fact -- with non-A, non-B or with hepatitis C was, in fact, rare. Most patients were asymptomatic, but this patient obviously was not.

Q. Do you recall whether you told your patients that you were proposing to send information about them on a named basis to Oxford as part of the Oxford return process?

A. I think the patients were aware of the Oxford returns. I don't think we specifically asked individually for permission, for consent, but they were aware of them. And, in fact, I think in her article in the bulletin, Sister [redacted] actually refers to the Oxford returns, so I think it was widely known about.

MS RICHARDS: Could we just stop the live transmission for a moment.

SIR BRIAN LANGSTAFF: Yes, certainly.

MS RICHARDS: We will remove from the transcript the name.

SIR BRIAN LANGSTAFF: Yes.

A. Sorry. *(Pause)*

MS RICHARDS: So I've just been asking you more generally,

Dr Mitchell, about the process for submitting information to Oxford. We know from other centre records that, at least in early part of the 1980s, data was sent, including patient names, to Oxford, and I was simply asking you what knowledge you think your patients had of that process.

A. Yes.

Q. Your answer, I think, was you thought patients were aware of it, but you don't recall specifically raising it or asking for consent?

A. No.

Q. In terms of the process of testing for hepatitis C, can you recall what arrangements were made for the testing of patients with hepatitis C?

A. I think they were very similar if not identical to those that we use in testing patients for HTLV-III antibody. The sister contacted them, invited them to attend for the blood test, saw them, told what the test was all about, sent the test off, and then I saw the patients individually to give them their results and to discuss the significance.

Q. Can you recall -- this would have been, I think, the early 1990s --

A. Yes.

Q. -- what information were you able to provide to

patients, did you provide to patients, about hepatitis C at that time?

A. It was somewhat similar in that, again, the complete significance of the antibody results was not known, and there were even suggestions that this just showed exposure rather than continuing infection. But on the assumption that there was continuing infection, we would give them general advice. They had already been advised, I think, to moderate alcohol. We might have reinforced that, and we would have talked about how they could keep others safe by -- and we would probably have mentioned the possibility of sexual transmission, although that was much less of a problem, as it turned out, than with HIV.

And we would then say that we would review and keep an eye on them.

Q. What were the arrangements for reviewing patients who had tested positive for hepatitis C?

A. I think initially they were reviewed in the haemophilia centre, and of course they continued to attend haemophilia review clinics. But I think as treatment became available, I think one or two patients were treated in the centre by us. But then, again, as things became -- more expertise was obtained, we transferred -- or, we transferred that

part of their case to Professor Karl Nicholson and Dr Martin Wiselka. We did do a joint hepatitis clinic, so we saw the patients together.

Q. Your statement recalls some difficulty, at least in the early days I think, in obtaining funding for interferon and ribavirin?

A. Yes, that was particularly for the patient with hepatitis B. We had hoped that that might -- he might get rid of the virus but, in fact, it turned out that he became a carrier. And I wanted to give him interferon and ribavirin, and it took a bit of persuading to get the hospital to agree to fund that.

Q. You don't, I understand from your statement, have data as to precisely how many patients tested positive for hepatitis C?

A. Not nowadays, no. No longer.

Q. You have just mentioned there a patient with hepatitis B, and I wonder if we can look at an article in the British Journal of Haematology co-authored by you which considers two cases of hepatitis B.

Soumik, it's IPSN0000156_089.

So this is an article from 1988 in the British Journal of Haematology, "Transmission of hepatitis by dry heat-treated Factor VIII and IX concentrates" and then there are two cases that you describe here of

patients who were infected with hepatitis B following treatment with concentrates. Could you just briefly describe to us the circumstances of each case and the circumstances in which they were infected with hepatitis B?

A. One of them was a patient from elsewhere with mild haemophilia who required major open heart cardiac surgery. He had been treated in the past with cryoprecipitate and non-heat-treated Factor VIII commercial concentrate. He came along to us -- one of our problems was that operations were always carried out in the other hospitals, so the orthopaedic operations were usually at the Glenfield or the General, and the cardiac unit, the cardiothoracic unit, regional cardiothoracic unit, was at Glenfield, which stretched us a bit.

So we obviously gave him a trial of DDAVP and decided that was sufficient to take him through his cardiac catheterisation, but it wasn't sufficient to take him through his major cardiac surgery. I had to approach the virologist, consultant virologist, at that time to get access to hepatitis B vaccine, and he had to be tested to make sure that he wasn't immune because of previous infection. We gave him two doses of the Factor VIII -- sorry, the hepatitis B vaccine,

but the cardiac surgeons then said that they had to operate on him, they couldn't wait for the third injection, the vaccination. I should have said that we covered his catheterisation with DDAVP. Have I said that?

He had his operation, which was covered by heat-treated commercial Factor VIII concentrate. When we came to give him the third injection four months later, because it was -- second injection was one month after the first and then it was another four months after that, he was found actually to be hepatitis surface antigen positive, so -- and it was confirmed on repeat testing.

The Blood Transfusion Service tested the donors of the blood and platelet units he had received during the course of the operation and they were all negative, so there was circumstantial evidence and, I believed, fairly convincing evidence that he had been infected from his commercial concentrate, heat-treated commercial concentrate.

The other patient was a boy with severe Christmas disease. Because the parents were concerned about the risk of HIV, he was moved over on to commercial heat-treated Factor IX concentrate. They didn't want to wait until NHS heat-treated Factor IX

concentrate was available. After 11 months he was found to be positive for hepatitis B.

Q. We looked at the returns earlier for 1986 which showed some use of a commercial Factor IX concentrate, and that was in relation to this particular case?

A. Just this one.

Q. Because the rest of your patients were treated with NHS Factor IX concentrate, unheated and then heated?

A. Yes.

Q. Then, in relation to the response of the pharmaceutical companies to these two cases, I just want to look at a handful of documents with Dr Mitchell.

Could we have, please, Soumik, BAYP0000010_071.

So we can see that this is a letter from you dated 3 April 1987 to Cutter. We don't, I think, need to go through the detail of it, but this was you reporting the first case, the case of the patient who had undergone cardiac surgery and developed hepatitis B, to Cutter.

Then if we look at the response, that's BAYP0000010_105, please, Soumik.

We can see -- this is a response dated 14 May 1987 from GM Akin in Miles Pharmaceuticals, and the response is essentially yours in the last

paragraph, to say:

"In view of the foregoing laboratory studies, with the lack of other hepatitis reports regarding this Lot, and considering the patient's having received blood and platelets, we do not believe Koate HT to be the probable source for his hepatitis B."

So you reported this to the pharmaceutical company but their response was, as set out here, to reject the association with the heat-treated product?

A. Yes.

Q. As I understand your statement and the article that we just looked at, you remained of the view that it was the heat-treated product which transmitted hepatitis B in this case?

A. Yes.

Q. After you published your article, or after it was published, did you have any further response from the pharmaceutical company to the published article?

A. No.

Q. Then in relation to patient 2, if we have BAYP0000008_102, please, we can see here this is a letter from Cutter to you referring to a report of a development of hepatitis in a patient receiving Konyne and asking for further information, which you

submitted.

We'll just look at BAYP0000008_259.

We can see here that you were then requesting further information. You requested information on the follow-up carried out on the batch of Konyne which was reported to have caused hepatitis B positivity in one of the patients. It refers to the parents being keen to have further information.

The outcome of that appears to have been, again, a rejection of there being any connection with the Cutter product. So if we look at BAYP0000008_288, please, we can see this is a letter from Cutter to you, July '86, it says:

"Our representative ... has told [us] that you are still awaiting information on the batch ..."

And there's an apology for the delay in responding, and then it says:

"We can confirm that there have been no other reports of hepatitis related to administration of this batch ... the records confirm that the batch passed all tests ..."

Then there's a reference to the patient having received National Health Service product shortly before the first injection of Konyne heat-treated.

And so that's the response that you received.

Do you have any observations to make on the suggestion that the patient had received NHS product --

A. It was 11 months before he was found to be hepatitis B positive, so I don't -- and he had been tested several times in the interval. So I don't believe for a moment it was due to his NHS product. And there were reports of intermediate purity heat-treated concentrates passing on or causing hepatitis B and hepatitis C. So, no, I remained convinced that it was due to his heat-treated Factor IX.

I thought there was some -- one other thing when they referred to other people having had ... not on this one. One of the other things says something about six other patients, but they certainly weren't Leicester patients.

Q. I'm not sure I've got the reference to that to hand, Dr Mitchell.

A. No.

Q. There is one other document I just wanted to ask you about. It's BAYP0000008_338. It's the bottom half of the page, so the first is reference to a different report in relation to Koate HT and hepatitis, and then this, under the heading, "Konyne HT":

"Apparently Dr Mitchell was satisfied with the information provided as he has not raised the subject

again. I will let you know if there are any further developments but we are not actively following up this case at the moment."

As I understand your statement, you have said that there wasn't a mechanism for resolving the dispute.

A. Not that I'm aware -- with -- I would have raised it with any representative from Cutter I met, and I can't believe -- I don't know who Marie Tatt is but she knows this isn't correct because we published the letter. So she knows that we're not happy that it wasn't their product, otherwise we wouldn't have published the letter.

Q. I wanted to ask you next about some observations in your statement, Dr Mitchell, and to offer you the opportunity to elaborate upon them.

You say in your statement that you believe that heat-treated factor concentrates should have been made available sooner and that concerns about liver disease should have led to much greater efforts to make safer products from the late 1970s, and you express the view that it took the HIV epidemic to motivate governments and plasma fractionators into doing so.

A. That is very much a personal view. I think you were asking me for my personal view and that was my

personal view, that there seemed to be, to a certain degree, hurry and scurry after the realisation about HIV, and a much more laid back view about liver disease. There was controversy. I mean, there were people like Professor Mannucci saying for some years that this liver disease is non-progressive, and I think there were some reports from Manchester and elsewhere, but there are also people like the Sheffield group and others who were emphasising the serious nature of liver disease. And this -- as you have demonstrated in this Inquiry, this wasn't a new thing. This had been going on for years.

I don't think that governments, fractionators and blood transfusion services really took the matter seriously enough. But this is my personal view.

Q. There's one other no doubt personal view I wanted to invite your comment on that you express in an article in the Prescribers' Journal.

Soumik, it is WITN3174004.

This is an article you authored in 1992, it's entitled "Coagulation factor concentrates", and I understand the context for it is the debate over higher purity products and their availability and the possibility of recombinant. Is that correct?

A. It's actually an article that goes to primarily

non-haematologists. It's a Government publication which was sent to everybody licensed to prescribe in the United Kingdom, and the editorial board were clinical pharmacologists and pharmacists. It was they who insisted that there be clear identification of costs, for example. But I was trying to give people perhaps who were not aware of coagulation factor concentrates a basic understanding. That was really the purpose of it.

Q. So we can see, picking it up under the heading "Cryoprecipitate", you refer to the discovery of cryoprecipitate and how for a number of years -- or how that was a major advance in haemophilia care, and:

"For a number of years cryoprecipitate provided a safe and effective treatment for haemophilia A and von Willebrand's disease."

You then go on, under the heading "Intermediate purity products" to talk about the inevitability of viral contamination. So you say:

"But producing batches of concentrate on this scale required the use of pooled plasma from thousands of donations, so that viral contamination was inevitable. By the late 1970s the dangers of hepatitis and chronic liver disease were becoming apparent. Most previously untreated patients who

received the concentrates showed evidence of non-A, non-B hepatitis."

And then the point you just made, Dr Mitchell:

"Attempts to reduce the viral transmission became more urgent after the realisation that HIV could also be transmitted by blood products."

Then if we go over the page, you then talk -- and I am not going to go through the detail of it -- about high purity concentrates and recombinant.

Then I just wanted to go to the last page and invite any further observations you have to make your conclusion. You say this:

"The history of blood product use in haemophilia should convince us that only the safest possible treatment is permissible and that economic factors cannot be the only, or even the most important, consideration."

Then you go on to talk about high purity concentrates and the demand for those products and the demand for recombinant products.

Do you have any further observations to add to the statement that you set out there, Dr Mitchell?

A. I think it's -- I believe it to be true, but also it was perhaps a little bit of a response to the fact that the editorial board had insisted that I talk

about the economic consequences in this article. So although I did that, I wanted to point out that although they are important they are not the most important consideration. So it was, I suppose, a little bit of a rebuff to their response. But, I mean, it was written for non-haematologists. I mean, obviously haematologists could read it but it was meant for a much wider audience than that.

So it was something I believed. And the bit about the relative impurity is really -- it's very similar to what Ted Tuddenham was saying to you, when you talked to him, about the impurity of concentrates. And in cryoprecipitate, for instance, you are giving Factor VIII, which is almost a trace contaminant of the fibrinogen, fibronectin and other proteins that are in that preparation.

There's something else that --

Q. Carry on, Dr Mitchell.

A. Sorry?

Q. I'm sorry, I didn't quite catch that last bit because I spoke over you.

A. I'm sorry, I was just saying, is there anything else you wanted me to elaborate on?

Q. No, not in that particular article, thank you.

A. Thank you.

Q. I wanted to just ask you more broadly about UKHCDO. You described to us already that certainly in the 1980s, early 1980s, when you arrived, you were very much on your own. Do I understand, first of all, in terms of regional influences, were there any regular meetings with the other Trent-based centres or with the Regional Transfusion Centre or the health authorities?

A. No.

Q. In terms of UKHCDO, did you generally attend the annual general meetings?

A. Yes. Yes -- I don't know which was the first I went to. Whether it was 1980 or later than that, I don't know.

Q. You have already told us that you didn't receive the Reference Centre Director minutes or the specific working party reports unless they were sent out specifically to directors. To what extent did the AGM, the annual AGM, or the setup of UKHCDO in the 1980s allow the directors of smaller centres such as yourself to have a voice?

A. Well, I imagine you could do if you were sufficiently determined but I don't think it was actually encouraged. It was very much a series of presentations by Dr Rizza and Dr Craske and others on

what they saw as the issue of the day or brief reports of what the various working parties -- had been done, and these obviously were summaries of -- because these working parties had met on a whole number of occasions through the year. So it was really just keeping the smaller centres up-to-date, I suppose, but in a brief way.

Q. Then if we come forward into the 1990s, still on the topic of UKHCDO, if we could have, please, HCDO0000248_013, please.

So this is now September 1992. It's the minutes of a meeting of centre directors.

And if we go, please, Soumik, to page 5.

We can see that under the heading 7 and the word "Re-Write", there was a discussion about the way in which haemophilia centres should be organised and funded. And if we pick it up in the long paragraph in the second half of the page, there's a reference to the aim of a document, this being a Department of Health produced document:

"... to inform and remind purchasers that haemophilia care is both expensive and unpredictable."

And then it goes on to talk, a few lines down, to definitions of a haemophilia centre and a comprehensive care centre:

"The designation of Centres would not come under the jurisdiction of the Department of Health but would emanate from the peer group."

Then there's a reference to a lively discussion, and you're recorded as querying the figure of 40 plus patients for the designation of a comprehensive care centre. There's then reference to Dr Mayne saying it was:

"... inadvisable to set a lower figure because the figure of 40 severely affected patients would indicate and guarantee that a Centre would have full experience of all the complications of haemophilia care. However she indicated that the figure was not rigid ..."

Then you are recorded as expressing concern about the relationship between a haemophilia centre and a comprehensive care centre, feeling it could result in a loss of funds, and the conversation continues.

Can you recall anything about this issue, this structural issue, and what your concerns were at the time?

A. Yes. This reminds me. This was an initial attempt by the Reference Centre Directors to reorganise their structure and the structure of haemophilia care

generally. And I have no objection to their setting standards or enforcing those standards, but I had -- this was sprung on us, effectively. I'm not accusing Dr Mayne of doing that but the -- many of the people in the audience whom this would affect, and their centres would be affected, were totally unaware of these proposals. I was certainly totally unaware. I wasn't sure whether Leicester would or would not qualify as a comprehensive care centre. In fact, three years later we did, and probably would have done at that time.

But I was a bit concerned, if all the patients in Leicester were registered at Sheffield, as the only reference centre/comprehensive care centre, then that could have major repercussions on Leicester. It could even be that we would lose funding. There would have been some in the hospital authorities who would actually welcome such a move and say: oh, well, they are all Sheffield patients now, do we need another haemophilia sister? In fact, do we need a haemophilia sister at all? Do we need a new haemophilia centre that's been planned for the Osborn Building? Because these are now Sheffield patients.

The other thing is that the representative of the Department of Health says that orthopaedic

operations, for example, would not be available. But we were not just doing orthopaedic operations, we were doing major cardiothoracic surgery on a number of occasions, including total correction of a Fallot's tetralogy in a small child, a baby effectively.

So I didn't feel that this was going to deliver the right result, not just for Leicester but for other places like Nottingham, et cetera. So I queried it. But, I mean, it did evolve. It didn't stay at this point. This was an intermediate stage.

Q. Then moving to a separate topic, Dr Mitchell, could we have NHBT0036651_002.

This is a letter dated July 1995 about the hepatitis C look-back, and it's a letter from you to the Trent Blood Transfusion Service in the Regional Transfusion Centre in Sheffield. It says you have finally been able to locate some funding which you hope will enable you to make progress:

"It will probably take us 2-3 months to trace all 100 patients who received infected donations."

What, if anything, can you recall about your involvement or Leicester's involvement in the hepatitis C look-back exercise?

A. Well, I think if you had asked me a few days ago I would have said I had no involvement in the Blood

Transfusion Service look-back, but my understanding from this letter is that the Blood Transfusion Service had approached us, I'm not sure why it came to me, but they probably spoke to our chief MLSO in blood transfusion and asked him to trace 100 donations which came from patients who had, subsequently, been found to be positive for hepatitis C antibody.

He was running three very busy blood banks in three different hospitals, and this would have involved a lot of work, looking at old ledgers and so on, which he couldn't spare the time or the staff to do. I think, therefore, it was suggested that some of his staff should be paid to do this, weekends or out-of-hours or something like that, and I imagine my job was to persuade the pathology business manager that he should provide this funding.

He would probably have said, "This is a Blood Transfusion Service look-back, why aren't they providing this?" So I was probably, if you like, a go-between. My last sentence I think is a little bit misleading. Although they may have informed us about 100 donations which came from people who subsequently -- came from donors who subsequently tested positive for hepatitis C antibody, that does not translate into 100 patients. So although there

would have been no difficulty at the time because the people reading this letter will only have been interested in the middle sentence, it might be misleading to people who are reading the letter now, analysing it at this stage.

If I looked up the report of the results of the look-back, which is published in Transfusion in September 2002, that shows that there were 9,222 blood components made from donors who were subsequently shown to have antibodies for hepatitis C virus. They were given to only half that number, 4,424 recipients, and of those only 1,351 were traced, and 50 per cent of those, so something like about 675, were found to be infected with hepatitis C virus.

So that's actually only -- if you do that in proportion, that would mean only seven of our -- seven patients in the Trent would be expected to become hepatitis C virus positive, antibody positive, as a result of receiving this 100 donations.

Q. Do you --

A. Many of the -- sorry?

Q. No, carry on.

A. Many of -- part of the reason for this is, of course, that because of the reasons that people get transfused, I think they found that about 50 per cent

of the patients were deceased by the time this look-back was done. And if you think of the reasons -- somebody with a ruptured aortic aneurysm, for example, may receive many, many units of blood, platelets, cryoprecipitate and so on. But, in fact, at that time, the outcome was quite poor, so many of these patients did die of the underlying condition, not of liver disease.

Q. Do you know --

A. I'm not an expert on this, and I'm sure you will be speaking to people who know far more about the blood transfusion look-back than I do.

Q. Do you recall anything more about what happened in Leicester, in terms of the completion of the look-back exercise?

A. My understanding is that anybody who was found to -- who is traced and found to be -- have antibodies to hepatitis C were referred to the same doctors, Dr Karl Nicholson and Dr Martin Wiselka, who were part of a Trent-wide hepatitis C interest group.

Q. Then I wanted to ask you about a further publication of yours concerned now with parvovirus.

Could we please have, Soumik, BPLL0016110_039. If we look a little closer at the bottom left-hand column, go down to the bottom of the page, we can see

there's an article there or a letter, "Symptomatic parvovirus B19 infection and heat-treated Factor IX concentrate". And this is published in The Lancet of May of 1989. You're one of the authors. It says:

"Dry heating of Factor VIII and IX concentrate at 80 degrees centigrade for 72 hours may prevent transmission of non-A, non-B hepatitis and HIV."

But then you refer to a study showing:

"A very low seroconversion rate for B19 virus after first treatment of haemophilic boys with NHS heat-treated Factor VIII concentrate."

And then you say this:

"We've seen 3 patients who had symptomatic B19 infection after infusion of NHS heat-treated Factor IX concentrate. Patients had little previous exposure to blood products. Two had received only heat-treated factor concentrate."

Then you go on to describe symptoms in those 3 patients. And then if we go to the conclusion, so top of the next page -- sorry, top of the right-hand column, please, Soumik, we can see that the conclusion is -- well, penultimate paragraph:

"Transmission of B19 virus by Factor IX concentrate is implicated in these patients by the development of clinical illness and serologically

confirmed B19 infection after infusion of Factor IX concentrate."

And you go on at the end of that paragraph to suggest that:

"B19 virus may be transmitted by heat-treated Factor IX concentrates."

You set out what the B19 virus can cause there and refer to persistent B19 infection documented in children with leukaemia, et cetera:

"Blood-borne viruses [this is the last sentence of the letter] may continue to present an infective hazard to haemophiliacs despite vigorous heat treatment of coagulation factor concentrates."

Can you recall anything about what prompted the sending of this letter and the cases of B19 parvovirus that were observed in your patients?

A. The publication actually was stimulated by the virologists who were very keen to publish this. As I understood it, the evidence was suggestive but not conclusive, because PCR investigations for viruses can remain positive even when the virus is not viable. So the parvovirus could have been in the blood transfusions, been degraded by the virucidal treatment, but you might still get a positive PCR.

Nevertheless, the fact that we had three

patients presenting with clinical features of parvovirus -- I mean, it's a common infection. It commonly occurs in children where it's often called slapped cheek syndrome or fifth disease, and many of us will have had it in the past. But, nevertheless, three of these patients presented with clinical features suggestive -- well, showing this disease, and it was confirmed by doing antibody testing. And it seemed to us that this was highly suggestive that it had been passed on by the NHS Factor IX concentrate.

Q. To what extent was it a wider problem? Were these the only three patients you recall --

A. The only three we ever saw, and we were very alert to viral transmission. We didn't see any other patients.

Q. Then can I ask you more generally about your interactions with pharmaceutical companies during your time as director, particularly in the 1980s, Dr Mitchell. We've seen reference to various Cutter documents in which we can see sales representatives paying you visits.

Did you also receive visits routinely from representatives of other companies trying to persuade you to change products?

A. Yes. Occasionally, yes.

Q. Some evidence has been received by the Tribunal of

there being potentially offers of quite lavish hospitality by pharmaceutical companies. Do you recall anything of that kind being offered to you?

A. Not lavish, no. I was given assistance to attend educational meetings. The first time, I think, was in 1986. So I'd been a consultant for six years by then, and I was given assistance by Cutter to attend the World Federation of Haemophilia meeting in Milan.

I mean, it was actually quite important for me to go to these meetings because I was, effectively, professionally isolated. It certainly wasn't on a lavish scale. I did hear people -- I did hear stories of people getting first-class flights and all that stuff. It never applied to me. I heard Leaky Parapia -- sorry, Professor Parapia, who I was quite friendly with, saying that he knew people had been lavishly treated. Well, I've often found myself in the same hotel as him, so I don't think we were in the lavish treatment group.

MS RICHARDS: Sir, I've pretty much come to the end of my questions for Dr Mitchell, but we need to afford the opportunity for the recognised legal representatives to suggest any further questions. So I wonder whether we could take our lunch now, early, and it may be there are some further questions for you after lunch,

Dr Mitchell, or it may be there are very few.
SIR BRIAN LANGSTAFF: Let me explain, Dr Mitchell. What happens is that those who have been watching remotely who are Core Participants, represented Core Participants, have a right to suggest further questions which they may have for you to Counsel for the Inquiry. And if they have any, or if she herself thinks of any further questions, she will ask those after the lunch break.

So you are nearly finished but not quite. So we will take a break, and we will take it until, shall we say, 1.45. Would that suit?
A. That's fine. Thank you very much.
SIR BRIAN LANGSTAFF: So 1.45. The same rules apply to this break as did last time. Thank you very much so far.
A. Thank you.
SIR BRIAN LANGSTAFF: 1.45.
(12.42 pm)
(Luncheon Adjournment)
(1.45 pm)
MS RICHARDS: Dr Mitchell, I have just a handful of further questions on a range of different topics.

First of all, you told us this morning that, in terms of the process for testing patients for HIV and

HCV, the system at Leicester was to invite patients to come in, to inform them of the tests, and to seek their consent to the testing process. Is that a practice you would have expected to be standard at the time?
A. I don't see why not really.
Q. Thank you. Then you mentioned when I asked you shortly before the lunch break about funding from pharmaceutical companies that you'd had some funding from Cutter to attend educational conferences or an educational conference.

Were there any other sources of funding that were made available to you or those in your position to attend such conferences?
A. You had to apply for study leave, and the hospital might finance the trip. But they had a space on the form saying "Are you receiving funding from any other source?" So if you said there you were getting, you know, hotel and flight from Cutter, they would then just give you study leave only. Study leave without, you know, paying for it. That's what used to happen.
Q. So it was possible, in principle, to get funding from your health authority hospital employer, but if --
A. I think they welcomed funding from elsewhere, in fact.
Q. When you say "welcomed", is that because it would

release NHS funding, scarce NHS resources?
A. No. I think it's probably that the committee -- it was done by a committee. I think they probably had a very limited budget and, therefore, they didn't have to refuse lots of people if there was external funding, which was accepted then.
Q. Do you know whether there were any rules or policies or regulations at the time that limited or regulated the receipt of funding or hospitality or gifts that a clinician could receive from pharmaceutical companies?
A. I'm sure there were, but I don't know details. I'm sorry.
Q. Then going to back to your evidence about your treatment policy, Dr Mitchell, can you recall roughly how long it took you after you arrived at Leicester in late 1979 to develop and implement that policy?
A. I think it probably took a year or a bit more, because in the first year, there was no haemophilia centre, there was no base, there was no sister. We were all very, very busy. We didn't have all that many junior staff either, and it took me a while to find my way around. I wasn't presented with it when I -- I'd never seen those previous documents that you showed me of the returns from 1976. I wasn't given a folder,

and I had to find out who the patients were. So it did take a while, probably a year, 18 months, before it was fully implemented. But the policy of not giving concentrates to people with mild disease, I would have done that straight away.
Q. Once you had formulated for your own purposes that policy, is that something that you shared with any of your fellow directors at other centres?
A. Well, I was professionally isolated. I didn't even know -- Ted Blecher in Nottingham, for instance, was my nearest -- 30 miles away. I didn't even know him at that point.

When I went to my first UKHCDO annual meeting, the only people I knew there were Prof Bloom very, very slightly from having worked with him five years before, and Eric Preston who didn't need any advice from me about hepatitis really. He was the country's expert on hepatitis in haemophilia. So both I and the sister will have talked about it, perhaps with the people next to us or something like that at lunch, but I -- you know. Yes, we didn't keep quiet about it, no.
Q. And then I asked you this morning about the extent to which you were able to adhere to your policy, and we looked at those UKHCDO records that suggested in 1984

a patient receiving NHS Factor VIII.

If you did for any reason change a patient's treatment programme or change product, is that something that you'd discussed with the patients and explained the reasons for the change?

A. Absolutely. Yes, absolutely. We would always hope that we're changing to a better product than the one they'd been receiving, or a safer product.

Q. I think you say in your statement if, with increasing availability, you transferred a patient from commercial to NHS concentrate, you would have explained why you believed it to be safer.

A. Yes.

Q. Then in terms of the shortfall of NHS factor concentrates, you've told us you'd raised that with Dr Wagstaff, the director of the Regional Transfusion Centre in Sheffield. Was there any other person or process with whom it could be raised or through which it could be raised?

A. Not that I'm aware of. As I understand it, and I heard this several times at the annual general meetings of the UKHCDO, the amount of NHS factor concentrate which the Trent received was absolutely proportionate to the amount of plasma which Trent National Blood Transfusion Service sent down to the

fractionators.

So Bill Wagstaff would then have this amount of whatever it was -- 8Y eventually, or before that, NHS Factor VIII concentrate -- to share amongst the five haemophilia centres in the Trent. It was a big region; a population of about 5 million, the same as Scotland, so he would have to decide. I presume traditionally most of it would have gone to Sheffield, although I think Charlie Hay said they only got 40 per cent of what they needed. So it was rationed out. I think Bill Wagstaff was the person who made the decisions.

Q. We may hear evidence in relation to another haemophilia centre of patients being provided with a document or statement which described what product they received so that if they required treatment at another centre, that other centre would know what treatment to give. Was there any such system in operation at Leicester, to your knowledge?

A. No, there wasn't, but the patients knew what they were taking. It would be the first thing we would ask if there was a visiting haemophilia patient: what have you been receiving? And we would always write back to that centre saying what we'd given them and what batches it had come from. What batches of what

material, in other words.

Q. In terms of cryoprecipitate supplies, you've told us already that there were not shortfalls in supply, but I think your statement queries whether it would have been possible for Trent to produce enough cryoprecipitate for everybody if there'd been a switch from concentrates to cryoprecipitate.

Did you ever raise with Dr Wagstaff the possibility of obtaining more cryoprecipitate?

A. No.

Q. Then in terms of the discussions that you have told us you would have had, or that the nursing sister would have had, with patients to talk about risks of HIV or risks in relation to liver abnormalities, would you expect those kinds of discussions to have been recorded by you or by the sister in the patient's medical notes?

A. I can't be certain. They may have been or, they may have been recorded in the letter to the GP. I can't be certain.

Q. Would you --

A. We did a lot more talking than writing.

Q. Then in terms of the absence of counselling and any kind of formal psychological support, did you take any steps to try and obtain such specialist support, and

if so, what was the response to your efforts?

A. I tried to get social worker support. I didn't try and get it -- it was beyond me to get a clinical psychologist for the Leicester Royal Infirmary.

I did try and get social worker support. I was successful. And I then had a letter from the head of the Social Services Department saying they were being reorganised, and it was no longer -- I think they may actually have been moved out from the hospital to the community -- I'm not certain of that -- and it was no longer possible to assign specific social workers to specific tasks, but I was welcome to apply. But, I mean, that's not really what we needed. I think that happened other places as well.

Q. Up until the point of your retirement in 2003, was there ever any psychological support available for patients?

A. They still don't have a clinical psychologist attached to the haemophilia centre. I've looked at their quality report, which is what we would have called an audit report. And they have to -- there are clinical psychologists in the hospital now, obviously. That and counselling has increased enormously over this period of 40 years. But they have to -- even these days, they have to refer the patient to one of the

hospital clinical psychologists, and that can cause a delay of up to three months, apparently. So it's improved but not improved enormously. I know some centres do have their own clinical psychologist, which strikes me as ideal.

Q. Professor Parapia in his evidence provided the Inquiry with a document which was a record, or appeared to be a record of a meeting of something called the haemostasis club.

A. Yes.

Q. Do you have any knowledge of the haemostasis club and what it was?

A. It was -- the one I know about was run by Dr Savidge and was in St Thomas' and was largely very theoretical, not clinically based really at all. I went, I think, once or twice at the most. There was very little clinical stuff -- clinical discussion there at all. It was all about the intricacies of the clotting process. So it was people who were doing PhDs and things in clotting.

Q. And then last question. In relation to UKHCDO annual meetings, were you aware at those meetings or the scientific sessions which accompanied them of the presence of pharmaceutical companies and the sponsorship by pharmaceutical companies?

A. I think what they did is -- I don't think on the one-day meetings that happened. On the two-day meetings, which had a scientific meeting as well, I think there was a sort of display by pharmaceutical companies.

Q. Was there an opportunity for pharmaceutical companies to approach centre directors and try and influence them to purchase their products at the AGM or at the scientific sessions?

A. I suppose if in the lunchtime you went up to their stand, they would talk to you.

MS RICHARDS: Those are the questions I have for you, Dr Mitchell.

Sir, do you have any questions for Dr Mitchell?

Questioned by SIR BRIAN LANGSTAFF

SIR BRIAN LANGSTAFF: Yes, I do.

Dr Mitchell, you said in an article in 1992 that only the safest possible treatment is permissible. As a statement of principle, do I take it you still think that's the right principle to have applied?

A. Yes.

SIR BRIAN LANGSTAFF: Now, can I just ask you one or two questions about how that pans out, in terms of practice?

The risks -- because adopting that principle

must involve being alert to and safeguarding against what is a risk; am I right?

A. Yes.

SIR BRIAN LANGSTAFF: The risks theoretically posed by large pool factor concentrates would come from three main ways, I would suggest, and I want to know if you agree: first, the nature of the donors who make donations to the pool -- that's first -- secondly, the size of the pool and, thirdly, the frequency with which, or the amount with which that is given. The amount, I suppose, is a mixture of the treatment and its frequency during which the large pool concentrate is given. Is that broadly right?

A. I think it probably is, although I would have thought that also the number of batches one was exposed to would have a role as well, and that could vary enormously.

In the -- I noticed in the paper about liver biopsies in children that I've just been -- either I've been sent or read again, I was looking at that and the table, and I notice that the first patient, seven years old, had received 45 batches. Not 45 treatments but 45 batches. Now, that must increase risk, I think, as well as the factors you've mentioned, and that is what I was trying not to do,

but it's all imperfect.

SIR BRIAN LANGSTAFF: Moving on from that, it would be wrong for me to comment on the degree to which it was or wasn't imperfect.

A. I mean, the treatment generally was imperfect. I'm not talking purely about one hospital. I mean, across the board our treatment was imperfect. We did not have the perfect treatment.

SIR BRIAN LANGSTAFF: I suppose that one thing which would contribute to reducing the risk would have been the factor which you also draw attention to in your statement, which is having taken steps earlier than were taken to secure the inactivation of virus by whatever means was available.

A. Yes.

SIR BRIAN LANGSTAFF: One way in which it was suggested, as I understand it, in the very early 1980s was the concept of giving patients small pool concentrates. Did that cross your radar?

A. No, it didn't, and I wasn't aware that this was available or that BPL were making small pool concentrates. It didn't -- well, I wasn't getting that information.

SIR BRIAN LANGSTAFF: So if there had been small pool concentrates available and if you had known about

them, is that something that you might have wanted to use, do you think?

A. Absolutely, yes. Yes, particularly for people that you had to give concentrates to but who hadn't -- like the chap who had an open heart surgery, for example --

SIR BRIAN LANGSTAFF: Well --

A. -- might not need concentrate in the future because he was around 10 per cent or something.

SIR BRIAN LANGSTAFF: One of the aspects of making sure a treatment is as safe as possible is, I suppose, auditing to see -- or "checking" might be a better word -- to see how successful it has been in practice or appears to have been in practice.

You did that, I think, as reflected in your article where you talk about the comparative rate of infection with HTLV-III in Leicester as compared to the average or the mean across the country.

Do you know whether you were broadly successful in reducing the incidence of hepatitis?

A. No, I don't. No, I don't have that information now. I would hope that we had. And certainly one of the things that we will have done is to reduce the number of patients who were doubly infective, because that group seemed to do particularly badly.

Q. So you would like to think, at any rate, that the --

if to the extent that those who were treated at Leicester developed hepatitis, that because they didn't also develop HIV/HTLV-III infection, their hepatitis was less severe and less progressive for them?

A. I would hope so, and that's what I've understood. I mean, also the fact that so many of our patients -- I think it must be about 40 per cent of them if you look at that letter -- were only receiving single donor products, that I would have hoped that the prevalence of hepatitis C in Leicester patients would have been less as well. But I don't have those figures.

SIR BRIAN LANGSTAFF: Now, you are, I think, one of the clinicians who has particularly articulated the policy of the safest treatment permissible to us. Not many, perhaps, have set it out in such clear terms. You felt, I think, a little bit isolated in Leicester, in terms of having contact with fellow directors or fellow haematologists dealing with haemophilia. Did you ever have any reaction from others in the field, such as you had any reaction, to what you were doing and the policies you were applying in Leicester?

A. Only after we published the letter, so, late in the day, and not a lot then either really.

Professor Bloom said it was a good letter and one or two other people expressed a view that it was a difficult policy to carry out because there would be mistakes made out-of-hours and so on.

Perhaps it would have been more difficult for a large centre. On the other hand, large centres had many more staff and it was basically 25 per cent or 20 per cent of me and a single-handed nurse and whatever we could grab of the junior staff. But I don't know the answer to that really.

SIR BRIAN LANGSTAFF: One of the lessons which may -- subject to what is submitted to me at the end of the Inquiry by those who are interested, may be that if other centres generally had adopted the policy which you adopted, there would have been a considerable reduction in the extent of infection, particularly with HIV.

Assuming for the moment that that is so, because other centres may not have adopted the same policy so clearly, what do you think might be the main reasons why they didn't?

A. I don't know. There were -- I mean, I've heard evidence from this Inquiry that many directors believed it was essential to have at least two or more types of concentrate in case there should be

a shortfall in one of them. I think some people did try to be batch-specific but I don't know when they started doing that. I think you have to start doing it very early.

I don't really know why people didn't. I think one -- just as important, or more important, in fact, was to be as careful as you could possibly be that you did not give concentrates unless you had to.

So if you take the example of this mild haemophiliac from elsewhere who had open heart surgery, we could have done his cardiac catheterisation with concentrate, saying, "Well, this chap's going to have a whole pile of concentrate in a couple of months' time, so why not give it to him now?" But on the other hand, what if the cardiac surgeons found him to be unsuitable or he had in fact decided he didn't want the operation? We would then have given him commercial concentrate for no good reason.

So you had to be -- all this, of course, was in another hospital as well, which is a problem for us. But, you know, so you had to be fairly obsessional about not giving concentrate unless you felt it was really necessary.

SIR BRIAN LANGSTAFF: Yes. Well, thank you very much,

doctor.

Ms Richards.

MS RICHARDS: Dr Mitchell, is there anything further that you would like to say?

A. Simply that the accounts I've read by people who have been affected by this have been harrowing and I'm very sorry for that. I do hope that this Inquiry -- well, this long and thorough Inquiry -- will help them and I do believe it will.

MS RICHARDS: Thank you.

Sir.

SIR BRIAN LANGSTAFF: It's my turn to thank you, and it's thanks to you that are particularly due, for giving us such a straightforward account of what happened at Leicester in such a sensible, thorough, considered, clear and helpful way.

It's always an intrusion to come into your home, to ask you questions and you have been prepared to allow us to do that. Can I thank you for that and apologise to your wife for any intrusion that she may feel from your being sequestered in front of a camera for so long during the day.

But I simply wish you well in what remains of your retirement, if you have any retirement?

A. Yes, I do. Thank you very much.

Thank you.

MS RICHARDS: Sir, tomorrow we have Dr Giangrande at 10 o'clock, and I anticipate that we should be able to complete Dr Giangrande's evidence by the end of the day. And we will not, therefore, need to sit on Friday.

SIR BRIAN LANGSTAFF: Very well. Ten o'clock, then, tomorrow. Those of you who might have been expecting to hear the Inquiry on Friday -- it had been announced -- should know that the likelihood is, subject to anything unexpected tomorrow, that we will not be sitting to hear any further evidence on Friday. But it's Dr Giangrande tomorrow.

MS RICHARDS: Yes, sir.

SIR BRIAN LANGSTAFF: Thank you very much.

(2.09 pm)

(Adjourned until 10.00 am the following day)

F:

F:

F:

F: