

1 Thursday, 29 October 2020
 2 (10.00 am)
 3 **SIR BRIAN LANGSTAFF:** Today we welcome Dr Parapia. May he
 4 be sworn, please.
 5 **PROFESSOR LIAKAT PARAPIA (sworn)**
 6 **Questioned by MS SCOTT**
 7 **MS SCOTT:** Professor Parapia, I'm going to start by asking
 8 you some questions about your CV. So you undertook
 9 your medical training in the early 1970s at the Welsh
 10 National School of Medicine; is that right?
 11 **A.** Yes.
 12 **Q.** Can you recall what kind of haematology training you
 13 had?
 14 **A.** Well, Cardiff, the Welsh National School of Medicine
 15 was very, very strong in haematology, very reputable,
 16 some very big names at the time, including
 17 Professor Bloom. Even I was taught by
 18 Professor Tuddenham but in terms of actually content
 19 of the training for the medical school, there was very
 20 little time given for haematology.
 21 **Q.** So you were taught by Professor Tuddenham at
 22 university?
 23 **A.** Well, in the component that he had, yes. So I knew
 24 him from then. But, like I said, in terms of the
 25 curriculum there was very little haematology.

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1 **Q.** Then you graduated in 1974 and you became a House
 2 Officer at the Cardiff and Carmarthen Hospital and the
 3 following year Senior House Officer at Wythenshawe
 4 Hospital in Manchester?
 5 **A.** Yes, that's right, yes.
 6 **Q.** During your time in those two posts, did you treat any
 7 haemophiliacs?
 8 **A.** None whatsoever.
 9 **Q.** Then you took up a role as a Senior House Officer in
 10 pathology at the Wythenshawe Hospital. What did that
 11 involve?
 12 **A.** Well, first Senior House Officer in medicine, general
 13 medicine -- I did a medical rotation and then I did
 14 pathology rotation as the Senior House Officer. That
 15 means I went through all the components, including
 16 haematology for three months, and then I did become
 17 registrar in haematology, combining my medical and my
 18 pathology training together and, by this time, I had
 19 the membership of the Royal College of Physicians.
 20 **Q.** So you became a registrar in 1977 and that was, again,
 21 in the Wythenshawe Hospital in Manchester?
 22 **A.** That's right, yes.
 23 **Q.** At that stage, so while you were working there in
 24 haematology and doing your pathology rotation, were
 25 you caring for any haemophiliacs in the haemophilia

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1 centre?
 2 **A.** No, none at all. There was no haemophilia centre
 3 there. There's a good cardiac unit, et cetera, but
 4 no -- haemophilia was being treated at Manchester
 5 Royal and at Withington Hospital on the coagulation
 6 disorders.
 7 **Q.** So you had no experience at that stage of dealing with
 8 anyone with haemophilia?
 9 **A.** No, none at all.
 10 **Q.** Then in August 1978 you became Senior Registrar in
 11 haematology between Leeds and Bradford, and you held
 12 that post for three years?
 13 **A.** Yes, that's right, yes.
 14 **Q.** You rotated between the two, between Leeds and
 15 Bradford, did you?
 16 **A.** Yes, the rotation was divided between Leeds General
 17 Infirmary, St James's Hospital, which was
 18 a haemophilia centre, Blood Transfusion Service for
 19 six months, including paediatrics, and the time at
 20 Bradford Royal, which was a haemophilia centre.
 21 **Q.** When you were at the Blood Transfusion Service what
 22 did that involve?
 23 **A.** That was combined with paediatrics. We learnt about
 24 bench work, but I think largely we were really a pair
 25 of hands. There was very little what I would call

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1 formal training. But we were, apprentices to the
 2 consultants.
 3 **Q.** So you were -- where physically were you during that
 4 period?
 5 **A.** Blood Transfusion Centre in Leeds.
 6 **Q.** In Leeds, primarily in the laboratory there?
 7 **A.** Primarily in the laboratories sort of setting but we
 8 were also doing paediatrics at the same time. So we
 9 did the paediatric bone marrows, et cetera, giving
 10 support to the paediatric oncologist.
 11 **Q.** While you were in Leeds at St James's Hospital and at
 12 Bradford, were you working in the haemophilia centres
 13 there?
 14 **A.** Yes, but the primary focus in both hospitals was to do
 15 with chemotherapy and leukaemia and, well, in Bradford
 16 solid tumours, lymphomas, and so on. But the
 17 haemophilia care, was there, yes and that's where
 18 I got my experiences, yes.
 19 **Q.** So your first experience of working with people with
 20 haemophilia was in 1978?
 21 **A.** In '78 I started at Bradford where the senior
 22 registrar, really, was primarily involved in treating
 23 haemophiliacs, and then at St James's again, it was
 24 really the junior staff that treated the bleeding
 25 disorders.

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1 Q. Who was the director of the Leeds centre at that time?
 2 A. Dr Swinburne was -- she wasn't a haematologist, she
 3 was an immunologist. She wasn't a clinician but she
 4 was in charge of haemophiliacs.
 5 Q. In the Leeds centre?
 6 A. In Leeds, at St James's.
 7 Q. Then in the Bradford centre, it was Professor Turner;
 8 is that right?
 9 A. Yes, it was Professor Turner who, by the way, set up
 10 the first haemophilia centre in the country, it was in
 11 Bradford. So he was quite instrumental. In his early
 12 days, he did a lot of work with coagulation,
 13 especially with Factor XIII and so on. But his main
 14 focus was to do with oncology. His professorship was
 15 to do with oncology at University of Bradford. But,
 16 yes, we had a haemophilia centre there and the
 17 laboratory staff were excellent there, actually, in
 18 terms of teaching me about coagulation, et cetera.
 19 I mean, I'm really very grateful.
 20 Q. Then in 1981 you were appointed consultant at
 21 Bradford; is that right?
 22 A. Well, Professor Turner was taken ill and I had just
 23 passed my MRCPATH and within two weeks -- we were on
 24 holiday and I was informed that he was ill and would
 25 I take over. I was the Senior Registrar so, in fact,

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1 I took over as locum consultant but also effectively
 2 in charge of the department there, and I would be the
 3 locum director of the haemophilia centre as well. But
 4 we lost staff. I was a Senior Registrar became locum
 5 consultant.
 6 Q. So that, as you described, happened rather suddenly?
 7 A. Very suddenly.
 8 Q. You were only 32 or something --
 9 A. 31 --
 10 Q. 31.
 11 A. -- and it was seven years post qualification. So
 12 I was one of the youngest consultants in Yorkshire but
 13 treating both haematology and oncology. So I was also
 14 treating solid tumours, breast cancers, and so on.
 15 Q. So you suddenly in 1981 are appointed consultant and
 16 effectively acting director of the centre?
 17 A. That's right.
 18 Q. Does Professor Turner ever return to his role as
 19 director of the centre?
 20 A. Well, he came back for a couple of weeks and then he
 21 retired totally and, by that time, I think two years,
 22 I was appointed to substantial post in 1982.
 23 Q. So, although it says on your CV "appointed centre
 24 director 1982", in fact, you were carrying out that
 25 role from 1981?

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1 A. Yes, I was, yes.
 2 Q. You mentioned that you were also carrying out a role
 3 in oncology. Can you give us an idea of how much of
 4 your working week was divided between your role as
 5 an oncologist, haematologist and your haemophilia care
 6 in that early period 1981?
 7 A. It was a tough time for me because I was doing too
 8 many jobs, basically. There were only two
 9 consultants, two of us for a size city of Bradford,
 10 you know. I would have said --
 11 Q. Two consultants for in what speciality?
 12 A. One in haematology and I became the
 13 haematologist/oncologist. I was then accredited in
 14 oncology, which very few people in the country who
 15 were both accredited in both specialties, you know,
 16 but purely by accident, I think. But in terms of how
 17 much time I spent, most of my time, probably
 18 90 per cent of the time, was spent to do with
 19 chemotherapy and haematological malignancies and solid
 20 tumours. A small amount of time spent with
 21 haemophilia care or coagulation, and I think we'll
 22 talk probably more about it because coagulation
 23 disorders was a very big thing in Bradford but not
 24 necessarily haemophiliacs.
 25 Q. So you're split 90/10 in those early years?

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1 A. Possibly.
 2 Q. I understand it's a long time ago, your best estimate
 3 in those early years, and did that remain the case
 4 through your working life or did that change as the
 5 years went by?
 6 A. Well, as years went by, I wanted to give up the
 7 oncology because I really did not have formal
 8 training. It was an impossible job for anybody to do
 9 all that. So we agreed with the Trust and health
 10 authority, they were going to appoint a third
 11 haematologist but that -- we agreed that that should
 12 become an oncologist. So it was the first medical
 13 oncologist in Yorkshire was appointed in Bradford,
 14 pure medical oncologist, not radiotherapy. So
 15 I dropped oncological work and did haematology and the
 16 director of the haemophilia centre. But the cost of
 17 that was that I was only given four clinical beds for
 18 haematology and for haemophilia work. It was grossly
 19 inadequate, you know. But, I think, as my story
 20 evolves, we started a charity, Annette Fox Leukaemia
 21 Fund. We started gathering money, we built a unit
 22 which then could also treat both the leukaemias, and
 23 so on, but at the same time we could have a place
 24 where we could treat people with coagulation
 25 disorders. Also at the time we tried to enlist

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1 Dr Minford, Adrian Minford, paediatrician to try and
 2 help me to look after the children because I wasn't
 3 qualified for that. I had no paediatric training.
 4 But we were very lucky because we were able to build
 5 up a team, and so on.
 6 Sorry, I'm carrying on a bit.
 7 **Q.** That's quite all right. Just going back then to when
 8 you think you dropped the oncology and you got the
 9 oncologist, the third consultant, when do you think
 10 that was?
 11 **A.** Probably I think '84/'85, something like that.
 12 **Q.** So then you had more time to, spend on the centre than
 13 you had before; is that right? That was the idea
 14 presumably?
 15 **A.** I never had enough time, ever, until I retired.
 16 **Q.** Then, Professor Parapia, you also, in amongst all of
 17 that, were carrying out various teaching and academic
 18 roles with the Leeds Medical School and with the --
 19 and director between 1991 and 1996 of post-graduate
 20 education at Bradford Teaching Hospital?
 21 **A.** Yes, I tried to -- we tried to get into research.
 22 Like I said, I tried to build a team. I built links
 23 with the University of Bradford, which is where I got
 24 my visiting professorship. I started haemostasis
 25 thrombosis unit there as well. One of the things

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1 I think it's often not realised -- it wasn't realised
 2 by managers or Health Service or UKHCDO, and so on,
 3 Bradford had a large population of Pakistani
 4 immigrants, and one of the things about them,
 5 including in other places like Birmingham, and so on,
 6 was there was a lot of consanguineous marriages, so we
 7 had children, and some adults but largely children,
 8 who had very rare disorders, disorders that even now
 9 haven't been fully recognised.
 10 So although haemophilia may've had a greater
 11 impact because of the amount of money we spent, and
 12 Haemophilia Society and UKHCDO and so on, but we had
 13 a large number of people with bleeding disorders that
 14 made up our centre and took up a lot of our time. And
 15 from my publications and so on you would have seen
 16 that we had rare platelet disorders, we had
 17 Factor XIII deficiency. And Dr Minford gratefully --
 18 and protein C deficiency. And Dr Minford gratefully,
 19 you know, got into partnership and we produced a lot
 20 of research and papers based on that. Which is one of
 21 the reasons why I always felt that UK Haemophilia
 22 Centres Directors, that we were a big centre, short of
 23 resources and staff, but never got the acknowledgement
 24 as the Reference Centres did.
 25 So it was one way of getting resources, if you

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1 had been upgraded, you know. But we managed.
 2 **Q.** Then you continued in those roles until your
 3 retirement in 2009?
 4 **A.** Yes. In between, like I said, I -- you see, one of
 5 the important things was to keep our staff. And there
 6 was always this pressure that because we were in
 7 proximity to Leeds and so on that the senior registrar
 8 and the registrar training should be taken away from
 9 Bradford. So, you know, we had to build a department
 10 so we could retain.
 11 So we did have -- you know, made sure that we
 12 were training people, carrying out research. We made
 13 sure that the registrars and senior registrars got
 14 proper formal training, and they produced papers,
 15 et cetera. We tried to get resources, money, and
 16 built a ward. My wife was a trustee as well, you
 17 know, and we raised money.
 18 But in order to keep our department intact with
 19 staff and resources, we had to build links. And so,
 20 in the later years, I became one of the sub-deans at
 21 Leeds medical school, an honorary senior lecturer,
 22 et cetera.
 23 I mean, there's a whole load of appointments
 24 that I had. I was Director of Postgraduate Education
 25 in Bradford, and then, obviously, I was an examiner at

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1 various colleges and so on.
 2 **Q.** Then you had your first meeting, that I've been able
 3 to find, of the UKHCDO, so annual directors' meeting.
 4 You attended that in November 1979. So that is when
 5 you were a senior registrar in Leeds and Bradford.
 6 Does that sound right to you?
 7 **A.** Unusual for a senior registrar to have attended the
 8 UKHCDO meeting. I can't remember it but if you've got
 9 it there it's obviously there, you know.
 10 **Q.** So there's a record of you attending on November 1979,
 11 October 1981, and that's when you've described that
 12 you were *de facto* centre director --
 13 **A.** Yes, that's right.
 14 **Q.** -- albeit not yet appointed. And then from then on
 15 you were a very regular attender. I think there's
 16 only one year that I've identified that you missed.
 17 Does that sound right?
 18 **A.** Yes, very important meetings to attend, because that's
 19 where we often got our information, you know. I've
 20 got all the minutes for every year. But they were so
 21 you could meet colleagues as well. You know, very
 22 important indeed.
 23 **Q.** But you never held a role on any of the working party
 24 groups. As you've described, you were never
 25 a Reference Centre Director, so your attendance was

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1 limited to those annual general meetings?
 2 **A.** Yes, although after a few years there were working
 3 parties for platelet disorders and rare coagulation
 4 disorders, and we produced guidelines, but they were
 5 not the main workings of the UKHCDO. No, I wasn't an
 6 executive or within the inner circle, as one would
 7 say.
 8 **Q.** You very kindly shared some of your papers with the
 9 Inquiry, and in there we find minutes of working party
 10 groups, Reference Centre Director meetings that you
 11 didn't attend but you seemed to have the minutes. Can
 12 you recall how you got those minutes?
 13 **A.** I usually tried to attend all the meetings of the
 14 wider UKHCDO, because -- but obviously the UKHCDO
 15 Reference Directors' meeting which I couldn't attend.
 16 **Q.** But you seem to have the minutes. Do you recall how
 17 you got the minutes?
 18 **A.** Well, I presume they must have been sent to me.
 19 I think they would have been circulated.
 20 **Q.** Do you have a recollection of getting regular minutes
 21 of meetings of Reference Centre Directors and so on?
 22 **A.** I tried to get minutes of most meetings because -- we
 23 were all desperate for knowledge, to make the best
 24 decisions. We needed information. Now, any source of
 25 information, whether it's UKHCDO, from pharmaceutical

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1 companies, from regional meetings or lectures,
 2 international meetings, we would try and get that
 3 information. If it was written, and I kept quite
 4 a lot of it -- I still have a lot by the way, you
 5 know, that you could have. So, yes, you know, I must
 6 have received much of these, you know.
 7 **Q.** You also mention in your witness statement that there
 8 were other committees that you were members of and, in
 9 particular, a member of the Regional Haemophilia Group
 10 in Yorkshire, and from one of the documents that we'll
 11 go to in due course, there's a list of attendees, and
 12 I just wonder if you have in recollection yourself of
 13 who would attend those meetings?
 14 **A.** Well, Leeds was the largest centre.
 15 **Q.** Yes.
 16 **A.** We were the second largest, in terms of haemophiliacs.
 17 But other -- you see, it was a bit complicated because
 18 you had the haemophilia centre, then at that time you
 19 had associated haemophilia centres. I think the idea
 20 was to help the haemophilia centres, so it was like
 21 York and I think Harrogate -- Hull was reasonably big,
 22 but then you had the associate. Now I can't remember
 23 which ones were which. But -- Huddersfield may have
 24 been associate. But I really can't tell you how the
 25 membership was organised.

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1 **Q.** So the minutes of this particular meeting suggest that
 2 you were there, Dr Swinburne was there, from Leeds,
 3 Dr Tovey. I understand he was from the Regional
 4 Transfusion Centre?
 5 **A.** Yes, he was the director of the Regional
 6 Transfusion --
 7 **Q.** Of the Yorkshire Regional Transfusion Centre, is it?
 8 **A.** That's right, yes.
 9 **Q.** Dr A Robinson, Angela Robinson, from the Blood
 10 Transfusion Service?
 11 **A.** Yes, that's right.
 12 **Q.** Was she from the Regional Blood Transfusion Service at
 13 that stage?
 14 **A.** Yes, Regional Transfusion Centre, but she also had
 15 slight involvement with paediatrics I think.
 16 **Q.** Dr Hutchinson?
 17 **A.** I don't remember him.
 18 **Q.** Dr Barnard --
 19 **A.** Dr Barnard, yes, he was a haematologist at St James's
 20 Hospital.
 21 **Q.** And Dr McEvoy?
 22 **A.** Dr McEvoy was at Harrogate, and he was one of the very
 23 senior haematologists. Lot of experience and very
 24 wise.
 25 **Q.** Can you recall whether, in those group meetings,

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1 anybody from Sheffield would attend, because, of
 2 course, Sheffield was a Reference Centre, wasn't it?
 3 **A.** No.
 4 **Q.** No-one from Sheffield there?
 5 **A.** No. And Sheffield was always considered a competitor,
 6 in terms of the transfusion centres, with Leeds. But
 7 no, no, we wouldn't have. That was a different
 8 region.
 9 **Q.** Thinking back to those meetings, it seems from the
 10 minutes and documents we've got -- and we'll go to
 11 some of them during the course of your evidence --
 12 that the issues that were discussed in that forum were
 13 allocation of NHS product from the Regional Blood
 14 Transfusion Centre, regional contracting for
 15 commercial products, treatment policies and so on.
 16 Does that sound right?
 17 **A.** I think that's a simplification, yes. That's
 18 a summary. You're right.
 19 **Q.** What do you recall -- the forum? What do you recall
 20 being discussed at those meetings generally?
 21 **A.** Well, they discussed what you've just stated, what our
 22 requirements were. But I think they could have done
 23 better. They could have been more detailed and -- for
 24 example, in those minutes it will say what we required
 25 and what we were likely to use and what the overall

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1 requirement, but it doesn't actually talk of stock
 2 control.
 3 **Q.** We can come to some of that detail when we look at the
 4 documents.
 5 Then, just moving through, as well you were
 6 a member of The Haemophilia Society but you never had
 7 a role on their Medical Advisory Panel or any other
 8 such advisory panel?
 9 **A.** No, all directors were made members of The Haemophilia
 10 Society but I did have a few articles printed in
 11 there. I think you've got some of them.
 12 **Q.** Yes.
 13 **A.** I mean, we might have had one or two small grants.
 14 **Q.** Then moving on then to ask you some questions about
 15 the facilities and services at the centre itself, and
 16 you've already given some evidence in relation to
 17 that. I think you described that you only had four
 18 beds when you first started?
 19 **A.** And it got worse. Go on.
 20 **Q.** What were the facilities like in terms of the
 21 physical -- in terms of bed space and where the unit
 22 actually -- what centre it actually was when you first
 23 came to Bradford in 1978?
 24 **A.** You see, in terms of haemophilia care, we seemed to
 25 concentrate on concentrates and treatment, but

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1 haemophiliacs were patients, you know, and we were --
 2 the haemophilia centres were often their best friends
 3 because they spent a lot of time with us and they came
 4 to know us.
 5 The facilities in Bradford when I got there in
 6 '81 were abysmal, terrible. We used to use
 7 cryoprecipitate which was made by the blood bank.
 8 They didn't have any physical space where they could
 9 actually be treated. And it was really if there was
 10 space left over from treating cancers and so on. They
 11 might have to be seen in the lab. There was no
 12 clinical area one could look at. They would have to
 13 come into the laboratory, into my office. The offices
 14 were in the laboratory, with the microscopes, you
 15 know. We often had to see them there. We often had
 16 to see them in chairs outside. We often -- I mean, it
 17 was terrible. As they were getting cryoprecipitate
 18 they often had to stay in the hospital for a while,
 19 you know, a few hours at a time.
 20 They were very disabled. I think that's been
 21 mentioned a few times by other directors, how disabled
 22 they were. And really the whole thing was awful.
 23 They were not being treated like proper human beings.
 24 You know, the cancer patients had better facilities.
 25 The focus was on malignant -- malignancies, cancers,

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1 more emotive, and it was very, very sad.
 2 **Q.** You've described how you built a unit. So until the
 3 time when you built a unit, was that the position?
 4 There was no treatment room, nowhere for anyone with
 5 haemophilia to be treated?
 6 **A.** No, what I had to do, because I couldn't get anywhere
 7 with the trust -- they weren't trusts then, were they?
 8 They were hospital boards or whatever -- I got health
 9 and safety people, and they put a notice up saying
 10 that this place wasn't fit to treat people, you know,
 11 to look at patients. And I thought that might do the
 12 trick because I wasn't getting anywhere. Well, there
 13 was Crown immunity at that time. They couldn't have
 14 cared less what the health and safety people said. It
 15 wasn't the hospital management's worry, about that.
 16 Anyway, after really --
 17 **Q.** When was that?
 18 **A.** That would be, like, '84 I think, round about that
 19 time. It made me unpopular by the way. I was never
 20 popular with managers.
 21 But anyway, they made me a little room with
 22 a skylight -- but this was before our unit was built,
 23 you know -- and that was a big step in the right
 24 direction, because we could put somebody there, give
 25 them privacy, you know, counselling, talk to them,

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1 time, et cetera. But that was before we built the
 2 unit.
 3 **Q.** So when do you think you got that room, that treatment
 4 room you could use for treatment and counselling?
 5 **A.** I think it must have been '84/'85, because the unit
 6 was built ...
 7 **Q.** '92?
 8 **A.** Yes, that was in early 90s. So it was a bonus just to
 9 have a place, you know. But I think the overall
 10 message is we think of haemophilia with concentrates,
 11 et cetera, but we forget that they needed all the
 12 other supporting things to help them be treated like
 13 normal human beings, you know.
 14 **Q.** So when you arrived at the centre in '78, were there
 15 any joint clinics with dentists or --
 16 **A.** No.
 17 **Q.** It was people came in for their haemophilia care and
 18 that was it?
 19 **A.** Nothing, nothing really at all. So when I got
 20 appointed, I started recruiting -- remember, we
 21 weren't Reference Centre. We weren't given resources.
 22 You know, we had to fight from within what the
 23 hospitals had, and we were very, very lucky to have
 24 some incredibly great people. You know,
 25 Adrian Minford, who was never trained as

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1 a haematologist, he helped to take up children and
 2 start learning about haemophiliac -- you know,
 3 bleeding disorders. We got a community dental
 4 surgeon, Hugh McCarthy. He wasn't getting paid extra
 5 and so on, but he joined us and he started -- they had
 6 had no dental care. Haemophiliacs didn't have any
 7 dental care because dentists wouldn't touch them with
 8 a bargepole. They wouldn't come anywhere near. And
 9 so Hugh McCarthy was a community dental officer who
 10 took them as part of his job. You know, incredible.

11 Then we had Sister Pauline Sharp, who was
 12 a dermatology sister, but when I had two beds on her
 13 ward she started taking interest in haemophilia, and
 14 we got her gradually trained up to become a nurse
 15 specialist. Again, no extra resources, again from
 16 within our own resources.

17 Then we had Brian Hamilton, orthopaedic surgeon.
 18 Again, he gave up his own time to come to our clinics
 19 and started looking at the joints, et cetera.

20 Then we did get one resource from social
 21 services, which was they managed to give some time for
 22 a social worker who was trained as a counsellor. So
 23 I think we were the first in Yorkshire to have
 24 somebody who was sort of dedicated doing the social
 25 aspects, you know, and so on. But much, much later

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1 when we had the unit, obviously, the leukaemia fund
 2 started funding various things that the haemophiliacs
 3 could use.

4 But yes, we built up a team and started clinics,
 5 dedicated clinics, from again within our own
 6 resources, otherwise the haemophiliacs used to come to
 7 a general haematological -- there may be 50 to 100
 8 patients and they would be at the end of the queue,
 9 you know, because we had to decide what blood types
 10 they had as well, you know. So it was quite
 11 a struggle.

12 Q. Henry, can we have up HSOC002093, page 8. HSOC002093.
 13 That's not got enough digits in it. It must be 000.
 14 HSOC0020293.

15 Is that the right -- you got that? In fact, can
 16 we show page 1 first and go over to page 2. This is
 17 a publication, I think, it says at the bottom there
 18 papers taken from an International Symposium on HIV,
 19 Haemophilia and Community held at Bradford University
 20 on 23 and 24 April 1987. Then if we go to page 7, we
 21 can see a paper by you, "*Advances in Haemophilia
 22 Care*". If we go over to page 8, there's a diagram on
 23 the right-hand side, we can just go into there and you
 24 have set out the services in 1987 at the centre and
 25 you've got there the haemophilia sister and that's

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1 Pauline Sharp, is it?

2 A. That's right.

3 Q. You have described a consultant haematologist and
 4 Senior Registrar, so that's obviously you and a Senior
 5 Registrar, and then the consultant orthopaedic surgeon
 6 and a physiotherapist, at that stage.

7 A. That's right.

8 Q. Social worker and counselling, and you have
 9 described -- I think in your witness statement you say
 10 you had a social worker/counsellor for a few years?

11 A. That's right, Andrea Bridge.

12 Q. From another document that you provided to the
 13 Inquiry, it looks like you were about to get the
 14 social worker at the end of 1985; does that sound
 15 about the right sort of time?

16 A. Yes.

17 Q. Then you've described the dental surgeon and
 18 a Dr Minford, the paediatrician. Can you recall -- we
 19 know that was all in place by April 1987. You arrive
 20 in 1981, centre director in 1982; can you recall how
 21 long it took you to get up to this service?

22 A. I can't give you exact times but it was like
 23 completing a jigsaw, you know, bit by bit whatever we
 24 could get. These were not working exclusively for the
 25 centre, because they had their own jobs, and so on.

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1 By the way, I didn't mention but we had a very good
 2 physiotherapist who from their department who started
 3 taking an interest as well.

4 But what we had here was -- the big talk then
 5 was comprehensive care. So instead of Reference
 6 Centres they should have called them Comprehensive
 7 Care Centres. Reference means you refer, don't you?
 8 You get advice, et cetera, but even the Reference
 9 Centres didn't have this model and we were putting
 10 this forward that this is how they should be treating,
 11 not exclusively, because you couldn't do that for 40
 12 or even 100 people with bleeding disorders. But this
 13 was what I would have called an ideal model, which we
 14 were trying to today attain and which we did largely,
 15 purely because of goodwill from a lot of very good
 16 people in the hospital. But this was what we had set
 17 up.

18 The conference, really, was to put this forward.
 19 I think there's some other papers in there where,
 20 I think, Professor Tuddenham attended that as well and
 21 Professor Zimmerman from La Jolla in California, who
 22 is a very, very great man, great scientist. I think
 23 you might come to that because not everybody had this
 24 journal, by the way. It's a Bradford-printed journal.

25 Q. We have a statement from Dr Minford and in his

24

1 statement he says that, as you've described, he came
2 to work with you. He was a consultant paediatrician,
3 no training in haematology, but he came to work with
4 you to help you in your clinics with the children, and
5 he describes having joint clinics with you once
6 a month from between about 1983 to about 1986 and
7 thereafter he then went and took his children patients
8 to a separate out-patient clinic where he managed them
9 on his own.

10 Does that accord with your recollection of how
11 you divided care for the children with haemophilia at
12 that time?

13 **A.** Absolutely. You know that would be correct. But, you
14 know, it's, a great commendation that here's
15 a paediatrician that takes on a completely new area of
16 work, which is full of controversy and it's amazing.
17 Even until recently he has been travelling the world
18 and giving talks on Protein C deficiency, et cetera,
19 you know. His interest has been maintained. A great
20 man.

21 **Q.** So how frequently did you have, in that early 1980s
22 period how frequently were you having clinics for
23 adults; was that once a month, as well?

24 **A.** The comprehensive clinic was once month. Now, we used
25 to see people all the time because the way I worked

25

1 was I was accessible to any patient at any time in my
2 office laboratory, you know, where I was. I had
3 an open door policy, literally accessible and
4 accessible on the phone seven days a week. You know,
5 it was open -- that was -- but haematology clinics we
6 had twice a week, which they had access to as well,
7 particularly on Monday afternoons. But the
8 comprehensive care model was once a month with all
9 these people trying to get involved on that particular
10 day.

11 **Q.** So if people needed to come and have treatment outside
12 those clinic times, where would they come and how
13 would they be treated?

14 **A.** They would ring my secretaries or the laboratory,
15 quite often the laboratory, because the laboratory
16 prepared the material, you know the blood bank in our
17 hospital. They would inform the doctor on call or me,
18 but often the doctor on call. Later on, Sister Sharp
19 became nurse specialist, so the calls also went
20 through her. I can't remember now the dates and
21 times, but we were very accessible very easily.

22 But having a good organisation, you know, good
23 communication meant that the time it took for
24 a haemophiliac to be treated was shorter and shorter
25 and better. Something I don't think we've talked in

26

1 the directors -- you know, you've interviewed before.
2 If somebody had a bleed the damage done waiting two
3 hours, three hours before they got their
4 cryoprecipitate or treatment or whatever, that causes
5 damage. It causes pain, discomfort. So the sooner
6 they get treatment, the better it is and home
7 treatment was great for that, you know. There was no
8 time wasted before they got treated for a bleed, you
9 know.

10 **Q.** So if they needed urgent treatment during the working
11 week or during the day, they could make a phone call
12 and come on to -- what you describe there, really
13 there was no area for them to come to but they could
14 come to the laboratory or your office?

15 **A.** Out-of-hours they would have to go to the ward.

16 **Q.** The haematology ward?

17 **A.** Yes.

18 **Q.** If they needed treatment, you know, in the middle of
19 the night, for example, would they have to go to A&E?

20 **A.** No. That's something I think it was terrible because
21 that used to happen and often accidents mistakes in
22 treating people happened because haemophiliacs went to
23 A&E. I think that was a dangerous area for them
24 because they would be looked at initially by people
25 who had no knowledge of haemophilia and haemophiliac

27

1 care.

2 But, I mean, if they did turn up at A&E the
3 whole message there was call the haematologist on
4 call, call the doctor on call, you know.

5 **Q.** So patients would turn up at the haematology ward in
6 the middle of the night, would they, if they needed
7 treatment --

8 **A.** We tried to -- we tried to help them not go to A&E.

9 **Q.** We looked in 1987 there was you and a Senior Registrar
10 and, of course, Dr Minford providing paediatric care.
11 How did the on-call rota work then, were there quite
12 a few people delivering care to people with
13 haemophilia outside office hours, or was it just split
14 between the two of you?

15 **A.** You see, fortunately, as we developed into a proper
16 training, et cetera, we had a few middle-grade doctors
17 that could be on call, first on call. We tried not to
18 use House Officers, which often happens even in
19 Reference Centres, in big centres and so on. House
20 Officers were the least trained, but we had
21 middle-grade, SHOs, Registrars and Senior Registrars
22 were better trained. So that was accessible to the
23 patients with bleeding disorders and then we were
24 there, obviously, I was there. I couldn't be first on
25 call all the time but I was always there, even on

28

1 holidays, at Christmas time. It's stressful that.
 2 **Q.** So there might be -- you and your Senior Registrar,
 3 obviously, couldn't cover all the on-calls?
 4 **A.** Registrars and Senior House Officers, yes.
 5 **Q.** Who would cover. Did you have any written treatment
 6 guidelines, at any stage, that they could refer to for
 7 when patients came in and you weren't there?
 8 **A.** Always, but not only that, we made sure that the
 9 laboratory -- so when they asked for blood products
 10 from the laboratory, who prepared the products. The
 11 laboratory had a guideline and we had such good staff
 12 that they actually came to know the patients and they
 13 had a book which they would look up, and each patient
 14 we had written down what sort of treatment they should
 15 get, what products.
 16 I noticed from the previous directors you've
 17 had -- we tried not to mix the products because if
 18 something went wrong at least we would know which
 19 batch or what was happening there. We tried not to
 20 give each person each patient different batches from
 21 different companies. But, yes, it was always written
 22 down. It was protocolised and, obviously, UKHCDO was
 23 very helpful in there, because they did produce
 24 guidelines, and we tried to stick to UKHCDO
 25 guidelines, as far as we could.

29

1 **Q.** Can you remember when you drew up your first protocol
 2 or treatment guidelines for other members of staff to
 3 refer to when they were providing treatment?
 4 **A.** Now, it's quite interesting in that when I got
 5 there -- and I have a conscious about this actually --
 6 so when I got there in '81, they were using
 7 cryoprecipitate almost exclusively but because we were
 8 using cryoprecipitate there were a lot of centres that
 9 were thinking that Bradford was an inferior place that
 10 didn't keep up with the times, you know, and a lot of
 11 patients also felt that we were not keeping up with
 12 the times because they were well informed from
 13 society, and so on, and from companies by the way.
 14 They would go to other centres, and so on.
 15 I have a little problem myself because I was the
 16 first one who really to order the commercial products.
 17 Now, cryoprecipitate wasn't the best treatment but, as
 18 soon as we started having a choice of treatments, we
 19 had to have a protocol and then, obviously, we needed
 20 protocol because mild haemophiliacs and
 21 von Willebrand's, and so on, the first call would be
 22 on DDAVP, you know. It wouldn't be on --
 23 **Q.** So you had to have a protocol when you had a choice of
 24 treatment. So, as soon as concentrates came on the
 25 scene, you think that's when you would have drawn up

30

1 your first treatment protocol?
 2 **A.** Not only concentrates, when we had DDAVP, you know.
 3 That came on the scene. But that was also different,
 4 we had different choices between different
 5 concentrates.
 6 **Q.** Again, so that would mean that you would have to have
 7 a protocol. Where would that protocol have been kept;
 8 would it have been on the ward?
 9 **A.** Well, in the laboratory, very important, because they
 10 checked -- whenever anybody needed treatment we made
 11 sure that they knew -- ward definitely and obviously
 12 that the doctors were informed. They were well
 13 circulated, you know. If in doubt they rang me, you
 14 know.
 15 **Q.** Do you know where they were kept? No protocols have
 16 been disclosed to the Inquiry. Do you know what could
 17 have happened to them or where we might find copies of
 18 those now?
 19 **A.** Very difficult, but I think you have from the
 20 documents from me, that UKHCDO it does set out
 21 a protocol -- a recommendation not protocol. Protocol
 22 is the wrong word, recommendations. Those were the
 23 recommendations that would have been given. You've
 24 got minutes of the regional meetings where also we
 25 state what should be used and we adhered to it, you

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1 know.
 2 **Q.** We can come to those in due course.
 3 So I think you were describing a book that the
 4 laboratory clinicians could refer to when patients
 5 came to get treatment, and in your witness statement
 6 you have said that there were effectively two sets of
 7 notes: you had the hospital notes and then you had
 8 your own records of treatment that you kept.
 9 Your own records, is that what you're referring
 10 to when you describe the book?
 11 **A.** No, no. The blood bank had a book with each patient's
 12 name and what products they were getting, and also at
 13 the top it would say what the recommendation was.
 14 That was one.
 15 The hospital case notes, which are an absolute
 16 mess, they were hospital notes, like all other notes.
 17 If you wanted the hospital notes to look up treatment,
 18 et cetera, it could take two hours to two days. So we
 19 kept our own what we called "green cards", and they
 20 were kept in my room in a filing cabinet that anybody
 21 could come and pick it out and that actually mentioned
 22 what treatment they should get and the record of what
 23 they were getting and also the clinical notes were
 24 written on it. That was accessible almost
 25 immediately, okay.

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1 So there are three different areas.

2 **Q.** Was everything that was on the green card also in the
3 hospital notes?

4 **A.** Well, if anybody was seen as an emergency or something
5 you wrote in the green card, it may or may not have
6 gone into the main case notes. But if they were seen
7 in the clinic or -- then there was always a letter,
8 there was always a letter in the case notes.

9 **Q.** Was the green card system the system in place until
10 you retired in 2009?

11 **A.** Yes, it was. Yes. But now I think they have
12 computerised everything.

13 **Q.** So when you left in 2009, your office still had that
14 filing cabinet with that information in it?

15 **A.** That's right. I'm not sure what records were
16 destroyed and what weren't but I think there's a lot
17 of material that's -- can't find it.

18 **Q.** We'll talk about home treatment in a little while but
19 just while we're on records, when people were on home
20 treatment, what was the expectation of them in terms
21 of keeping records and sending you information about
22 their treatment?

23 **A.** If they didn't keep records they would not get home
24 treatment. So what -- we kept records of what was
25 issued but we kept records of what they brought back,

33

1 otherwise they wouldn't get the next issue. That
2 means they had to note down the bleeds they had and
3 why they had the Factor VIII. And they had to bring
4 back the needles. You know, they were given
5 appropriate containers. So all those records were
6 kept just as if they were being treated in hospital.

7 **Q.** That would have been entered onto the green card
8 system?

9 **A.** That would have been entered in the blood bank
10 records, because they couldn't exchange. So it was
11 the blood bank staff who issued new bottles and home
12 treatment packs of needles or whatever they needed.

13 **Q.** I am just going to ask you some questions now about
14 patient numbers, and treatment policies over those
15 years in the early 1980s.

16 Before I do, can I just ask whether or not you
17 recall whether or not you were given any guidance or
18 training by Professor Turner when you were working
19 with him about treatment policies?

20 **A.** I don't think he had treatment policies except that
21 they were using cryoprecipitate almost exclusively.
22 Very little commercial product was used. And I think
23 the commercial product that I see on the returns,
24 which didn't know until I saw those returns, may have
25 been -- haemophiliacs were able to travel once they

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1 could carry Factor VIII with them. You know, they
2 were unable to travel otherwise. And I think
3 sometimes if they were in Bradford, they would bring
4 the bottles and get treated, and that would be
5 recorded. But Professor -- he was quite old fashioned
6 and he believed cryoprecipitate was okay.

7 **Q.** So shall we look at -- we'll look at the 1976 return.
8 So this is before you arrive but it's under his
9 directorship.

10 Henry, it's HCDO000037_002.

11 We can see there, 1976, Professor Turner, total
12 number of people with haemophilia treated during the
13 year, 18. And then he's given primarily
14 cryoprecipitate and he's given a small amount of
15 Kryobulin.

16 That was more or less the picture, was it, when
17 you arrived in 1978?

18 **A.** Now this Kryobulin may have been somebody --
19 a traveller, a tourist, you know, somebody going
20 through Bradford --

21 **Q.** So you think --

22 **A.** -- getting his own material.

23 **Q.** So you think that's unlikely that that would have been
24 prescribed by Professor Turner?

25 **A.** Completely. Very unlikely. Actually, he would not

35

1 have known what Kryobulin was.

2 **Q.** We don't have the returns up to 1981 but are you
3 pretty confident then that up to the time when you
4 stepped in as acting director, it would have been
5 primarily cryoprecipitate?

6 **A.** Absolutely.

7 **Q.** And then when you took over in 1981, before you were
8 appointed director in 1982, were you able to make any
9 changes to the treatment policy at that stage or did
10 you feel you had to wait until you were appointed
11 director?

12 **A.** Well, this is the bit that I've tried to remember,
13 whether -- because there was a lot of pressure to
14 change, you know.

15 So I can't recall but I was responsible for
16 ordering the first concentrate. And whether I did it
17 through pharmacy or Blood Transfusion Service I'm not
18 sure. But it may have been in 1982, I think, that may
19 have happened.

20 **Q.** Can we look then at the 1982 return.
21 Henry, that's at PARA0000003.

22 **A.** See, by this time there was a large amount of
23 commercial factor being used in the country.
24 Actually, there was more commercial products being
25 used than NHS material, you know. So we were quite

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1 late on the scene, really.
 2 **Q.** PARA0000003. That's definitely the right -- can you
 3 access PARA0000002.
 4 (Pause)
 5 We don't have that document, so we may have to
 6 come back to that.
 7 I note the time, sir. I wonder whether now is
 8 a good --
 9 **SIR BRIAN LANGSTAFF:** It might be convenient if we took
 10 our morning break now so that the document can be
 11 located, and any other documents that you might want
 12 to refer to you can just check are on the system.
 13 **MS SCOTT:** Thank you.
 14 **SIR BRIAN LANGSTAFF:** Professor, the rule that we operate
 15 is that when you are giving evidence you can't talk
 16 during a break of any sort, any length, to anyone at
 17 all about your evidence. You can talk about anything
 18 else you like but not about your evidence, either what
 19 you have said or what you think you might be asked to
 20 say. Can I ask you to observe that, please.
 21 We will have a break in the morning. It's
 22 always a lengthy-ish break because we have to make
 23 sure that people keep social distance, and we'll be
 24 back in just under half an hour, 11.25.
 25 So 11.25 if you, please.

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1 (10.57 am)
 2 (A short break)
 3 (11.25 am)
 4 **MS SCOTT:** I think, Henry, you now have PARA0000003. This
 5 is the 1982 return. You can see you're noted as
 6 centre director. You treated 22 patients with
 7 haemophilia A that year and five with von Willebrand's
 8 disease. We can see there that your treatments are
 9 made up of NHS Factor VIII, a small amount of
 10 Factor VIII and Kryobulin for those with haemophilia A
 11 and then with cryoprecipitate for those with
 12 von Willebrand's.
 13 So that was the new policy, treatment policy,
 14 that you'd brought in as centre director to move away
 15 from cryoprecipitate to factor concentrates.
 16 **SIR BRIAN LANGSTAFF:** It looks as though there's home
 17 treatment, which is largely a ratio of about 4 to 1
 18 Factor VIII compared to NHS; is that right?
 19 **A.** Absolutely. I think this would be right, sir.
 20 I would be responsible for ordering the commercial
 21 products and I would have been responsible for
 22 introducing home treatment.
 23 **SIR BRIAN LANGSTAFF:** Before this, before you had factor
 24 concentrate, did you have home treatment?
 25 **A.** No, not really. I can't remember. I don't think so,

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1 no. I don't think we used cryoprecipitate as home
 2 treatment.
 3 **MS SCOTT:** Do you recall whether, at this stage, you had
 4 a prophylaxis treatment programme?
 5 **A.** No, I think prophylaxis came a bit later.
 6 **Q.** Can you recall when that came in?
 7 **A.** You see -- once you had home treatment, patients quite
 8 often actually gave it prophylactically, particularly
 9 if they felt they were going to play a football match
 10 or do something that could make them bleed, and we
 11 were quite happy for that. You know -- I mean, I had
 12 one patient who did karate, against my advice by the
 13 way, he was a black belt. I said you mustn't do that.
 14 But he would give himself a shot, you know, before
 15 doing. I think, in a sense, we had started and once
 16 you started home treatment -- so if they were having
 17 to give themselves injections three times a week, say,
 18 because of three bleeds on a regular basis, you might
 19 as well give it three times regularly rather than wait
 20 for a bleed.
 21 So I think there is a slight overlap. But the
 22 formal prophylaxis, if one did that, you had to see
 23 how much of material we had, you know, how much we
 24 could afford. Also the home packs. You know, it was
 25 important to know how the home packs were organised,

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1 and one would have to be very careful about abuse as
 2 well, because prophylaxis wasn't about total
 3 replacement. You know, it was about stopping to get
 4 a bleed.
 5 **Q.** Do you recall when the formal programme came in?
 6 **A.** Sorry, I can't remember because, like I said, there is
 7 an overlap between the two.
 8 **Q.** Just looking down at other materials --
 9 **SIR BRIAN LANGSTAFF:** Just a moment before you do, you
 10 described a process of prophylaxis *ad hoc*, somebody
 11 going to do karate, play football. When the person on
 12 home treatment came back to the hospital, with their
 13 record of what they had used for the bleeds they had,
 14 of course they wouldn't have had a bleed on that
 15 occasion.
 16 **A.** No, and we didn't examine the records that closely.
 17 **SIR BRIAN LANGSTAFF:** You didn't?
 18 **A.** No, because I think it's a question of if, on balance,
 19 they were well, surely I'm happy with that, as long as
 20 they didn't use it excessively, you know. We didn't
 21 police it that closely, as long as they didn't go
 22 beyond a reasonable use, you know.
 23 **SIR BRIAN LANGSTAFF:** So within limits it was expected
 24 they might use it?
 25 **A.** Absolutely, yes. I mean, it was inevitable, wasn't

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1 it, once you got the material at home, you know?
 2 **SIR BRIAN LANGSTAFF:** Particularly, I suspect, if they are
 3 young adults.
 4 **A.** Absolutely. One of the things about haemophilia care
 5 was that you wanted them to be fit. You wanted them
 6 to exercise, you wanted them to have as far as normal
 7 lives as possible. The better fitness they had, the
 8 less bleeds they had. So we didn't mind at all as
 9 long as it was for the right reasons, you know.
 10 **SIR BRIAN LANGSTAFF:** Thank you.
 11 **MS SCOTT:** Just looking down at the bottom of that page at
 12 other materials, if you had been treating with DDAVP
 13 or tranexamic acid, would you have expected to have
 14 recorded that there?
 15 **A.** Yes, we would, and the reason why it's not recorded,
 16 I suspect, is because these are records from the blood
 17 bank. DDAVP is a pharmaceutical product that would
 18 not be kept recorded in the blood bank. So the
 19 returns were largely prepared by staff in the
 20 laboratory.
 21 **Q.** So this doesn't necessarily tell us that you didn't
 22 use DDAVP?
 23 **A.** Yes, that's right. Once it was available we did use
 24 it but because the returns were not -- were done by
 25 the laboratory staff, blood bank staff, it may not

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1 have been recorded.
 2 **Q.** Henry, could we have PARA0000002, please. This, as I
 3 understand it, is a survey of European haemophilia
 4 centres and if we go to the second page, Henry, to the
 5 bottom, we see it says there:
 6 "Please return to [Professor Bloom] as soon as
 7 possible before 20 January 1984."
 8 Then if we go back to the first page, the first
 9 question is to ask how many patients you treated each
 10 year at your centre, eg 1982. Then it's question 2:
 11 "During the last four years what products have
 12 you used ..."
 13 You set out there the products that you've used
 14 presumably during your time at the Bradford centre and
 15 we don't see any record there of DDAVP or tranexamic
 16 acid. Looking at that, do you think that, by the time
 17 you filled this in, which seems to be probably the end
 18 of 1983/beginning of 1984, that actually you weren't
 19 using that product at that time?
 20 **A.** I can't remember when DDAVP came into use but if it
 21 was there, we would have used it, you know,
 22 undoubtedly Tranexamic acid we were probably one of
 23 the first and used it quite commonly but, I think --
 24 I don't know. We may have been concentrating on
 25 concentrates and cryo and NHS, I can't remember.

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1 **Q.** So your recollection is you did use it, even though
 2 it's not recorded in any of the --
 3 **A.** When it was available, yes. I'm trying to think.
 4 **SIR BRIAN LANGSTAFF:** It would, I think, have been
 5 available from 1978 onwards.
 6 **A.** Then we would have used it, yes. We would have used
 7 it, yes. But, like I said, because it was recorded
 8 via pharmacy, so it would have been on the green cards
 9 but not in the laboratory. No, we would have used it
 10 because we tried to avoid, as you know -- so in
 11 von Willebrand's and mild haemophilia we used DDAVP.
 12 **MS SCOTT:** Henry, can we have HCDO0000228_002.
 13 **A.** I think, I suspect when I filled that in I probably
 14 had in mind about blood products rather than thinking
 15 of pharmaceutical products, you know.
 16 **Q.** This is the 1983 return and we can see here, again,
 17 the pattern continues that you're treating, both at
 18 home and in hospital with a mixture of NHS factor and
 19 commercial factor, here Factor VIII and Kryobulin for
 20 those with haemophilia A, and for those with
 21 von Willebrand's you're treating, no home treatment,
 22 just cryoprecipitate in hospital.
 23 Can I just ask you what your treatment policies
 24 were at that time in terms of deciding who had NHS
 25 factor and who had commercial factor?

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1 **A.** I mean, we followed the UKHCDO guidelines. We tried
 2 to keep to one product all the time but something that
 3 tipped us towards the commercial was home treatment.
 4 The home treatment packs were far better. NHS packs,
 5 if I remember, had to be made up. They didn't come in
 6 ready-made packs. But the commercial were all ready
 7 in a nice little box with the needle and everything.
 8 The commercial products were far more soluble
 9 because they were purer than the NHS, the
 10 intermediate. So that may have tipped us because you
 11 needed less water to mix.
 12 **Q.** What was the advantage of needing less water; what was
 13 that advantage?
 14 **A.** Well, you needed everything smaller so it was more
 15 soluble, less water to mix the product, less to draw
 16 up, less to inject, you know, rather than a bigger
 17 volume. This is all from memory. I think that may
 18 explain why we got a lot more for home treatment, the
 19 commercial product, than using the NHS.
 20 Now, in terms of -- we would have followed
 21 UKHCDO guidelines so, for people who weren't exposed
 22 to commercial, we would have tried to use NHS. If
 23 they had been using NHS, we would have tried to use
 24 NHS but for home treatment -- and these are for severe
 25 ones. Because home treatment, by the way, was not

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1 given for mild ones; they were for very severe
 2 haemophiliacs. That may explain why we got more
 3 commercial for home treatments.
 4 **Q.** So before UKHCDO provided any recommendations, would
 5 you have chosen between NHS factor and commercial
 6 factor, simply on the convenience of the home
 7 treatment packs, as you have described?
 8 **A.** No, no, I don't think so. I think from the documents
 9 I've given, you'll see that time and time again I said
 10 we prefer NHS products, you know, to commercial. So
 11 I think if they came to hospital it's very likely that
 12 they had NHS. So the infrequent users would have
 13 probably had NHS.
 14 I think that's as far as -- but we followed the
 15 guidelines, you know.
 16 **Q.** So there's quite a lot of predominantly commercial
 17 factor being used in hospital there, rather than NHS.
 18 **A.** Yes.
 19 **Q.** Does that assist at all in identifying what the policy
 20 was at that stage? I think in your witness statement
 21 you've said that you had -- you didn't have any
 22 problems with supply of NHS Factor VIII over these
 23 years, you had sufficient supply?
 24 **A.** Always.
 25 **Q.** Always.

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1 **A.** But I'm sure you'll want to talk about that later.
 2 **Q.** Yes. But your recollection is that you always had
 3 enough NHS supply?
 4 **A.** Yes, but --
 5 **Q.** So the reason for putting people on commercial was
 6 because it was more convenient?
 7 **A.** Yes, but also maybe I can explain about the NHS. When
 8 we ordered NHS material it was always available but
 9 the official line from the Blood Transfusion Service
 10 and official line nationally, and from UKHCDO, that
 11 there wasn't enough NHS material. So we had to use
 12 it -- you know, we had to be aware that we didn't use
 13 up all the NHS material from the region. So there had
 14 to be balance to give other centres a chance to use in
 15 proportion, you know, that we used NHS material and we
 16 used commercial, but without just using NHS all the
 17 time because that wouldn't have been fair.
 18 **Q.** So when you say you never had any problems with NHS
 19 supply, it wasn't that you could have said to the
 20 Blood Transfusion Centre: I want enough NHS product to
 21 meet all my treatment needs, all my patients'
 22 treatment needs?
 23 **A.** That wouldn't have been allowed --
 24 **Q.** Right.
 25 **A.** -- because, you've seen the regional guidelines as

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1 well. What I didn't know, and it baffles me actually
 2 it still baffles me, is we could have used more NHS if
 3 people had given us like stock control and said "Look
 4 we've got this much lying here, yes, you can have
 5 a bit more, you can use more". It was never like
 6 that; you ordered and you got. So we had to use our
 7 own balance, you know, of how much to use and
 8 obviously one didn't want to go predominantly NHS when
 9 you didn't know that there were other centres involved
 10 in the region as well.
 11 **Q.** So did you ever -- was there ever a circumstance where
 12 you said to the regional Blood Transfusion Centre
 13 I want more NHS and they said "No, actually all you
 14 can have is this"; you always got what you asked for,
 15 did you?
 16 **A.** Yes, we did, yes. I mean, that's what I meant by --
 17 we had never trouble -- we were never denied NHS
 18 products from transfusion centre. On the other hand,
 19 we never knew how much they had that they could spare.
 20 **Q.** But you didn't feel, as a matter of fairness to other
 21 centres, that you could ask for more than you had
 22 asked for because then there wouldn't be any for
 23 anybody else?
 24 **A.** Absolutely. It just makes me wonder that -- why
 25 weren't there sort of regular information about stock

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1 control and what was available and what wasn't and
 2 what it was costing and what the budgets were, how
 3 much was affordable, because you were paying more for
 4 commercial products than NHS. At the end of the day,
 5 and I think this what all the directors would say, we
 6 were trying to use the best product, that we thought
 7 was the best product in the interest of the patient
 8 and that also meant what was also easier to
 9 administer, easier to obtain, et cetera, you know.
 10 **Q.** So just trying to think back about what the treatment
 11 policies were, you said NHS was the best product on
 12 some levels?
 13 **A.** On some levels, yes.
 14 **Q.** Commercial product was the best product for other
 15 factors, like convenience?
 16 **A.** Yes, but also, because I don't know the exact dates
 17 and so on, the commercial products always had an edge
 18 over scientific -- you know, on producing a better
 19 product while NHS were always following whatever
 20 commercial companies first achieved like the heat
 21 treatment and raising the level of the heat, you know,
 22 the purer Factor VIII, et cetera. So we would always
 23 be looking to see what was the most convenient and the
 24 best at the time, you know.
 25 I mean, it's very sad, and I think you probably

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1 want to discuss this, why couldn't NHS keep up
 2 commercially, you know, as a commercial organisation?
 3 Because it was not a commercial organisation, you
 4 know.
 5 **Q.** So do you have a clear recollection of the basis upon
 6 which you gave NHS concentrate to some patients and
 7 commercial to others in that 1981, 1982, 1983 period?
 8 **A.** I really couldn't go into detail. I can't remember
 9 what exact -- but it would have been on clinical
 10 situations and need, you know.
 11 **Q.** When you say "clinical situations", what do you mean
 12 by that?
 13 **A.** Well, we've mentioned about home treatment. For
 14 a clinical situation, if somebody was bleeding three
 15 or four times a week, then it's better for him to
 16 treat it at home, you know, and that obviously led on
 17 to prophylaxis. And then it led on to getting,
 18 saying, well, we should attain a higher level of
 19 Factor VIII. But that's another question.
 20 I honestly can't remember details of how exactly
 21 but we did follow UKHCDO guidelines, you know.
 22 **Q.** We can come on to that.
 23 **SIR BRIAN LANGSTAFF:** Just before we leave this page,
 24 I wonder if I can just go back to your answers about
 25 preferring commercial concentrate for home use? If we

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1 look at the figures on the sheet, if we just have
 2 a quick look, it looks broadly as though the same
 3 total amount of units were used in hospital as were at
 4 home, broadly. It comes to about 290-odd units in
 5 both. But there's rather more NHS used at home
 6 proportionately than in hospital.
 7 So at this stage it may have been transitional?
 8 **A.** I think it's transitional because NHS would have gone
 9 down and commercial would have gone up.
 10 **SIR BRIAN LANGSTAFF:** So the next year we should see the
 11 total use for home treatment of NHS would be rather
 12 less proportionately and that commercial rather more?
 13 **A.** Probably, but we also felt that we should try and keep
 14 people on the same product, as far as we could,
 15 because then you would know about viral transmissions
 16 and about batches.
 17 **SIR BRIAN LANGSTAFF:** So the same product would be either
 18 NHS or commercial, would it?
 19 **A.** I mean, if you ask me detail I really can't remember,
 20 you know, the exact circumstances. But I can tell you
 21 as a matter of principle, you know.
 22 **SIR BRIAN LANGSTAFF:** As a matter of principle it would
 23 seem to follow that if someone had received Armour
 24 Factorate, for instance, in hospital they would get it
 25 at home and vice versa.

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1 **A.** Quite possibly, yes, absolutely.
 2 **SIR BRIAN LANGSTAFF:** Well, it follows. If the principle
 3 was keeping them on the same, that must follow,
 4 mustn't it?
 5 **A.** Yes, but also we would have to look at the stocks in
 6 the blood bank. So a clinical situation arises and
 7 there's also stock control in our own blood bank.
 8 **SIR BRIAN LANGSTAFF:** So there may have been occasions
 9 when you weren't able to do it?
 10 **A.** I honestly couldn't remember but it's not simple. You
 11 know, you treat patients as a clinical situation
 12 arises, you know.
 13 **SIR BRIAN LANGSTAFF:** Yes.
 14 **A.** The overall principle was try and keep them on the
 15 same. There's no doubt that the commercial packs,
 16 et cetera -- for children particularly, you know,
 17 it's -- their home packs were so well done, you know,
 18 that they must have done a lot of customer feedback
 19 and, obviously, these pharmaceutical companies were
 20 international and they had to produce competitive
 21 products, you know, competitive packs, competitive
 22 everything really, which NHS didn't have to, BPL.
 23 **MS SCOTT:** In your statement you say that initially you
 24 were responsible for selecting blood products for the
 25 centre and then at some point that moved into regional

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1 contracting; is that right?
 2 **A.** Yes. Well -- or, the other way. There was regional
 3 contracting and we fed in what we wanted.
 4 **Q.** So there wasn't a time when you were ordering your own
 5 blood products for your centre, it was always regional
 6 contracting?
 7 **A.** When I first started using commercial, the first time,
 8 I did order it through pharmacy and I think that was
 9 ignorance, actually, that was my naiveté, because
 10 really that should have gone via transfusion. But it
 11 was only a small amount. It was almost like
 12 experimental -- I think it was 10,000 units, which is
 13 very, very small.
 14 **Q.** Is it right that you ordered or you were responsible
 15 for the prescribing of all the products, even for the
 16 paediatric clinic, certainly up until sort of 1986?
 17 **A.** I think it's better to put it that I was -- as
 18 a director I was accountable for that, rather than
 19 ordering it, because obviously ordering and using on
 20 a daily -- minute-to-minute -- it's a decision -- it's
 21 a clinical decision made by the doctor or nurse
 22 looking at the patient, you know. But yes, I was the
 23 director.
 24 **Q.** The decisions, in terms of the decision that you --
 25 the input that the centre had, if I can put it that

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1 way, into the regional contracting arrangements for
 2 the supply of blood products, that was your job. It
 3 wasn't something that Dr Minford got involved with?
 4 **A.** No, it was my job entirely. My responsibility.
 5 **Q.** Can we look then at, Henry, PARA0000015.
 6 This is a letter from Dr Swinburne to you, dated
 7 7 July 1983, and she says:
 8 "I have discussed the supply of Factor VIII and
 9 related products with Dr Tovey."
 10 So he is from the Regional Blood Transfusion
 11 Centre.
 12 "In the light of the discussions we had had
 13 about AIDS, he and Dr Rajah have agreed to look into
 14 the question of Cryoprecipitate and to maintain the
 15 supply."
 16 I'm going to come back and ask you some
 17 questions about that in due course. There's a second
 18 paragraph I just want to draw your attention to now:
 19 "Dr Tovey would like to know predicted
 20 requirement for 1984/85, and suggested Suppliers
 21 towards the end of September; following this he will
 22 make recommendations to the RHA and they will ask for
 23 tenders. This arrangement worked [well] last year,
 24 and we are lucky to be one of the regions which, so
 25 far, has had an unrestricted supply."

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1 So, there, am I right to understand that "so
 2 far, has had an unrestricted supply" is talking, in
 3 fact about NHS product or is she there talking about
 4 commercial product?
 5 **A.** I don't know. Dr Tovey was the head of the blood
 6 bank, the Regional Blood Transfusion Centre. Like
 7 I said, I never -- there are documents that you have
 8 where it is mentioned that if he used exclusively
 9 commercial products -- NHS products, there wouldn't be
 10 enough for the region, but I never saw the actual
 11 figures. Now this is '84/'85, when I think -- I think
 12 that may have been a time when NHS was producing a lot
 13 more factor. I think there was a time when it was
 14 reaching self-sufficiency. But I couldn't tell you
 15 the detail.
 16 **Q.** What is suggested here is that the process is that the
 17 directors suggest commercial suppliers to Dr Tovey, he
 18 then makes recommendations to the Regional Health
 19 Authority, and then the Regional Health Authority deal
 20 with the tendering process. Does that accord with
 21 your recollection?
 22 **A.** That's how the system worked, yes, but I think the
 23 practice that they got from tendering, I think some
 24 other directors have mentioned, you could actually get
 25 it cheaper by doing it, but I mean, it's through the

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1 tender, regional tender. Yes, regional.
 2 **Q.** Then if we look at PARA0000010, we can see in that
 3 last big paragraph:
 4 "For the reasons stated before ..."
 5 This is a letter from you to Dr Swinburne in
 6 July 1983, so the year before.
 7 "... I would be grateful if Cutter laboratories
 8 were considered as one of the suppliers."
 9 So it seems to be you having a discussion with
 10 Dr Swinburne about who should be put forward as one of
 11 the potential suppliers to Dr Tovey, and you say:
 12 "It is important that there should be
 13 flexibility in choosing various commercial firms and
 14 the Haemophilia Centre Directors should not be
 15 excluded from showing their preferences."
 16 Can you recall why you had a preference for
 17 Cutter at that stage?
 18 **A.** I didn't. I think the principle was we shouldn't have
 19 exclusive contracts with one commercial company.
 20 Competition is good because that reduced the prices.
 21 But there was also the question of flexibility, that
 22 while we were treating in here, you found that one
 23 product, say, had showed a virus or infections or
 24 something, we could remove it and still have an option
 25 from another company. But other than that, there was

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1 no reason for choosing one over the other. It could
 2 have been any.
 3 **Q.** We'll see that, I think, in the next document, which
 4 is PARA0000020.
 5 This is a letter from Dr Swinburne to Dr Tovey,
 6 so this seems to be at the point where the tenders
 7 have come back in. And we look -- there she sets out
 8 the requirement for product, and she mentions another
 9 TV programme on AIDS:
 10 "... some reluctance to use ... commercial
 11 Factor VIII by a few patients, but in general the
 12 policy is unchanged."
 13 And then she goes on to say:
 14 "I have had quotations from Armour, Immuno, and
 15 Alpha ..."
 16 So it seems that the quotations were coming
 17 directly to Dr Swinburne. Do you recall that?
 18 **A.** Well, it should have been through Dr Tovey and then to
 19 Dr Swinburne, because they were both in Leeds and
 20 Leeds was the bigger centre. So they would have --
 21 you can see from the -- St James's using nearly
 22 3.5 million units while we were using 800,000 units.
 23 So they would have the bigger say. And they were
 24 using more commercial up to that period than NHS,
 25 while we were probably half and half, around abouts.

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1 Q. Would she have discussed -- I mean, she cc'd you into
2 this correspondence. Would she have discussed the
3 choice of suppliers? She then goes on to make the
4 choice of supplier with Cutter -- sorry:

5 "... continue using Armour as the main supplier
6 with Cutter ... as backup."

7 Should she have discussed that with you?

8 A. No.

9 Q. So that's a decision she made on her own for the
10 region?

11 A. Yes, on the basis of the information we gave,
12 obviously. You know, we gave her our views and -- but
13 she would have had to look at the region, not just
14 Bradford, you know.

15 Q. So she is making -- what looks like the only
16 consideration she's giving to which product is on
17 price, and that reflects what you have just said to
18 us, that it could be any of them. They were much of
19 the same -- much of a muchness. Was that the view at
20 that stage?

21 A. I think if you negotiated individually with companies
22 you could reduce the price, but obviously this is
23 a regional contract. But Dr Swinburne or Dr Tovey
24 would have had to look at what Harrogate, York and
25 Hull had to say, as well as Huddersfield. You know,

1 that's nearly a million units there, same amount as
2 Bradford. So I don't know what their preferences
3 were, what they said, you know.

4 Q. Was price -- were there any other factors that you
5 took into account or that you were aware that
6 Dr Swinburne took into account when deciding between
7 different commercial companies, different
8 pharmaceutical companies for this contract?

9 A. Well, I was very fearful, as time went on, that any of
10 these commercial companies could come up with
11 a problem. Which they did. You know, as we found
12 out, history has shown us. So it was a good thing not
13 to put all your eggs in one basket.

14 We were desperate for knowledge, absolutely
15 desperate. And I think I've said in my response, you
16 know, to the questions, commercial companies the reps
17 would come and see us and we would get information
18 from them. The BPL, you would hardly see them, and
19 I used to complain, I've actually put formal
20 complaints: why aren't we seeing them? Because I want
21 information about the BPL -- more about the BPL
22 products.

23 Obviously, we had input from UKHCDO and so on
24 and what we saw in journals, in the various
25 communications -- and I've given you a bundle.

1 I think the commercial companies were probably
2 about the same but we were fearful that things could
3 go wrong, you know. At that time it was very
4 difficult but at least we had a choice here, you know.

5 Q. So when commercial companies used to come and see you
6 or when you were considering at the point where you're
7 working out which pharmaceutical company to award the
8 contract to, do you recall getting any information
9 about things like where their donor sites were or who
10 these companies were getting their blood donations
11 from?

12 A. I think there's a letter and you might have got it
13 already is that when I ordered my first Factor VIII
14 I wanted to have reassurances about the donors and the
15 answer they gave is very simple: it's they're
16 following the American FDA, whatever guidance on the
17 donors. But, yes, that would be a question and in all
18 the things, the big bundle, I've given you there's
19 something from Cutter, for example, in the
20 promotional. The answer is, yes, we did look at it
21 but what they produced was for selling their product.

22 Q. Yes.

23 A. You know, how do we know what actually happens? But
24 we do know now because we've had various television
25 series and investigations, and so on.

1 Q. So your recollection is that you were asking those
2 questions --

3 A. All the time.

4 Q. -- you were getting information back from the
5 pharmaceutical companies addressing those issues?

6 A. "Addressing" may be a bit strong but we were certainly
7 being told that they conform to whatever American
8 standards had been set for donors and they varied, you
9 know, they changed all the time.

10 Q. What you're saying is: you know, how did we know
11 whether or not that was true or not; they were selling
12 us a product?

13 A. You see, you have to assume that there's a lot of
14 truth in that because they were licensed. A lot of
15 the products we used were licensed. I tried not to
16 use unlicensed product unless the evidence was strong
17 enough to say that, yes, it's a safer product, use it
18 on a named patient basis. If it was a licensed
19 product it would have gone through the procedure to
20 get the licences and they were probably tougher in
21 America than they were in Britain, you know. Things
22 were moving so fast. We were desperate for real
23 knowledge, truthful knowledge, the truth, and it
24 was -- it only came forward much later, sadly, you
25 know.

1 **Q.** So you, at that stage, were having to rely on the fact
 2 that the Licensing Authorities must have done their
 3 due diligence, because you weren't in a position to do
 4 it yourself?
 5 **A.** No, and we obviously listened to what UKHCDO directors
 6 said and they varied in their opinions and their
 7 usage. But they were people we obviously listened to
 8 very carefully and that was the great advantage to
 9 going to the meetings, international meetings and
 10 UKHCDO, that you listen to some people, and very
 11 difficult to say one product was better than the
 12 other.
 13 **Q.** In those UKHCDO annual meetings, was there discussion
 14 about one product over another?
 15 **A.** Not debate, as such, about one product or other but
 16 you could get a very strong on what they were saying
 17 in the guidelines, for example, or in their returns.
 18 And you talked to people. I mean, the main thing --
 19 the good thing about all these meetings often is you
 20 meet your peers, you talk about it, and so on, but you
 21 didn't get a clear -- they gave recommendations but
 22 they did not give instructions -- I think that's been
 23 mentioned a few times -- the UKHCDO.
 24 **Q.** Yes. So the early recommendations from the UKHCDO
 25 don't mention one product over another.

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1 **A.** No, and they varied a lot, didn't they, because you
 2 had Professor Bloom at one time and in his centre he
 3 used commercial products then you had Charles Rizza
 4 very much in favour of NHS products, you know, and
 5 then there was St Thomas', that used exclusively
 6 commercial products. So you couldn't get a sort of
 7 definite idea from the Reference Centre Directors.
 8 But you certainly could get a feeling, not the
 9 Reference Centre Director meetings but there were
 10 other meetings where you always had pharmaceutical
 11 companies with their stands and, you know, information
 12 and they produced printed information for people to
 13 look at. We were desperate for knowledge, we were
 14 desperate for guidance and the most important thing is
 15 we were desperate for leadership, which I don't think
 16 we ever got properly, either from the Government or
 17 UKHCDO or whatever, in difficult area.
 18 **Q.** You mentioned just now in your evidence that you got
 19 an idea of what the Reference Centre Directors
 20 favoured in terms of product from their returns. Did
 21 you see their Oxford returns?
 22 **A.** We had summaries of their Oxford returns, yes, because
 23 I think -- yes, we could see what proportions were
 24 being used overall but they were never complete
 25 because there were some centres that never gave in,

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1 that didn't want to give their returns. I don't know
 2 for what reason but they did not want them to be made
 3 public.
 4 I'm saying a lot of this from memory, you know.
 5 It's going back --
 6 **Q.** It's a long time ago.
 7 **A.** Yes.
 8 **Q.** In terms of just going then back to sort of logistics,
 9 in terms of the regional contract, did those products
 10 come to you directly from the pharmaceutical companies
 11 or were they held by the Regional Transfusion Centre?
 12 **A.** I honestly cannot remember because the blood bank, our
 13 blood bank, made -- I think they were delivered
 14 directly, you know. I don't think they went through
 15 the Blood Transfusion Service, but I can't remember.
 16 The NHS BPL, obviously, came via Transfusion Service
 17 but I really can't remember. My main concern was is
 18 there enough in the fridge, you know.
 19 **Q.** In terms of then NHS product, any cryoprecipitate that
 20 you used came presumably from the Regional Transfusion
 21 Centre?
 22 **A.** Yes, it did.
 23 **Q.** You didn't have any difficulties with supplies for
 24 that. There was always sufficient?
 25 **A.** Never, never.

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1 **Q.** We have talked a little bit about the NHS Factor VIII
 2 and that you never had any difficulties with supply.
 3 Again, can you recall how orders for that were made?
 4 Did you make those directly to the Regional
 5 Transfusion Centre or did that go through
 6 Dr Swinburne?
 7 **A.** No, it didn't go through Dr Swinburne, it was direct.
 8 It would be through the blood bank. I mean, it's
 9 interesting that the blood bank you're talking of --
 10 blood bank were not really trained to deal with
 11 pharmaceutical products and yet they were dealing with
 12 them on the other end. The BPL material was
 13 a pharmaceutical product which was going through the
 14 Blood Transfusion Service, which they were not trained
 15 to deal with pharmaceutical products, you know.
 16 **Q.** So I'm now going to move on to a different topic and
 17 that's knowledge of risk. I ask you to cast your mind
 18 way back and tell us what you can recall from your
 19 medical training, so both, you know, while you were at
 20 medical school but also you described training at the
 21 Blood Transfusion Service, and so on, in the 1970s,
 22 what you were told what you understood about the
 23 transmission of viruses through blood and blood
 24 products.
 25 **A.** Undergraduate days we would have known very little

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1 about it but once we started the post graduate and
 2 including doing MRCP, you did know that blood
 3 products' blood transmitted viruses -- not just
 4 viruses, blood-borne pathogens. We knew that from the
 5 day blood transfusion started. Certainly you wouldn't
 6 have passed the MRCP without knowing about
 7 blood-borne infections. I know in your knowledge you
 8 mentioned viruses from 1946 or 1940s. In the 1920s
 9 there was transmission of measles from blood
 10 transfusion, and we know about malaria. We know about
 11 other protozoans. It's only logical that anything
 12 that's in the human body, if you take a tissue from
 13 there and give it to anybody else, whatever that
 14 tissue has there's a potential of transmission and
 15 that applies now, as well.

16 So in terms of post graduate, we would have
 17 known about transmission about blood, you know from,
 18 blood products and blood transfusion, because you were
 19 giving transfusions. I mean, we were all training as
 20 either physicians or haematologists or pathologists or
 21 whatever. We were responsible for giving not just
 22 blood, blood products, plasma, cryoprecipitate,
 23 et cetera. You shouldn't have been doing that unless
 24 you knew that there were dangers to giving these
 25 materials.

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1 Q. What did you know about hepatitis B?

2 A. Well, hepatitis B was the well-known one, you know.
 3 The knowledge about hepatitis B -- because there was
 4 also a question of vaccinations, and so on. So, yes,
 5 that -- but blood was being screened, et cetera, so
 6 that was well-established, and then obviously then we
 7 knew about hepatitis A. What we didn't know enough
 8 was about hepatitis C and other viruses, it wasn't
 9 just hepatitis C.

10 Q. So do you recall during your training, your
 11 post-graduate training, learning anything about non-A,
 12 non-B, as it was then?

13 A. I'm sure it was mentioned but I think one of the
 14 problems was we did not know how much importance to
 15 place on it or the interpretation. I mean,
 16 transaminitis is a strange terminology, isn't it, how
 17 can you have inflammation of viruses -- of enzymes?
 18 Transaminases are viruses and you say transaminitis is
 19 inflammation of viruses; that's crazy. That's
 20 because -- that term was used because of lack of
 21 knowledge of what it meant.

22 Q. When you arrived, when you were a House Officer,
 23 a Senior House Officer, Registrar and then
 24 a Consultant, what journals or periodicals would you
 25 have been reading on a regular basis to keep yourself

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1 up-to-date?

2 A. Well, the top journals -- I mean, New England Journal
 3 of Medicine, superb, which I subscribe to, British
 4 Journal of Haematology, which was our haematological
 5 journal. I was a member of BMA so I had BMJ, again
 6 pretty good. The Lancet I didn't subscribe to, but it
 7 was obviously very good, top scientific -- I had a few
 8 others as well, which I can't remember, but these are
 9 the top journals. Journals are very, very important
 10 because they were peer-reviewed, very reliable,
 11 especially if you looked at who the authors were. But
 12 I think something you have got to be aware of, that by
 13 the time things were printed in journals, there was
 14 already a delay, maybe six months, maybe a year, by
 15 the time they got peer-reviewed, corrected, et cetera.
 16 Very good information but often a bit late.

17 Q. So you have already said that you were desperate for
 18 knowledge, other sources of knowledge appear to have
 19 been the UKHCDO, meetings with other colleagues like
 20 Dr Swinburne in the regional meetings, information
 21 from pharmaceutical companies about their products.
 22 Are there any other sources of information that you
 23 were using at that stage?

24 A. Do you know, it's partly amusing, actually, that
 25 often, even now, information that comes out in the

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1 Financial Times is probably quicker than it does in
 2 medical journals because of variation in share prices,
 3 et cetera. So, I mean, yes, the media was often quite
 4 important because they picked up information either in
 5 reality or gossip. But, yes, I mean, it could have
 6 been any source. It had to be verified. Haemophilia
 7 Society was also a source of information.

8 Q. We will come on to some of the publications in due
 9 course.

10 Did you watch the World in Action documentary
 11 Blood Money in 1975?

12 A. I must have watched it, I think I must have.

13 Q. Do you recall it creating any kind of impression on
 14 you?

15 A. They all made -- all these programmes had a great
 16 impression on me because I think they showed the human
 17 face of medicine. They are dealing with people,
 18 patients, not just concentrates and viruses, you know.
 19 I think this is the sad bit about haemophilia care:
 20 you were -- it had a human face, there was actual
 21 suffering, terrible suffering. And it wasn't just
 22 about what we -- mostly discuss about, you know.

23 Q. So if we take 1978 as the time that you go to Leeds
 24 and Bradford, presumably you knew by then that
 25 hepatitis B was a potentially serious condition that

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1 could have long-term consequences and was
 2 transmissible by blood and blood products; is that
 3 knowledge you had by 1978?
 4 **A.** Oh, absolutely. Yes, I did, yes. I think, '78 -- so
 5 that was -- that was four years after graduation.
 6 Yes, I would be doing the MRCP. I think it's
 7 something you had to know.
 8 **Q.** You've mentioned in your witness statement that you
 9 had knowledge and that single donation products such
 10 as fresh frozen plasma or cryoprecipitate were safer
 11 than pooled products?
 12 **A.** That's very logical actually, isn't it?
 13 **Q.** That's knowledge you would have had by, say, 1978?
 14 **A.** Well, we knew, and I think most clinicians would have
 15 known, that if a single unit of blood or single unit
 16 of plasma or cryoprecipitate has potential of one in
 17 whatever of passing on infection, British donor --
 18 much lower than American and so on -- that we would
 19 then give six units of cryo, which is roughly what we
 20 used to give as standard for knee bleeds and so on,
 21 then it's six times.
 22 Then if you go into a thousand, 500 or
 23 a thousand, it's that -- as many times. And then if
 24 you go to commercial products, and say 20,000, 30,000,
 25 it's just logical that whatever's wrong in there is

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1 going to be transmitted, you know.
 2 **Q.** Now the Inquiry sent you a number of articles that
 3 were published in the 1970s on non-A, non-B, and I'm
 4 just going to take you to a few of those.
 5 Henry, could we have NHBT0000092_002.
 6 This is a publication from Vox Sang from 1977.
 7 I'm just going to go over to page 2, please,
 8 right-hand column, last paragraph:
 9 "Although non-A, non-B hepatitis is, on the
 10 average, less acutely severe than type B hepatitis, it
 11 can cause severe acute disease and, more disturbing,
 12 it appears to have considerable propensity to progress
 13 to chronic hepatitis. The major thrust of
 14 post-transfusion hepatitis research must now be
 15 directed at developing detection methods for the
 16 non-A, non-B agent(s) or developing some reliable
 17 method of viral inactivation or removal which would be
 18 independent of testing."
 19 Do you recall -- would you have seen this
 20 article, do you think?
 21 **A.** I can't -- I can't recall this at all. It's before
 22 I was even appointed, actually. And it's not in
 23 a sort of a journal one would be reading as
 24 a registrar. It's specialist. But what it says is
 25 true, isn't it?

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1 **Q.** Yes. And do you recall whether or not that kind of
 2 information is information that you knew by, say,
 3 1978?
 4 **A.** I can't recall it but I do not think -- I don't think
 5 it would have been in the mainstay in my brain, you
 6 know, about this, because I wasn't actually practising
 7 proper -- you know, haematology to do with blood
 8 products, really. But what it says, it makes sense,
 9 you know.
 10 **Q.** So, then the next article is RLIT0000228.
 11 Again, this is a 1977 publication. So at this
 12 point you are a senior house officer in pathology in
 13 Manchester. Again, is this something that you recall
 14 reading at the time?
 15 **A.** Not at all.
 16 **Q.** Just look at the summary there.
 17 **SIR BRIAN LANGSTAFF:** If he doesn't remember it, shall we
 18 move on to something else.
 19 **MS SCOTT:** Then the next one is PRSE0003622.
 20 **Q.** This is September 1978, so by now you're between Leeds
 21 and Bradford. I understand you started your senior
 22 registrar in haematology in August, so this is coming
 23 out just after then. You said you didn't get
 24 The Lancet, but do you think that's something that you
 25 could have come across, given that it was in

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1 The Lancet?
 2 **A.** I think this publication is a major publication.
 3 **Q.** Yes.
 4 **A.** You know, it's a very, very important publication, by
 5 very important people. I've seen this a few times,
 6 maybe not in '78 but certainly in the last 20 years.
 7 **Q.** Can you recall when you did see it first?
 8 **A.** This would have been discussed in the first meetings
 9 that I went to, in international or national. There
 10 would have been presentations by Eric Preston or one
 11 of the others, maybe Dr Triger. You know, it's
 12 possible. So I would have come across it from 19 --
 13 in the early 80s, really.
 14 **Q.** So you think that's something you would have come
 15 across in meetings, as a Director of the Centre,
 16 UKHCDO or other international meetings, in the
 17 early 80s?
 18 **A.** This material would have been quoted or mentioned.
 19 All right, it's a few years later, but it's a very,
 20 very important publication, this.
 21 **Q.** And you don't think it's something that would have
 22 been talked about on the wards with Professor Turner,
 23 for example, or Dr Swinburne, when you were working
 24 between Leeds and Bradford in '78?
 25 **A.** No.

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1 **Q.** Because those sorts of discussions just didn't take
 2 place?
 3 **A.** No, because we had our own clinical practices and we
 4 never had -- or hardly ever, I think, we had joint
 5 meetings to discuss scientific papers or scientific
 6 knowledge or even -- even management of haemophiliacs
 7 as such. They were rare and in between. Maybe there
 8 should have been more meetings, more regional
 9 meetings. I think we had attempted to try to have
 10 more regional teachings but they were rare events, if
 11 they were at all, you know.
 12 **Q.** Just looking at the summary in this paper:
 13 "Systematic screening of 47 haemophiliacs in
 14 Sheffield revealed abnormal liver-function tests in 36
 15 (77 per cent) with a tendency for these abnormalities
 16 to persist. To assess the importance of these
 17 abnormalities ... liver biopsy was carried out on
 18 eight symptom-free patients ... A wide spectrum of
 19 chronic liver disease was demonstrated, including
 20 chronic ... hepatitis and cirrhosis."
 21 So would you accept that by the time you did
 22 become aware of this paper, for example, in -- I think
 23 you described in the early 80s, that you were aware
 24 that non-A, non-B was a clinically significant
 25 condition that carried a significant risk of causing

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1 liver disease?
 2 **A.** My first unfortunate experience with hepatitis, non-A,
 3 non-B, was at St James's when I was Senior Registrar.
 4 A gentleman came in, in his 70s, for a prostate
 5 operation. He was a mild haemophilic. He had never,
 6 ever been exposed to concentrates or cryo or any other
 7 blood products related to his haemophilia. I think
 8 his level was about 34 per cent or so, and he was
 9 treated with Factor VIII concentrate. I don't know
 10 whether it was commercial or whether it was NHS. He
 11 became jaundiced within about three or four weeks and
 12 he died.
 13 Now, that's the sort of education you don't
 14 forget, that people who have never been exposed, that
 15 were given concentrates could give them non-A, non-B
 16 hepatitis and it was not a benign disease.
 17 My other experience, which again, and I feel
 18 very sad about it because he was a very, very good
 19 friend, haemophilic in Bradford in the early '80s.
 20 He had liver disease with a big enlarged spleen, quite
 21 advanced liver disease, and he -- my predecessor
 22 should have advised him not to have alcohol, you know,
 23 which he did and I used to advise him not to drink
 24 alcohol. Now, alcohol and non-A, non-B hepatitis, or
 25 hepatitis of any sort, they don't go well together at

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1 all. So one of the things we always did was to
 2 advise -- and he died because of his non-A, non-B
 3 hepatitis. So, yes, the lessons were there. I didn't
 4 need a biopsy to tell me that some of these people
 5 died from non-A, non-B hepatitis, that it wasn't
 6 a purely benign disease.
 7 **Q.** That first experience that you had at St James's, that
 8 would have been somewhere between 1978 and 1981?
 9 **A.** Absolutely, yes.
 10 **Q.** Given your previous evidence, I suspect the answer to
 11 this is no, but was there any discussion, any
 12 opportunity during that period, for you to discuss
 13 liver disease, for example, with your colleagues who
 14 were working in the liver units and liver specialists?
 15 **A.** Yes, because if -- now, again, I can't tell you the
 16 exact times but I was in quite close links and talks,
 17 and Dr Bacarius(?) from Sheffield used to come to
 18 Bradford and give talks. I used to get people to come
 19 to Bradford, even like Tuddenham and Rizza came -- he
 20 was one I could listen to and I used to, but we had
 21 our own liver specialist and we used to work closely.
 22 If there was any inkling that there was
 23 significant liver disease then I would involve the
 24 hepatologists but we did not do liver biopsies.
 25 **Q.** So, by the time you were centre director, you have

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1 described how you had -- you know, you wanted to give
 2 people a good training and that seemed to make the
 3 hospital attractive to clinicians and students, and so
 4 on, then there was an opportunity for education from
 5 liver specialists, and so on. But before that, in the
 6 era where we're talking about, where you are working
 7 in 1978 to 1981 with Dr Swinburne and
 8 Professor Turner --
 9 **A.** Yes, sorry, my previous answer was when I was already
 10 director.
 11 **Q.** Yes.
 12 **A.** Now, '78 to '81 I don't think liver disease was
 13 discussed at any time -- mentioned maybe, yes. When
 14 I was senior registrar in Jimmy's, Dr Swinburne was
 15 immunologist. She never actually -- we never had any
 16 formal training from her about haemophilia, et cetera,
 17 although she was the director. We used to work with
 18 the haematologist Dr Barnard, and so on. But the
 19 focus was on malignant haematology and at Bradford, as
 20 you know, we had Professor Turner who was not well and
 21 never got involved in -- so our education as Senior
 22 Registrar was quite inadequate, you know. I think
 23 this applied to a lot of parts of Britain, by the way.
 24 We were not unique.
 25 **Q.** So as this knowledge about non-A, non-B was emerging,

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1 would you agree that patients being treated with
 2 factor concentrates should have been told about the
 3 risk arising from their treatment with factor
 4 concentrates?
 5 **A.** Patients were quite aware about viral infections
 6 because, you know, even -- they had their own groups,
 7 support groups, and certainly when I was consultant we
 8 had set up a group through the nurses, and so on.
 9 They were quite well informed by the society and so
 10 on.
 11 We always told them -- well, we always had
 12 a programme for vaccinations so they knew why they
 13 were getting vaccinations.
 14 **Q.** For hepatitis B, would this have been?
 15 **A.** Hepatitis B, yes. So it wasn't as if they were
 16 completely ignorant of the fact that -- what we were
 17 trying to do.
 18 What was difficult -- there were two areas of
 19 difficulty in the early 80s. One was if you had
 20 abnormal liver function enzymes, you know, what we
 21 call transaminitis, what it actually meant. So the
 22 best thing we could do there was do tests and tell the
 23 patients that, "You've got slight elevation of your
 24 liver enzymes and we're keeping an eye on it."
 25 Now, raised transaminases are very common even

1 now, you know. In my case, my transaminases were
 2 elevated. The doctors thought I had haemochromatosis
 3 and I didn't. It turned out it was a fatty liver.
 4 Very common to be raised transaminases in diabetics,
 5 et cetera. So it wasn't just confined to
 6 haemophiliacs. So the interpretation was difficult,
 7 and we couldn't, obviously, do liver biopsies. You
 8 could do ultrasound and so on, but they were told that
 9 "We are watching". Every three months, we used to
 10 keep an eye on it and if they went beyond a certain
 11 level, then I would refer them to a hepatologist.
 12 **Q.** Were they ever told they had or that you thought that
 13 they had non-A, non-B hepatitis?
 14 **A.** You've got to be careful because you are saying
 15 "non-A, non-B" and "hepatitis", so when you use the
 16 word "hepatitis", that brings a picture of inflamed
 17 liver, "Oh, I'm sick, I'm ill", okay?
 18 "Non-A, non-B" implies there's a C to Z, you
 19 know, which we didn't know anything about. So the
 20 patients were told that they've got possibly a slight
 21 inflammation of their liver, which in medical terms is
 22 hepatitis -- we might not have used that term -- and
 23 that we're watching their enzymes and they must not
 24 drink alcohol. I think that was something that would
 25 have to be told to them universally you know. That's

1 very important.
 2 **Q.** Would they have been given advice about infecting --
 3 potentially infecting other people --
 4 **A.** If we knew that it was non-A, non-B hepatitis, then
 5 obviously we would tell them. If they had hepatitis
 6 they would be told. But, like I said, the
 7 interpretation at that time was difficult.
 8 **Q.** So --
 9 **A.** That's why this liver biopsy, you know -- this was
 10 very important, you know, because what it said
 11 was: you can't actually rely on those enzymes only.
 12 So you can have very low enzymes and you can have
 13 quite serious liver disease and you can have very high
 14 enzymes, in which case you had hepatitis, non-A, non-B
 15 hepatitis.
 16 The way the UKHCDO in the studies define
 17 hepatitis is 2.5 times the transaminases, you know,
 18 when you were dealing with products that were given.
 19 Well, if they didn't have enzymes that were 2.5 times,
 20 how could you then say, you know, you didn't know?
 21 I mean, did I have hepatitis when I had raised
 22 enzymes? No, I didn't.
 23 **Q.** So in the late 70s, early 80s, how would you diagnose
 24 non-A, non-B in one of your patients with --
 25 **A.** Well, you had to look at the enzymes but also you were

1 looking at -- like I mentioned about this patient
 2 where he had a big spleen -- enlarged spleen at the
 3 same time, or if there were things that related to
 4 liver disease, other signs and symptoms of blood
 5 tests, you know, that -- then, yes, they would be
 6 investigated but simple raised enzymes by itself was
 7 very difficult interpretation for us.
 8 **Q.** So patients that were coming in with raised enzyme
 9 levels, from your evidence, very unlikely you would
 10 have mentioned non-A, non-B hepatitis to them?
 11 **A.** I think it's very unlikely we would have said they've
 12 got hepatitis, but we would have said that, "You have
 13 got slight inflammation", which is the same thing,
 14 "There is a possibility you've got inflammation of
 15 your liver, and it's not hepatitis -- we don't know,
 16 you know, it's something we have to keep an eye on,
 17 but avoid alcohol intake."
 18 **Q.** But unlikely those patients would have been given
 19 advice about not infecting others because the
 20 diagnosis --
 21 **A.** Well, if you proved it was infection, then yes, we
 22 would tell them --
 23 **Q.** But just with the raised transaminase you are saying
 24 that you wouldn't have known it was an infection?
 25 **A.** No, we wouldn't have.

1 And like I said, maybe 10 per cent of all UK
 2 residents have raised transaminases.
 3 **Q.** Did you have any patients that had the raised
 4 transaminase plus, if I can put it that way, so other
 5 features that would lead you, over that period, to
 6 diagnose them as having non-A, non-B?
 7 **A.** Yes, there would be, and that's where I would seek
 8 professional help.
 9 **Q.** And you recall having patients?
 10 **A.** You know, from liver specialists. Sorry?
 11 **Q.** You recall having patients?
 12 **A.** Well, I just mentioned one that died. But one of the
 13 impression was that it was a benign thing, as you
 14 know, and this -- the thing about the study you've
 15 shown is that it's not that benign. You know, now we
 16 know that it's not that benign. Because people like
 17 Eric Preston were brave enough to do liver biopsies.
 18 **Q.** So for those patients where you thought, well,
 19 actually, there may be non-A, non-B here, you've
 20 described that you would seek help from liver
 21 specialists?
 22 **A.** Yes, if there was a reason to worry, if they were
 23 increasing, if they were unwell, then we would seek --
 24 I would probably have done an ultrasound, you know, in
 25 the first instance as well.

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1 **Q.** What would you have told the patients?
 2 **A.** They would be investigated.
 3 **Q.** Would you have told them about hepatitis?
 4 **A.** Yes. But like I said, they were also very well
 5 informed, you know. But yes, we would have discussed
 6 it, yes, the possibilities, et cetera. I think it
 7 depends on individual circumstances, isn't it?
 8 I mean, you're asking a generalisation, and patients,
 9 you can't -- they are individuals at the end of the
 10 day.
 11 **Q.** But if you suspected non-A, non-B, would you give --
 12 irrespective of who the patient is, would you have
 13 given advice about not infecting others, do you think?
 14 **A.** If the suspicion was high enough, if there was
 15 sufficient abnormality, then the answer is yes. But,
 16 you know, one of the problems is, like I said, you
 17 think non-A, non-B, how much knowledge did we have,
 18 otherwise we wouldn't call them non-A, non-B until we
 19 had the hepatitis C diagnostic test. You know, it was
 20 a grey area for everyone.
 21 **Q.** So were you cautious about passing this information on
 22 to patients during this period before hepatitis C had
 23 been described?
 24 **A.** One thing about haemophiliacs, most of them were
 25 intelligent. They were very nice people, very

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1 intelligent, they had come to know me and my staff
 2 very well and we could talk, we could discuss things.
 3 There was no problem discussing anything about their
 4 tests at all, at any time.
 5 I think the danger was when you didn't discuss
 6 or you kept things away from them. Honesty paid with
 7 patients, haemophilia patients, because that was
 8 something they had to latch on. There wasn't much
 9 they could -- you know, we were their friends. They
 10 had to rely on what we said. Doctors were terribly
 11 important to them, you know.
 12 **Q.** I'm going to move on now to knowledge of HIV. Can you
 13 recall when you first became aware of AIDS?
 14 **A.** Like I said, we were always desperate for knowledge
 15 and information and, as soon as -- it must have
 16 been -- the first case, I think, was in '83, wasn't
 17 it, I think. I think by '84, '84 we were aware. As
 18 soon as the tests came, we tested people. So it must
 19 have been around '84, I think. I can't recall when
 20 the tests were. Was it 1984 it was available?
 21 **Q.** I will show you some documentation in relation to that
 22 in due course.
 23 So can I ask you again, the Inquiry have sent
 24 you a number of publications that were coming out at
 25 around the time the information about AIDS was

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1 emerging. First one is PRSE0000523. This is the MMWR
 2 report from July 1982 and the first paragraph there
 3 says that:
 4 "CDC recently received reports of three cases of
 5 [PCP] pneumonia among patients with haemophilia A and
 6 without other underlying disease. Two have died; one
 7 remains critically ill. All three were heterosexual
 8 males [with no IV] drug abuse."
 9 And all had lymphoma, et cetera.
 10 **SIR BRIAN LANGSTAFF:** Lymphopenia.
 11 **MS SCOTT:** Sorry. Then over the page, page 2 under
 12 "Editorial Note", second paragraph down:
 13 "The clinical and immunologic features these
 14 three patients share are strikingly similar to those
 15 recently observed among certain individuals from the
 16 following groups: homosexual males, heterosexuals [IV
 17 drugs abusers], and Haitians who recently entered the
 18 United States."
 19 Then:
 20 "Although the cause of the severe immune
 21 dysfunction is unknown, the occurrence among the three
 22 haemophiliac cases suggests the possible transmission
 23 of an agent through blood products."
 24 Then the last paragraph on that page, it just
 25 notes:

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1 "CDC has notified directors of haemophilia
 2 centres about these cases and, with the National
 3 Haemophilia Foundation, has initiated collaborative
 4 surveillance."
 5 Would you have seen that; is that something you
 6 would have seen at the time?
 7 **A.** Yes, I was aware of that, yes. I can't tell you
 8 exactly which date or when. That may have come from
 9 one of the documents I gave you, I don't know.
 10 **Q.** So it came out in July 1982. Do you think you would
 11 have seen it fairly soon after that?
 12 **A.** I might not have seen it because it's American but
 13 I would have heard of it. I mean, that was big news,
 14 wasn't it? Very relevant.
 15 **Q.** Yes, and you're a centre director by now --
 16 **A.** Yes.
 17 **Q.** -- and having discussions with your colleagues at
 18 presumably quite a high level and that's something --
 19 so reasonably soon after this came out, you think it's
 20 likely you would have been aware of it?
 21 Then, Henry, if you can go to PRSE0002410, which
 22 is a paper from the New England Journal of Medicine
 23 from January 1983. I think you said you had
 24 a subscription to this journal; is that right?
 25 **A.** Yes, I had the New England Journal, yes.

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1 **Q.** If we go, Henry, to the right-hand column, last
 2 paragraph:
 3 "Now we are becoming aware that treating
 4 haemophiliacs with Factor VIII preparations may exact
 5 a high cost. Reports from the CDC include three
 6 haemophiliacs among cases of Acquired Immunodeficiency
 7 Syndrome. Only recently recognised, this syndrome is
 8 associated with abnormalities of immuno-regulation and
 9 a profound susceptibility to opportunistic infections;
 10 it is eventually fatal in many patients."
 11 Then over the page, please, Henry, to the --
 12 again, last paragraph on that left-hand column:
 13 "The fact that haemophiliacs are at risk for
 14 AIDS is becoming clear. If the use of cryoprecipitate
 15 will minimise this risk the current home-infusion
 16 programme needs to be revised."
 17 Do you recall having discussions then with your
 18 colleagues about the recommendations in here or the
 19 suggestions in here?
 20 **A.** I can't recall having discussions within the region,
 21 you know. I'm not even sure whether there were
 22 communications. There must have been something but
 23 this was at a time we were listening very carefully to
 24 UKHCDO, and there were a lot of mixed messages, you
 25 know, starting from "Oh, it doesn't apply to British

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1 products", that this is a one-off, this is early,
 2 et cetera. What were we to do about it? It's just
 3 too early. I don't think we could have done anything
 4 really. We were waiting, again, for instruction or
 5 guidance or ...
 6 **Q.** We will look in a moment about some of the messages
 7 that were coming from UKHCDO. I want to take this in
 8 chronological order, if I may.
 9 Henry, can we have PARA000013. Now, this is
 10 a document that was in your papers and it seems to be
 11 a meeting from 8 March 1983. It's not a terribly good
 12 copy but it seems to be the Haemostats Club?
 13 **A.** Haemostasis Club.
 14 **Q.** What was that?
 15 **A.** I don't know because it says Professor Jeanne Luscher.
 16 That's American. So whether this was from there or
 17 whether somebody had copied -- you know, typed out
 18 information from that Haemostasis Club, I don't know
 19 but it says Professor Jeanne Luscher, and it starts
 20 very strangely:
 21 "Or if you have missed Herpes this is all you
 22 need to know ..."
 23 **Q.** Yes. So if we turn over the page to three paragraphs
 24 up:
 25 "There are no reports of AIDS in UK

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1 haemophiliacs yet."
 2 It does seem to suggest that this is a paper
 3 that was concerned anyway with the UK, albeit given by
 4 an American professor?
 5 **A.** But I think there was a Haemostasis Club in UK. So
 6 whether they transcribed, you know --
 7 **Q.** Do you know --
 8 **A.** I wasn't part of it.
 9 **Q.** You weren't part of it. Did you ever go to any of
 10 their meetings?
 11 **A.** No.
 12 **Q.** Do you know who was a part of it?
 13 **A.** Well, it would be some members of the UKHCDO and --
 14 I honestly couldn't tell you but it wasn't --
 15 **Q.** So this is not a meeting you would have gone to?
 16 **A.** No, or whether it was something in the south-east, you
 17 know, around that area. I don't know.
 18 **Q.** Do you have any recollection of how this document came
 19 to be in your possession?
 20 **A.** No, I can't recall whether -- it's been sent to me
 21 obviously. Whether it was sent through the region,
 22 you know, through Leeds or whether it was sent from
 23 somewhere else, I have no recollection. It's a very
 24 poor type, isn't it?
 25 **Q.** It is. And unfortunately some of the bottom half of

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1 the second page is missing as well.
 2 So can you help us at all with when you would
 3 have received that?
 4 **A.** No, not really. But it's an important document, and
 5 I think it's from the UK haemostasis group. And
 6 I think it would be -- it would have involved the
 7 directors from south-east England, you know.
 8 **Q.** Did you have a channel of communication with them for
 9 the exchange of information?
 10 **A.** No, not really. No.
 11 **Q.** We can see what is being said there, that the
 12 distribution of those with AIDS: 1 per cent
 13 haemophiliacs. That's under "Distribution", and
 14 then --
 15 **SIR BRIAN LANGSTAFF:** I think you are on the previous
 16 page, are you?
 17 **MS SCOTT:** Yes, sorry.
 18 First page, sorry, Henry.
 19 So under "Distribution" we can see:
 20 "Haemophiliacs: 1 per cent."
 21 And then under "Geographical Distribution", it
 22 says:
 23 "Mortality: 80 per cent so far."
 24 **SIR BRIAN LANGSTAFF:** Just pausing there, that 1 per cent
 25 is 1 per cent -- let's just go the page a bit please,

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1 Henry -- of the 1,250 cases.
 2 **MS SCOTT:** Yes.
 3 **SIR BRIAN LANGSTAFF:** So that's going to be 12 cases.
 4 **MS SCOTT:** Yes.
 5 Then underneath "Mortality" it says:
 6 "Communicable disease centre [CDC] in USA
 7 postulates that AIDS is caused by transmissible agent
 8 (probably new or variant [sic]" --
 9 **SIR BRIAN LANGSTAFF:** "Mutant".
 10 **MS SCOTT:** "Mutant", sorry.
 11 "... mutant virus) which entered populations in
 12 1978/1979 ..."
 13 Then it says:
 14 "Problem accentuated by 'fast lane' type
 15 individuals with as many as 100s - 1000s of sexual
 16 contacts. These individuals also tend to sell or
 17 donate blood - hence the possible reason for
 18 haemophiliacs coming into the chain."
 19 Then over the page:
 20 "AIDS shares some common properties with
 21 Hepatitis B, i.e. long incubation period which has
 22 been deduced from victims who have received only one
 23 blood donation contracting AIDS 12 months later."
 24 Then below "Immunological Defects" it says:
 25 "It is possible that haemophiliacs have altered

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1 T4/T8 ratio and immune status from continual antigenic
 2 bombardment, and therefore succumb to AIDS type virus
 3 more easily."
 4 Then it sets out the recommendations from the US
 5 National Treatment Council:
 6 "1. Use cryo or [fresh frozen plasma] for
 7 children under 4 ...
 8 "2. Use DDAVP where possible.
 9 "3. Do not undertake elective surgery if
 10 possible.
 11 "4. No longer obtain concentrate donations from
 12 high risk areas.
 13 "5. Attempt to screen out high risk groups eg
 14 use questionnaire ...
 15 "6. Heat treat concentrate to reduce virus ...
 16 "7. Suggestion raised to use Porcine
 17 Factor VIII, only [question mark] what grotty viruses
 18 do pigs have?"
 19 And then it says:
 20 "There are no reports of AIDS in UK
 21 haemophiliacs yet."
 22 Then there is a paragraph at the bottom of that
 23 which is cut off:
 24 "There was some discussion relating to lack of
 25 cases in UK but it was pointed ... [something] the

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1 epidemic may yet come.
 2 "The implications of this happening are cause
 3 for great concern."
 4 So would you agree that that --
 5 **SIR BRIAN LANGSTAFF:** We have missed that. Is that on the
 6 other page?
 7 **MS SCOTT:** Sorry, the next page. Go over to the next
 8 page:
 9 "The implication of this happening are cause for
 10 great concern."
 11 So would you agree that that document contains
 12 really all of the key information about AIDS: that
 13 it's via a transmissible agent, blood; haemophiliacs
 14 are at particular risk for that reason and so on; and
 15 setting out treatment recommendations. So that
 16 document provides all the key information that would
 17 be of huge significance to somebody treating people
 18 with haemophilia in March '83?
 19 **A.** Absolutely. And I think all that information is
 20 American. Obviously, somebody's brought it to the
 21 haemostasis club here, I think, in the UK, and printed
 22 it very badly. And it's also -- the last paragraph is
 23 slightly mixed up with -- that's acute lymphoblastic
 24 leukaemia trials but anyway.
 25 **SIR BRIAN LANGSTAFF:** Can you help just on the point of

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1 whether it's American or British.
 2 Dr Lilleyman; do you know of Dr Lilleyman?
 3 **A.** Yes, he's a paediatrician.
 4 **SIR BRIAN LANGSTAFF:** In England?
 5 **A.** In England, yes, it's British. But Luscher is
 6 American.
 7 **SIR BRIAN LANGSTAFF:** Yes. So it seem to be a rather
 8 mixed production.
 9 **A.** Yes. But I think this was always important, that what
 10 information -- Americans were well ahead with
 11 information, research, et cetera. It's how we
 12 translate it to Britain. And if it was now, it --
 13 I presume there are organisations in Britain that
 14 would have picked up immediately and taken action, you
 15 know, to -- that since whatever -- whatever, you know.
 16 Here it seems that you had the information, it
 17 was how it was going to be used in Britain and who's
 18 going to be responsible for noting this information
 19 and doing something about it. And people like us were
 20 really waiting for instruction, basically. Not just
 21 knowledge, but instruction.
 22 And if there was any suspicion of any of the
 23 products having this -- because it says that the
 24 American product, they were already thinking of
 25 litigations, they were already putting warnings on the

1 products, but the same products were coming here and
 2 nothing was happening. And we were not independent to
 3 make decisions of ourselves. We needed guidance. We
 4 needed leadership in this.
 5 Now whether that leadership could have been from
 6 UKHCDO, it could have been from Medicine Agency, it
 7 could have been from all sorts of things, but it
 8 didn't -- I don't think we actually got -- but there
 9 was a lot of this business, "Oh, we're not sure what
 10 it means", "Oh, British products", "There's been no
 11 cases in Britain". Well, once you get cases in
 12 Britain it's too late, because the horse has bolted,
 13 and that's exactly the history. I think that's what
 14 happened is we got all these cases after -- while
 15 people were waiting for them to happen, and they did
 16 happen.
 17 **SIR BRIAN LANGSTAFF:** And about this time there was quite
 18 a lot of talk in the press I think, in New Scientist
 19 and The Observer, in January of 1983.
 20 **A.** Yes.
 21 **SIR BRIAN LANGSTAFF:** So that obviously is the press. And
 22 you may read the media, I suppose, with the same eye
 23 that others do, you may think, well, do they really
 24 know what they are talking about, and you -- but it
 25 does raise questions, doesn't it?

1 **A.** Yes. And this is where I must say I feel sorry, you
 2 know, that with better guidance, better leadership,
 3 from whatever source -- you know, we were only minions
 4 in the big cog. We were not even a Reference Centre.
 5 But with better leadership from whatever source we may
 6 have saved some cases. Not all. We may have done
 7 better than we did.
 8 **SIR BRIAN LANGSTAFF:** You said that this particular
 9 document, in March of 1983, was a particularly
 10 important document to you?
 11 **A.** Yes, but I can't recall when I received it or how
 12 I received it. But it's a very important document,
 13 and I'm sure you will be able to find out what this
 14 "Haemostasis Club" is and find their minutes, you
 15 know.
 16 **SIR BRIAN LANGSTAFF:** Why do you regard it as so
 17 important, this particular document?
 18 **A.** Because it looks like pre-publication. It looks
 19 like -- you see, one of the things that -- there were
 20 small groups in America that produced their own
 21 newsletters. I'm trying to think of the lady that
 22 used to do it in California. She used to produce her
 23 own newsletter. And I think this Luscher may have --
 24 this information may have been from within their own
 25 discussions. But as I mentioned before, by the time

1 it reached publication there would be a delay of
 2 a year, maybe six months. So I suspect this was
 3 probably being discussed because there was -- possibly
 4 to help litigations. You know, they are already
 5 talking of somebody being sued.
 6 I think Americans are well aware of
 7 possibilities -- what -- if things went wrong,
 8 therapeutically. You know, unlike in Britain. Now
 9 it's obviously different, you know. I don't know.
 10 **SIR BRIAN LANGSTAFF:** Thank you very much.
 11 **MS SCOTT:** So having seen that New England Journal article
 12 in January 1983 that we went to earlier, would you
 13 agree that patients around about that time needed to
 14 be told that there was a real risk that blood products
 15 could transmit AIDS, not that it was certain but that
 16 there was a real risk that that was the case?
 17 **A.** You know, if you did that, what were the alternatives
 18 we were going to offer them? You know, it's like when
 19 you do a blood test, if you get an abnormal result --
 20 if you are going to do, then you should know what
 21 you're going to do about it.
 22 I think at that stage what we were really saying
 23 to everybody, and to ourselves, or convincing
 24 ourselves: let's wait for more information from people
 25 who are more learned than me. You know, who have more

1 at risk than me, more patients than me. Let's try and
 2 hear from the people who really matter in this
 3 country.
 4 And we were getting very mixed messages, as you
 5 know. And I think you've got all those articles and
 6 documents to see what mixed messages they were.
 7 **Q.** So there was no solution that could come from the
 8 medical world at that point but it would have made
 9 a difference to patients, wouldn't it, because they
 10 would have then had a choice about whether or not, for
 11 example, they wanted to continue with their treatment
 12 or what decisions they were going to make about their
 13 treatment, knowing the risk?
 14 **A.** You see, the alternative, if we were talking to them
 15 then they would say: well, Doctor what about NHS
 16 factor? You couldn't say NHS Factor VIII from up to
 17 5 to 10,000 donors couldn't carry a risk. You
 18 couldn't say that.
 19 **Q.** No.
 20 **A.** If you said, okay, go to cryoprecipitate, you couldn't
 21 promise them and then tell them to use cryoprecipitate
 22 which is really a very, very difficult thing to use,
 23 you know. So what you would be telling is: okay
 24 you're going to go backwards to the treatment of the
 25 '60s and '70s, you know. You must -- at the end of

1 the day, Factor VIII revolutionised haemophilia care,
 2 you know, from -- I mean, if you had seen how badly
 3 deformed -- what deformities haemophiliacs had and
 4 what sort of lives -- and the lifespan was reduced
 5 down to 40 or 50 years in the 1950s, in the '80s their
 6 lifespan was normal.
 7 So I think one has to be careful to say, look,
 8 we're going to turn the clock back, now, sorry we made
 9 a mistake or we think we are going to make a mistake;
 10 it doesn't quite work like that. What we needed was
 11 to say: right, this is a possibility, what is the
 12 Government doing, what is the Health Services doing,
 13 what is the Reference Centres doing, what are the
 14 scientists doing, what are the pharmaceutical
 15 companies doing about this?
 16 I think they were trying, I think they were
 17 trying to very hard. But I think in America they were
 18 trying harder than we were trying in Britain, although
 19 America had obviously their own problems about their
 20 donors, and so on. Britain was an ideal place,
 21 actually, because there were good British donors well
 22 tried out, and maybe the BPL and NHS should have taken
 23 a lead there, you know.
 24 **Q.** When do you think that you did start telling your
 25 patients about the risk of AIDS?

1 **A.** I think when we knew the risks of AIDS or what are the
 2 chances of risks of AIDS. You see, by the time we
 3 could test people for AIDS they were already positive.
 4 There's quite a lot of them positive. I think in our
 5 centre probably less than other places, and I think
 6 what you've got with Adrian Minford, there were four
 7 kids, children, which is low but serious. But by the
 8 time we were able to test them, quite a lot were
 9 already infected.
 10 **Q.** So do you think -- and I appreciate I'm asking you to
 11 remember things a long time ago -- but do you think
 12 you weren't having discussions with your patients
 13 about the risk of AIDS before the test became
 14 available, for example?
 15 **A.** We might. I cannot tell you because they read the
 16 press, you know. They have access to media, as much
 17 as I have.
 18 **Q.** So patients were coming to you in clinic and asking
 19 about it, were they?
 20 **A.** They probably would have and I would have talked
 21 frankly about it.
 22 **Q.** Do you have any actual recollection of that?
 23 **A.** I couldn't because it's a whole period full of --
 24 there were memories we didn't really want to bring
 25 back until this, you know. We had ourselves, as

1 directors, had quite traumatic period, you know, in
 2 the '80s.
 3 But I can't recall, honestly. I could try very
 4 hard but we were -- you see, at that time in the '80s,
 5 there was a lot of resistance from the gay rights
 6 group that we shouldn't even be testing people, you
 7 know, that it was -- we shouldn't be testing them and
 8 we shouldn't be telling them and in Bradford
 9 I remember having a difficult time because, all right,
 10 you should counsel them and test them, and so on, but
 11 there was this opposition that you should keep HIV out
 12 of, well, hospitals, everywhere, you know.
 13 Sorry, I'm ...
 14 **Q.** No, don't apologise to me. During the time you think
 15 when you started speaking to patients about AIDS was
 16 when you knew -- you said when you knew about it, when
 17 you understood that it was transmitted by blood; is
 18 that when you think you would have told them?
 19 **A.** I think the main time to discuss and talk about this
 20 was when the test was available because it was very
 21 important that we share it --
 22 **Q.** That was something you could do?
 23 **A.** Yes, but there was a moment that said don't tell them,
 24 which I totally disagreed with them. Actually, when
 25 you look at the earlier -- you showed some

1 comprehensive care, you'll see that we tried to have
2 a counsellor, social worker, et cetera, you know, we
3 tried to have a comprehensive -- and we tried to have
4 clinics where we could give them time to talk about
5 it, you know. So as soon as there was any possibility
6 of patients having HIV, we would discuss it, you know.

7 Like I said, you can achieve a lot of things by
8 being honest with patients. They are quite
9 intelligent, very knowledgeable, generally.

10 **MS SCOTT:** I note the time, sir, we are going to look at
11 some of the contemporaneous documents after lunch and
12 it may be that that will assist your memory.

13 **SIR BRIAN LANGSTAFF:** Yes, we will take a break now until
14 2 o'clock. So 2.00 the same rules apply. So 2.00,
15 please.

16 (1.01 pm)

(Luncheon Adjournment)

18 (2.00 pm)

19 **MS SCOTT:** I'm going to ask you some questions now about
20 some documents you have mentioned both in your witness
21 statement and this morning and it's the statement --
22 you mention that you were getting conflicting
23 information about AIDS, in particular from UKHCDO, and
24 you exhibit to your witness statement a letter written
25 by The Haemophilia Society which quotes

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1 Professor Bloom in May 1983, saying that the cause of
2 AIDS was quite unknown and it has not been proven to
3 result from transmission of a specific infective agent
4 in blood products. You are familiar with that letter?

5 **A.** Yes.

6 **Q.** Professor Bloom also makes a similar-ish comment in
7 October 1983 at a UKHCDO meeting that you attended.
8 He said:

9 "There's no need for patients to stop using
10 commercial concentrate because at present there's no
11 proof that the commercial concentrates were the cause
12 of AIDS."

13 The Inquiry has looked at both of those
14 documents, particularly that latter document, a minute
15 of that latter meeting on various occasions. Can you
16 recall that meeting? Do you remember that meeting in
17 October 1983 when Professor Bloom made that comment?

18 **A.** Not the meeting itself. I don't recall the meeting
19 itself but I would have been there. I think I was
20 there.

21 **Q.** But you do recall seeing the letter from The
22 Haemophilia Society in May 1983?

23 **A.** Yes, yes. That was in my possession, so ...

24 **Q.** Indeed. That was in your possession, exhibited to
25 your witness statement.

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1 Can you remember now what you thought about
2 that, about what Professor Bloom was saying, given
3 that you had, for example, read the January 1983
4 Lancet article which said something rather different?
5 Do you recall being surprised at what he was saying at
6 that stage?

7 **A.** Confused.

8 **Q.** Sorry?

9 **A.** Confused.

10 **Q.** Confused.

11 **A.** Because -- and it's odd, actually, you know. I think
12 to make a blatant statement like that it's a bit
13 unusual, you know, to -- a lot of medicine, if you've
14 got evidence somewhere else of something like this,
15 then you've also got to think of probability. So you
16 can't make -- with human beings when you're dealing
17 with them, you can't say: right we're going to -- we
18 must have at least ten people in this country who are
19 infected and three dead before we make a statement.
20 A statement should have been based on probability and
21 saying: it's likely but there's no evidence yet. So
22 I was a bit surprised and it's confusing.

23 I know why he was doing it, he was trying to
24 reassure the haemophilia population that don't rush
25 off to your centres and demand change.

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1 **Q.** So at the time, as you say, you were confused, was
2 that because you knew that what he was saying was
3 inaccurate and it was confusing why would he be saying
4 this?

5 **A.** Yes, why would he be saying that? Not inaccurate,
6 I wouldn't say it's inaccurate; it's probably
7 accurate.

8 **Q.** Yes.

9 **A.** But, you know, to tell a lot of people something that
10 could potentially be proved wrong it's not what
11 I would call a good politician, you know. That's
12 a wrong ... but that's not the sort of thing a person
13 in public eyes should be doing, you know.

14 **Q.** Presumably, your patients were reading this letter --

15 **A.** Yes.

16 **Q.** -- and not many of them, if any of them, would have
17 had access to the sort of Lancet articles and other
18 material that you and other clinicians have been able
19 to read. Did that concern you, that the information
20 that they were getting from The Haemophilia Society
21 was giving this particular impression which, while
22 accurate, may have been misleading?

23 **A.** Well, he wasn't wrong but it's not the sort of
24 statement you'd make. So, in a sense, I think he was
25 trying to reassure the haemophilia population and it

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1 obviously made our job that bit easier, because we
 2 didn't have loads of people ringing up, you know,
 3 about it. But it's an unfortunate -- I think it's
 4 an unfortunate letter. It's an unfortunate statement,
 5 specially from somebody like Professor Bloom who is
 6 very highly regarded. But how much pressure he was
 7 under to make a statement like that from the society,
 8 I don't know.

9 **Q.** Did it concern you that that was the information that
 10 your clients were getting?

11 **A.** Sorry?

12 **Q.** Did it concern you that that was the information your
 13 patients were getting?

14 **A.** I can't remember what I thought at the time.

15 **Q.** Do you recall whether or not, for example, you would
 16 have done anything in discussions with patients to
 17 actually make a rather more balanced appraisal of the
 18 risk?

19 **A.** This is a chronic cough, by the way.
 20 Sorry, could you repeat that, please?

21 **Q.** Yes. So do you recall whether you would have raised
 22 this with patients and given them perhaps a more
 23 balanced appraisal of the risk?

24 **A.** I wouldn't have raised it with the patients but the
 25 patients could have raised it with me, if they wished.

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1 **Q.** In response, would you have repeated what Dr Bloom
 2 says? Can you recall any --

3 **A.** No, I wouldn't have repeated it because we were all
 4 aware that some things were happening in America that
 5 ultimately would come here because it's the same
 6 product, you know. So I think I would have probably
 7 said let's wait and watch and see what happens and, as
 8 developments happen, as new information comes I will
 9 keep them informed and take action. There are actions
 10 I've taken. I think you may come to that later.

11 **Q.** Yes.
 12 Can I then move on to the other document I think
 13 you have referred to, which is the recommendations
 14 from UKHCDO if we can look at that, Henry, it's
 15 HCDO0000270_004. This is the 24 June 1983 Acquired
 16 Immune Deficiency Syndrome letter which you received
 17 from UKHCDO as a centre director and it sets out there
 18 following the meeting, this is the second paragraph
 19 down:
 20 "At the above mentioned meeting on May 13th the
 21 following general recommendations were [made]."
 22 Now, just before we get into that, is it your
 23 recollection that this was the first time the UKHCDO
 24 had made any sort of recommendation for treatment?

25 **A.** I don't know whether it's the first time but it's the

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1 one that we followed. You know, it's good advice.

2 **Q.** So you have there:
 3 "... mildly affected patients with haemophilia A
 4 or von Willebrand's disease and minor lesions,
 5 treatment with DDAVP should be considered."
 6 So you say you followed that?

7 **A.** Oh, yes we did, yes.

8 **Q.** Was that a change of treatment policy?

9 **A.** No. I can't remember exactly when we started DDAVP
 10 but it was quite early because we actually did some
 11 studies as well. I can't tell you exactly when and
 12 what but we weren't strangers to DDAVP.

13 **Q.** So that was, in effect, really just confirming what
 14 you were already doing?

15 **A.** Well, I would think so, yes, absolutely.

16 **Q.** Then paragraph 2:
 17 "... treatment of children and mildly affected
 18 patients or patients unexposed to imported
 19 concentrates many directors already reserve supplies
 20 of NHS concentrates ([whether cryo] or freeze-dried)
 21 and it would be circumspect to continue this policy."
 22 We had a bit of a discussion about that this
 23 morning about what your treatment policy was at this
 24 stage and I think you were a bit unsure about what it
 25 was. Can you recall whether on receiving this

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1 information, this letter, you changed your treatment
 2 policy?

3 **A.** I don't think we had to change. We were following it
 4 largely the same. I think Adrian Minford has put the
 5 same view, I think -- but you've got to remember that
 6 the way we treat patients it's -- there's -- you can
 7 have a guideline but it comes down to individual
 8 patients. So if a mildly affected patient was having
 9 a major operation, then DDAVP wouldn't work. It would
 10 be inappropriate. It wouldn't get enough. It would
 11 be an unreliable way of treating haemophilia because
 12 you couldn't predict what the response was going to be
 13 with DDAVP. Quite often, we gave a trial beforehand
 14 to see what sort of response they get, noted it so
 15 that we knew that when the time came we could give the
 16 DDAVP and we knew what the predicted response would
 17 be. But if it was a major operation you've got to
 18 have Factor VIII at surgical levels which is almost
 19 normal levels, otherwise there would be a danger of
 20 them bleeding.
 21 So on an individual basis -- but generally we
 22 would follow this, yes.

23 **Q.** Just on that point for surgery, was it your practice
 24 to ever use cryoprecipitate as cover for surgery?

25 **A.** No. No, cryoprecipitate is very unreliable, very

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1 cumbersome, takes a long time. Remember, when
 2 cryoprecipitate is prepared, if you don't give it
 3 fairly soon after preparation it itself has got
 4 a danger that it could get infected. No,
 5 cryoprecipitate really was not appropriate treatment.
 6 **Q.** I think from your statement for the returns that we've
 7 seen, you were only using cryoprecipitate at this
 8 point for von Willebrand's patients?
 9 **A.** Yes.
 10 **Q.** Then, from your statement, it appears that you didn't
 11 use cryoprecipitate for people with haemophilia A, at
 12 any stage?
 13 **A.** No, no, not generally and we used -- we had other
 14 bleeding disorders that we used cryoprecipitate. We
 15 were also a general hospital, so we had other bleeding
 16 problems that we used cryoprecipitate. So we did use
 17 cryoprecipitate in practice but, obviously, you know,
 18 this was as a general policy, yes, this is what we
 19 would have followed. On individual policy, it
 20 depended on the clinical condition that we were
 21 treating.
 22 **Q.** So do you remember, after receiving this document,
 23 ever offering a patient cryoprecipitate?
 24 **A.** I can't remember, no -- not with haemophilia, no.
 25 **Q.** Not?

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1 **A.** Not with haemophilia, no.
 2 **Q.** Not with haemophilia, even though the risk would have
 3 been lower of transmission of virus?
 4 **A.** Yes, but there were other risks with cryoprecipitate,
 5 you know, that really wouldn't have -- it wouldn't
 6 have made good medicine, medical practice. You know,
 7 cryoprecipitate it had a volume, it needed to be
 8 prepared, it was frozen, in a frozen state, there was
 9 delay in using it, unpredictable amounts of
 10 Factor VIII in it. There were a lot more impurities,
 11 protein impurities and other impurities, and you
 12 couldn't give vast amounts. There was a volume
 13 problem. So it's not the best product, really, to --
 14 **Q.** Is it fair to say that, really, you didn't -- I think
 15 you've said in your evidence earlier Factor VIII was
 16 revolutionary it was the new drug, cryoprecipitate was
 17 considered to be old fashioned. Is it fair to say
 18 that, really, you didn't even consider going back to
 19 cryoprecipitate at this stage?
 20 **A.** No, we didn't, no, unless it was for von Willebrand's,
 21 or Factor XIII we had deficiencies. There were other
 22 bleeding problems that we treated. We treated a lot
 23 more than other centres, you know.
 24 **Q.** Just picking up on that point can we go, Henry, please
 25 to PARA000015.

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1 This is a letter we've looked at already this
 2 morning. It's the letter from Dr Swinburne to you on
 3 7 July 1983 and we looked at it in relation to the
 4 contracting arrangements but it's the first paragraph
 5 I wanted to pick up with you now. It says there:
 6 "I have discussed the supply of Factor VIII and
 7 related products with Dr Tovey. In the light of the
 8 discussions we had about AIDS he and Dr Rajah have
 9 agreed to look into the question of cryoprecipitate
 10 and to maintain the supply."
 11 So I wonder whether you can recall the
 12 discussions that you were having with Dr Swinburne or
 13 the discussion you had with Dr Swinburne around this
 14 time about AIDS?
 15 **A.** Yes, but you've got this letter and then at the same
 16 time you've got another letter that says that
 17 Dr Swinburne was in favour of commercial products, in
 18 the same letter that I'd said that I favour NHS
 19 concentrates.
 20 **Q.** Yes, we're going to come on to that.
 21 **A.** Yes. So these are sort of contradictions, aren't
 22 they?
 23 **Q.** Yes, so do you recall the discussions that you had?
 24 The inference -- and I wonder if you would agree this
 25 is an appropriate inference to draw -- the inference

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1 that could be drawn from this letter is that you've
 2 had a discussion about AIDS and a concern about
 3 transmission of AIDS through factor products has been
 4 discussed, and so you're looking into whether or not
 5 you ought to be treating with cryoprecipitate in order
 6 to reduce that risk?
 7 **A.** Not necessarily because the question -- we use
 8 cryoprecipitate in lots of other things in
 9 haematology. So the fact that they were maintaining
 10 supply of cryoprecipitate was good news because we
 11 had DIC, you know disseminated intravascular
 12 coagulopathy --
 13 **SIR BRIAN LANGSTAFF:** I'm not sure that's reading it right
 14 because "maintain the supply" may, and in context,
 15 perhaps does, refer to the opening words of that
 16 paragraph "I have discussed the supply of Factor VIII
 17 and related products". So quite what it means isn't
 18 entirely clear. It's only clear to those who were
 19 party to whatever was going on at the time.
 20 Who is Dr Rajah?
 21 **A.** Dr Rajah worked in the blood transfusion but his main
 22 involvement was because it was a cardiothoracic centre
 23 at Seacroft and his main concern was to do with
 24 cardiac surgery. He played almost no role in treating
 25 inherited bleeding disorders.

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1 **SIR BRIAN LANGSTAFF:** So, in short, this is nothing to do
 2 with them looking into the question of what treatment
 3 to use, it's just a question of them both being
 4 involved in the supply side, looking to see whether
 5 they could supply perhaps more cryoprecipitate,
 6 perhaps the same amount of cryoprecipitate, it depends
 7 how you read it, and to maintain the supply of
 8 Factor VIII, if that's how you read it.

9 **A.** Well, I'm surprised Dr Rajah is mentioned, if it's to
 10 do with Factor VIII only, because he didn't use any
 11 Factor VIII but he did use large amounts of plasma and
 12 possibly cryoprecipitate, because it was a major
 13 cardiothoracic centre. He was a big user of blood,
 14 cryoprecipitate, plasma, et cetera but he never
 15 treated haemophilia or inherited bleeding disorders.
 16 So I'm surprised, you know, in what context his name
 17 is there. I think his name is in the context that
 18 a general supply of cryoprecipitate will be
 19 maintained, you know, for whatever treatment
 20 because -- and it's got lower risk of HIV.

21 **SIR BRIAN LANGSTAFF:** Thank you very much.

22 **MS SCOTT:** You have given evidence already that there was
 23 never a problem with cryoprecipitate but here there's
 24 a question about maintaining the supply. As far as
 25 you're aware, was that maintained?

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1 **A.** Oh, yes never had problems getting cryoprecipitate or
 2 fresh frozen plasma or platelets, you know. Very good
 3 Regional Blood Transfusion Centre actually.

4 **Q.** Can I then turn on to a meeting that took place in
 5 December 1984, which is at PARA0000008. This is
 6 a meeting held at the Blood Transfusion Service.
 7 You're present with Dr Swinburne, Dr Tovey,
 8 Dr Robinson and others. And we tried to identify who
 9 they were this morning.

10 It's a discussion about heat-treated Factor VIII
 11 or NHS untreated Factor VIII. That seems to be the
 12 discussion. It starts off:

13 "Although there is no proof or guarantee of its
 14 safety with regards to AIDS, it was agreed that on
 15 theoretical grounds heat-treated material was likely
 16 to be safe than non-heat treated material. However,
 17 Dr McEvoy and Dr Parapia agreed that they felt the NHS
 18 material was preferable to heat-treated American
 19 supplies. Dr Barnard and Dr Swinburne were in favour
 20 of heat-treated material from either source, but at
 21 the moment there is no hard evidence on which to base
 22 the choice."

23 So, just pausing there, do you remember this
 24 choice, as it were, at that time, between balancing on
 25 the one hand heat-treated commercial versus

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1 unheat-treated NHS Factor VIII?

2 **A.** Well, as a general principle I always supported NHS
 3 products whatever, but, like I said, the perception
 4 was that if any -- or, reasonably big centre like us
 5 managed to use NHS products only, that we would
 6 actually cause a shortage and -- St James's Hospital
 7 did use more commercial than NHS. I think we were
 8 probably balanced but gradually going on to
 9 commercial. Gradually. But -- I don't know.
 10 I think, in a sense, we were proved right, that the
 11 commercial products were not as safe as people
 12 thought, you know.

13 **Q.** So --

14 **A.** Then, having said that, I think if you gave enough of
 15 the NHS stuff, if you give enough, then the advantage
 16 was lost because the number of donors went up.

17 **Q.** So at that time, in December '84, you preferred -- if
 18 you had to choose between NHS unheated and heated
 19 commercial, your preference was for NHS unheated.
 20 That's what this letter said --

21 **A.** Yes, but having said that, again, I think the heat
 22 treatment as it -- they began to show the benefits of
 23 heat treatment. You know, because the lower
 24 temperature then higher temperature and then wet.
 25 This is only a letter in one point in that history,

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1 you know.

2 **Q.** Yes. So what I'm asking is, can you remember why you
 3 came to that view at that time?

4 **A.** No, I couldn't tell you. But I wanted a balance, and
 5 we got that balance I think. Or some sort of balance.

6 **Q.** But was your view -- your preference for NHS unheated,
 7 was that based on the risk of the product rather than
 8 some other factor, like convenience, or other factors
 9 that we discussed today?

10 **A.** No, I think at that particular -- there may have been
 11 a question about heat treatment. I don't know. Maybe
 12 there had been cases of heat-treated commercial that
 13 had transmitted. I really can't remember the actual
 14 reasoning why I -- at that time, but you know, like
 15 I said, I think it -- dependent on individual patients
 16 and what we were treating and et cetera. But I didn't
 17 want the NHS Factor VIII to be stopped full stop, you
 18 know. I can't remember what the discussion -- the
 19 detailed discussion was actually.

20 **Q.** Then three conclusions are set out:

21 "After reviewing the financial position:
 22 "1) It was agreed that no more untreated
 23 Factor VIII should be purchased. Existing stocks were
 24 low."
 25 So that's a decision being made, no more

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1 unheated Factor VIII:
 2 "2) Centres would continue to use existing
 3 stocks of Elstree Factor VIII or cryoprecipitate."
 4 Can you recall whether Leeds were using
 5 cryoprecipitate for people with haemophilia at that
 6 stage?
 7 **A.** No, I think they were the same as us. I think they
 8 actually moved to commercial in a big way. But no,
 9 they weren't using cryoprecipitate for haemophiliacs.
 10 Maybe for von Willebrand's they were.
 11 **Q.** Then:
 12 "3) No further decisions can be made until after
 13 a meeting of Reference Centre Directors and Dr Lane
 14 have been held next week. It is hoped that this will
 15 result in a statement of policy, and, more details of
 16 the plan to heat treat NHS Factor VIII, and how this
 17 will affect the supply position in the next few
 18 months."
 19 So it looks there like you've decided -- or, in
 20 spite of your preference for NHS unheated over
 21 commercial heated, you've decided: don't buy any more
 22 unheated and let's see what happens at this meeting
 23 because we can see there's going to be supply problems
 24 coming down the road. Then there's talk about what
 25 your requirements for the year are and usage to date

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1 and so on, and that there will be a deficit -- so it's
 2 a deficit of 230,000 units which will need to be
 3 filled by purchasing heat-treated material.
 4 So that, at the end of '84, seems that there
 5 isn't -- as you say, you would have required
 6 commercial product at that stage, you couldn't have
 7 got all your needs met by the NHS. Does that accord
 8 with your recollection?
 9 **A.** Yes. I mean, there was always -- any meeting you went
 10 to, whether it was UKHCDO or local or regional, there
 11 was always a question of saying: NHS will not be able
 12 to meet your requirements. And therefore we must buy
 13 commercial.
 14 What I haven't seen, and I'm quite amazed, is
 15 I've never seen documents where they said: well, this
 16 was what we manufactured, this is what we used, and
 17 this is what we carried over. You know, stock control
 18 statements. Never seen that with NHS material.
 19 **Q.** So it was left to you to sort of guess, in a way, how
 20 much you could ask for, rather than them saying to
 21 you, "Look, this is what we've got and you can have
 22 this much of it"?
 23 **A.** Exactly. There wasn't -- they weren't saying, "Look,
 24 this is what we're going to have and this is your
 25 entitlement, so that we can have a fair entitlement of

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1 the NHS products spread out in the region."
 2 **Q.** That would have been helpful to you because you may
 3 have been able to end up -- you may have ended up with
 4 more NHS product than you actually had?
 5 **A.** Yes, we would have. I'm not quite sure whether the
 6 transfusion centre was geared up to keeping proper
 7 stock controls and looking at the dates and expiries
 8 and supplies and -- but, yes, I never had problem
 9 getting NHS material.
 10 **Q.** Then, so just looking then at the document that came
 11 out of that meeting that you were waiting for. So you
 12 see, at the bottom of that letter, you have arranged
 13 a further meeting on 18 December, following the
 14 meeting of the UKHCDO. And Dr Lane -- and we know,
 15 and this is a document that the Inquiry has looked at
 16 on a number of occasions, but the document that came
 17 out of that meeting is HCDO0000270_007.
 18 It's called the AIDS Advisory Document. That's
 19 a document that was in your papers and you received as
 20 a Centre Director, as I understand; is that right?
 21 **A.** Yes.
 22 **Q.** It sets out on page 2 a number of recommendations,
 23 beginning at the bottom of page 2:
 24 "1. Concentrate is still needed ...
 25 "2. Use DDAVP ..."

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1 And then over the next page, please, Henry, it
 2 sets out haemophilia A recommendations under (3) and B
 3 under (4). And then says this:
 4 "In individual patients there may ...
 5 be a choice. In general heated concentrate appears to
 6 be the recommendation of virologists consulted but
 7 individual Directors may wish to make up their own
 8 minds. This is particularly true of unheated NHS
 9 material. The evidence that heated US Factor VIII is
 10 safer than unheated NHS is debatable and some
 11 Directors may wish to continue using unheated NHS
 12 material until all supplies are heated. This is valid
 13 for carefully selected patients but must be on
 14 individual decision based on the assumption that
 15 somebody batches of NHS materials will be contaminated
 16 with HTLV-III."
 17 So there it seems there's -- the same discussion
 18 that you were having back and forth in your meeting
 19 a few days earlier is being had in this meeting with
 20 UKHCDO?
 21 **A.** This may have prompted me to perhaps move -- stop
 22 using unheated NHS material and use more of heated
 23 material.
 24 **Q.** Because of the reference there to the assumption that
 25 some batches of NHS material will be contaminated by

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1 HTLV-III?
 2 A. That's right.
 3 Q. So seeing that there so starkly may have altered your
 4 treatment policy. We'll look at some documents after
 5 that.
 6 A. We always followed UKHCDO documents very closely.
 7 Q. Although that's very much leaving it up to the
 8 individual director, isn't it?
 9 A. Oh yes, always.
 10 Q. Then what I think is the report from the -- then the
 11 meeting you planned was for 18 December, having
 12 received that document, and I think, as
 13 I understand it, the report from that is at
 14 PARA0000017.
 15 This is a letter from Dr Swinburne to you dated
 16 27 December 1984 and it starts by saying:
 17 "I enclose some more comments for those of us
 18 who were not able to be present at the last meeting of
 19 Directors."
 20 Have you got any recollection of whether or not
 21 this is the follow-up letter, if you like, from that
 22 18 December meeting?
 23 A. No.
 24 Q. Do you recall whether you went to that 18 December
 25 meeting?

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1 A. I would have gone.
 2 Q. You would have gone.
 3 A. I would have gone. I tried to go to all these
 4 meetings because, like I said, we were looking for
 5 answers and information.
 6 Q. So, first of all, she says:
 7 "Please note that heat-treated materials can
 8 only be supplied on a named patient basis."
 9 She must there be referring to NHS heat-treated
 10 materials, mustn't she?
 11 A. Well, I would think so because one of the things about
 12 heat-treated commercial material was we tried to use
 13 licensed products. If they were not licensed they
 14 would be on named-patient basis and that would have
 15 been -- you know, we would have ordered it and that
 16 would have been quite reasonable.
 17 So I presume -- I don't know. I can't remember
 18 whether -- if it's heat-treated NHS material,
 19 obviously, that's very good, you know. That would be
 20 preferable to unheated NHS product. I mean, if it
 21 meant -- sorry, on a named-patient basis you know.
 22 Q. Then she makes a reference to how that can be done and
 23 we'll come to some documents in relation to that in
 24 due course.
 25 Then she says this:

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1 "Because of the cost Dr Barnard and I have
 2 agreed to continue to use Elstree Factor VIII for
 3 heavy users converting to heat-treated NHS material as
 4 and when available."
 5 So that seems to be -- she seems to be, on the
 6 basis of cost, deciding, although she prefers the
 7 heated commercial, to stick on the unheated NHS, for
 8 heavy users, in any event. Then:
 9 "Patients using less than 20,000 units per
 10 annum, new patients, and small children will be given
 11 heat-treated commercial material or cryoprecipitate."
 12 Your recollection is that, in fact, in Leeds
 13 they weren't treating with cryoprecipitate at this
 14 time?
 15 A. They weren't using cryoprecipitate but it's
 16 interesting because their returns showed that
 17 two-thirds of the materials they used were actually
 18 commercial, not NHS. So this is not in line with
 19 their returns, you know.
 20 Q. So this policy is something that you question whether
 21 it was followed?
 22 A. But you have a document saying how much commercial
 23 they use and how much NHS.
 24 Q. Then it says:
 25 "We estimate that two thirds of our patients

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1 will then be getting heat-treated material."
 2 There's then a reference to the HTLV-III test,
 3 which I'll come back to.
 4 A. Yes, it says there that two-thirds of the patients
 5 were getting heat-treated material, you know.
 6 Q. Yes, commercial material or cryoprecipitate. Do you
 7 recall this --
 8 SIR BRIAN LANGSTAFF: I think it actually says two-thirds
 9 will then be getting heat-treated material, in other
 10 words that leaves one-third would weren't? Whether
 11 the one-third were getting unheated NHS or, for that
 12 matter, unheated commercial or cryoprecipitate is not
 13 clear.
 14 A. No.
 15 MS SCOTT: So that seems to be the policy of Dr Swinburne
 16 following that meeting. Do you recollect whether or
 17 not that was something that you adopted as well, as
 18 a policy?
 19 A. We didn't necessarily follow the same as Leeds did.
 20 We really acted quite independently but, obviously,
 21 within reason, you know, and what is available and
 22 what's best for patients.
 23 Q. So the next document may assist you in answering that
 24 question if we could go please, Henry, to PARA0000016,
 25 this is a document from a little bit later on,

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1 24 February 1986, from the Yorkshire Regional Health
2 Authority National Blood Transfusion Service. That
3 seems to be the full title of your local Blood
4 Transfusion Centre where Dr Tovey was the director.

5 It records that a batch of unheat-treated
6 Factor VIII was supplied on 22 January and then again
7 on 5 February by the Regional Transfusion Centre to,
8 amongst others, your centre. So that would suggest
9 that, like Dr Swinburne, you were after December still
10 using untreated NHS Factor VIII; does that sound
11 right?

12 **A.** I honestly can't remember and I can't remember whether
13 we used any of this. That would really depend on how
14 much we returned, you know, for destruction. But,
15 I mean, the question is we were supplied with it,
16 whether -- how much we used I couldn't tell you.

17 **Q.** So that was my next question: do you recall the
18 investigations that had to be undertaken following
19 receipt of this letter about whether or not there had
20 been an infection?

21 **A.** I honestly can't remember. But we would have followed
22 the instruction to the letter. You know, we would
23 have returned it. We might have returned all of it
24 back, you know. I don't know how much of it we would
25 have used. I doubt -- you know, once we were told

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1 that heat-treated -- or if there was doubt on the
2 unheat-treated we wouldn't have used it, you know.

3 **Q.** So following the letter at the meeting of 18 December,
4 where Dr Swinburne sets out her policy that she will
5 use unheated NHS factor, on the basis, it seems, of
6 price, could the Blood Transfusion Service have simply
7 sent you untreated Factor VIII --

8 **A.** They could have, yes.

9 **Q.** -- and you look at it and what would you do when you
10 received that?

11 **A.** Well, they could have sent it, we would have it in
12 stock but whether we used it or not I couldn't tell
13 you because we had our own individual policies for
14 patients, you know. But this would have been
15 returned, you know, for destruction straight away but
16 I couldn't tell you how much was and how much wasn't,
17 you know.

18 **SIR BRIAN LANGSTAFF:** The dates may help. This is
19 a letter in February 1986, and it looks as though the
20 batch was distributed some time after 5 February 1985,
21 that's about a year. Do you think it likely that if
22 it did come to you, you would have used it within
23 a year or would there have been any left to return, do
24 you think?

25 **A.** I honestly -- I couldn't tell you without facts and

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1 figures but, like it says, if they said return it for
2 destruction we would have done it.

3 **SIR BRIAN LANGSTAFF:** If there was any left to return by
4 then?

5 **A.** Yes, if there was. This was distributed on 1985.
6 What's the --

7 **SIR BRIAN LANGSTAFF:** The date of this is a year later,
8 24 February 1986.

9 **A.** I couldn't tell you how much was used or not used.
10 But it's a long time to have it, isn't it, it's
11 a year.

12 **SIR BRIAN LANGSTAFF:** I think what counsel was asking you
13 is if you hadn't returned it all, the last full big
14 paragraph at the bottom of the page that we can see
15 says:

16 "... secondly would you find out if any of your
17 patients have been treated with any material from this
18 batch."

19 **A.** We would have done that.

20 **SIR BRIAN LANGSTAFF:** So do you have any recollection of
21 that is what she was asking.

22 **A.** I don't have any recollection, no. But we were -- we
23 had a very good blood bank and we would have proceeded
24 anyway, we would have followed it up.

25 **MS SCOTT:** So this letter suggests that you were sent

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1 unheated Factor VIII in January 1985. I think you
2 said, well, we might have been sent it even if we
3 weren't going to use it.

4 **A.** Possible, yes.

5 **Q.** Would you then have sent it back? Would it not be
6 likely that you would have sent that back if you
7 weren't going to use it?

8 **A.** Well, at some -- sometimes we kept products because --
9 as a backup, you know, emergency, et cetera. It's
10 good to have a good stock. I couldn't tell you how
11 much was used and how much was not used and how much
12 was kept back and -- but, really, unless I knew what
13 or how we used it, I just couldn't tell you. There's
14 no -- I can't recollect. That's too much detail.

15 **Q.** Then the next document, Henry, is PARA0000018. This
16 is a document from 7 February 1985 and it's a letter
17 from Dr Swinburne to Dr Tovey. Again, this was
18 a letter that you had in your papers, and it starts by
19 saying:

20 "The local directors have discussed the Elstree
21 protocols and are not very interested in their offer
22 of an interim heat-treated product likely to be
23 available for only 2-3 months. They prefer to wait
24 until April when a better product is promised. This
25 also will need full evaluation for safety and

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1 efficiency. Nevertheless I have applied to Elstree
 2 for heat-treated material for 10 heavy users to test
 3 their reaction."
 4 So, first of all, can you recall what the
 5 Elstree protocols were?
 6 **A.** No.
 7 **Q.** Do you remember this --
 8 **A.** I've never seen the Elstree protocol. Elstree
 9 protocols I can't recall -- obviously, it's there
 10 somewhere but I really can't recall Elstree had
 11 protocols.
 12 **Q.** Do you recall making this decision? It looks like
 13 it's not just a decision of Dr Swinburne, it looks
 14 like a decision of the local directors but a joint
 15 decision not to accept interim heat-treated NHS
 16 product but instead to wait until, I think, April or
 17 thereabouts, when Elstree were saying that they could
 18 provide all of their product heat-treated. Do you
 19 recall the reasons why you came to that view?
 20 **A.** No, but we didn't always to the same as Jimmy's, you
 21 know. We had the same status, whether it applied to
 22 Leeds only or to all of us, I can't recall, or whether
 23 we followed the -- if it's -- the instruction, you
 24 know.
 25 **Q.** So you can't remember anything about that decision in

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1 February not to have an interim heat-treated NHS
 2 product?
 3 **A.** No, I cannot remember that at all. It seems unusual,
 4 doesn't it? I mean, it's obviously 30/40 years ago
 5 but I think I would have probably accepted that.
 6 **Q.** You'd have accepted it; what do you mean by that?
 7 **A.** Well, interim heat-treated NHS product would be very
 8 attractive, even if it's interim. But there were --
 9 in those meetings, there were five or six directors,
 10 you know, and a lot followed Leeds' lead.
 11 **Q.** She goes on at paragraph 2:
 12 "In the interim all are willing to use the
 13 untreated BPL Factor VIII."
 14 Then calculates what's needed. Then:
 15 "Stocks should last till the end of March unless
 16 any users are found to be anti-HTLV-III negative and
 17 are refused by Elstree. In this case they will need
 18 to transfer to commercial material immediately."
 19 Do you know what that refers to?
 20 **A.** Sorry --
 21 **Q.** Paragraph 3.
 22 **A.** Where it says "heat-treated commercial"? No, I can't
 23 recall this but I'm a bit surprised in that
 24 heat-treated NHS material would have been a lot more
 25 attractive than unheated NHS material. This is

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1 unusual. I can't even recall.
 2 **Q.** Then it says "Bradford may need more commercial" --
 3 I think that says heat-treated Factor VIII, and then
 4 it talks about distributing BPL heat-treated material
 5 via the blood transfusion service, and then ends with:
 6 "There is still interest in a better version of
 7 cryoprecipitate, ie smaller volume."
 8 Again can you recall what the interest in
 9 cryoprecipitate was, at that stage?
 10 **A.** Interest in cryoprecipitate was minimal, you know.
 11 I'm sure in Yorkshire they didn't -- well, I shouldn't
 12 say -- certainly in Leeds/Bradford cryoprecipitate
 13 would not have been used for haemophiliacs.
 14 **Q.** So looking at that at this distance, that letter
 15 seems -- that decision seems a surprising one to you?
 16 **A.** There's still interest in a better version of
 17 cryoprecipitate, smaller volume. No, not from
 18 Bradford anyway. You know, when you're talking of
 19 seven or eight centres together, we were only one of
 20 them, so Dr Swinburne may have taken the majority
 21 view.
 22 **Q.** But that decision there to turn down the interim
 23 heat-treated product and use unheated product seems,
 24 from this distance, a surprising one to you?
 25 **A.** Very. Sounds very foreign to me. I think it would to

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1 most people.
 2 **Q.** Can you recall when Bradford, when your centre,
 3 switched completely to heat-treated materials?
 4 **A.** I think we had evidence that, you know -- and
 5 obviously licensing was important but, as soon as we
 6 had information that heat treatment improved the
 7 concentrates, we would have moved on, you know.
 8 **Q.** Here you are using commercial heat-treated
 9 concentrate, we can see in this letter. You're soon
 10 to be using unheated Factor VIII, NHS Factor VIII. Do
 11 you think that you would have moved over completely to
 12 heat-treated product once --
 13 **A.** Heat-treated NHS.
 14 **Q.** -- once you could get the NHS product?
 15 **A.** Oh, yes we would have, yes. If it was available, we
 16 would have.
 17 **Q.** Do you recall what, if any, steps were taken to deal
 18 with the unheated product that you already had once
 19 you had made the switch?
 20 **A.** Well, if there was a recall it would have gone to BTS
 21 but before the recall I couldn't tell you what
 22 happened, whether we were using it on selected
 23 patients, I don't know, I couldn't tell you.
 24 **Q.** So, let's say in April/May 1985, for the sake of
 25 argument, the centre goes over to heat-treated

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1 product, do you, at that stage, recall all the
 2 unheated product that's out with people in home
 3 treatment? Can you recall whether any steps were
 4 taken of that nature to swap unheated product for
 5 heated product?
 6 **A.** If there was indication that it was unsafe, then we
 7 would have recalled it. We would have brought it
 8 back. As I said, we only issued material that was
 9 outside the centre. We had them to come every month
 10 to exchange. They had to come every month. They
 11 would bring their old bottles and their needles and
 12 then they would be exchanged. So we would have been
 13 in touch and we never issued more than a month's
 14 supply for the severe. You know, it was very
 15 important that they didn't sit on supplies at home for
 16 long periods and it was mandatory that we reviewed --
 17 one of the conditions for home treatment, to have
 18 material at home, was they must come to clinics every
 19 three months. If they didn't, their home treatment
 20 would have been stopped, you know. This made sure
 21 that people weren't holding the stuff, keeping it
 22 home, keeping expired material at home.
 23 I think there was -- there is a letter somewhere
 24 about -- there was one patient who kept it for a long
 25 time because he wouldn't come to his clinic and he

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1 wouldn't -- I know his name but I can't obviously
 2 name, you know.
 3 **Q.** Can I just pick up one more point in this letter which
 4 is at the bottom of paragraph 1, Henry:
 5 "Nevertheless I have applied to Elstree for
 6 heat-treated material for 10 heavy users to test their
 7 reaction."
 8 I think that's a reference to getting
 9 heat-treated NHS product on a named patient basis,
 10 which you -- we have seen documents which suggest you
 11 put five patients forward at this stage for
 12 heat-treated NHS product; do you remember that?
 13 **A.** No, but it's obvious you have got information.
 14 **Q.** Yes, well, I can show you.
 15 Henry, it's BPLL0010619.
 16 **A.** As I said, heat-treated NHS was very attractive, you
 17 know.
 18 **Q.** The question really was whether or not you recall
 19 whether or not these patients were -- like
 20 Dr Swinburne did -- heavy users, being put forward
 21 to -- Dr Swinburne says -- test their reaction, or
 22 whether they were, you know, previously untreated
 23 patients?
 24 **A.** Well, if they were untreated patients, we would prefer
 25 them to go on a trial basis -- no, "trial" is the

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1 wrong word, because you're not trying, but we would
 2 have wanted to monitor them, you know, have a protocol
 3 et cetera. It would be a PUPs -- you know, what you
 4 call PUPs, previously untreated patient. So this --
 5 these, I presume, would already have been either on
 6 NHS or they were heavy users. But I can't tell you --
 7 I mean, what goes further down on that letter? Does
 8 it say?
 9 **Q.** It doesn't say --
 10 **A.** It just says "following five patients".
 11 **Q.** No --
 12 **A.** But those five patients would be previously treated.
 13 If they were untreated they would be -- we would
 14 possibly use the same thing, but they would come under
 15 special protocols.
 16 **Q.** Yes, so I think you entered one patient later on into
 17 the study, and that was in 19 --
 18 **A.** This was the product they were talking about.
 19 **Q.** It was the same product. It was the 8Y product.
 20 **A.** Yes, so we were -- so that is a very special
 21 situation, you know. That was the 8Y study which
 22 Dr Rizza I think was -- I think there was a few
 23 centres taking part but I think it came from Oxford,
 24 that study.
 25 But previously untreated patients, very, very

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1 important, you know, because you follow the protocol
 2 to make sure that -- you know, whether the new product
 3 was as safe as people said it was.
 4 **Q.** Can I just take you to one passage in your witness
 5 statement.
 6 Henry, it is WITN0785003.
 7 And and it's page 8, and it's the response to
 8 question 31. And you say, in response to a question,
 9 what steps did you take when you knew there might be
 10 an association between AIDS and use of blood products,
 11 and you say:
 12 "We discontinued using blood products that we
 13 felt had the possible risks of infections of HIV or
 14 Hepatitis C. NHS and commercial blood products were
 15 used on the basis of reassurances given by the
 16 suppliers."
 17 What are you describing there?
 18 **A.** You know, it actually should say -- the "possible
 19 risks", it should say "probable risks". Because there
 20 was a possible risk with all products.
 21 **Q.** Yes.
 22 **A.** It should have said "probable risks". Or we tried to
 23 use products with the least possibility of infections.
 24 **Q.** So how did you assess whether or not you should stop
 25 a product because of probable risks?

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1 A. Very difficult.

2 Q. Was it effectively when you got a letter saying "This

3 batch is infected"?

4 A. The information would have come from different

5 sources. One is our own source. So if anybody got

6 infected with a product we used -- and I think you've

7 got some evidence there -- that we were very quick to

8 point out.

9 The other one was if any of the neighbouring

10 centres or if UKHCDO or we were informed by any of the

11 centres within or from the regional, then there was

12 obviously -- there was an obligation on the companies

13 or whoever was producing this, they would have to

14 inform us immediately if we had their product and

15 there was a possibility that it transmitted infection.

16 But as soon as we thought that there was even

17 the slightest possibility now, then we would withdraw

18 it, you know.

19 Q. What do you mean when you say, "NHS and commercial

20 blood products were used on the basis of reassurances

21 given by the suppliers"?

22 A. Well, we needed reassurances all the time because --

23 you must remember, that we had to -- even now, with

24 any medicine that we use, we've got to be aware what

25 that medicine is and what are the side effects

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1 et cetera and what are the benefits and so on. We

2 really needed that in order to avoid litigation then,

3 you know, that we didn't knowingly give something that

4 shouldn't have been given.

5 Q. So what were you asking for? They can't have been

6 giving -- they weren't giving you reassurances, were

7 they, that the product was virus-free?

8 A. No, nobody did that. Even now.

9 Q. So what kind of reassurances were they giving you?

10 A. Well, that -- really I think there is a letter when

11 I first ordered materials to reassure me that they

12 were following the FDA rules.

13 Q. I see. So, you spoke about this this morning, yes.

14 A. I think, as far as they could give reassurances,

15 that -- you know, that they are following all the

16 regulations, et cetera. But on a named patient basis

17 it's a bit different, you know.

18 And obviously knowing that they were licensed

19 was important, because that gives some protection to

20 the directors as well.

21 Q. Henry, can we have HCDO0000321_002.

22 I hope this is -- yes, it is -- the 1986 return.

23 And it shows that you treated 26 patients that year

24 and it sets out that you have actually treated with

25 cryoprecipitate in hospital for somebody with

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1 haemophilia A, NHS factor and then a number of

2 different commercial factor products.

3 Is this return a reflection of that policy, do

4 you think, the reason there are so many different

5 products being used there?

6 A. Yes, it would be, really. I think these are the

7 products that Dr Swinburne had mentioned that they

8 were contracting with, you know. It's the same

9 products from the Regional Transfusion Centre. But we

10 tried to keep people on the same product as far as we

11 could. For obvious reasons, you know. Even for

12 reasons of inhibitors and so on, you know. They

13 weren't always identical so it was important that if

14 there were going to be side effects or inhibitors or

15 infection that we could identify the batches.

16 But you are right that there's a lot more

17 companies there than that was few years ago. And

18 we're also treating more people there and using more

19 product, you know.

20 MS SCOTT: Sir, I'm going to come on to a new topic now,

21 and I note the time.

22 SIR BRIAN LANGSTAFF: Yes. We will take a break. How

23 long do you think you might need?

24 MS SCOTT: For a break?

25 SIR BRIAN LANGSTAFF: Yes.

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1 MS SCOTT: 20 minutes.

2 SIR BRIAN LANGSTAFF: Will you be likely to be talking to

3 the representatives of -- the legal reps?

4 MS SCOTT: Yes.

5 SIR BRIAN LANGSTAFF: I will give you a bit longer so that

6 you can pick up any questions that Core Participants

7 might wish to ask. So shall we say be back at 3.30.

8 (2.57 pm)

9 (A short break)

10 (3.30 pm)

11 MS SCOTT: I'm going to ask you some questions about

12 testing for HIV. So, Henry, can we have PARA0000017,

13 which is a document we have already looked at but it

14 really is a memory prompt. So this is a document we

15 looked at a letter from Dr Swinburne to you

16 27 December 1984. Henry, it's the last paragraph.

17 "The PHLs are now able to screen haemophiliacs

18 for HTLV-III antibodies. A sample should be taken

19 from each patient prior to starting heat-treated

20 material. In due course all patients should be

21 screened although the interpretation of the test in

22 present circumstances is not yet clear and the results

23 should remain confidential."

24 So, first of all, just on timing, looking at

25 that, does that prompt your memory at all as to when

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1 you think you might have carried out HIV testing on
 2 your patients?
 3 **A.** As soon as the tests were available we were testing.
 4 So if it was available then, then we were doing it.
 5 **Q.** Did you tell your patients in advance that they were
 6 going to be tested for HIV?
 7 **A.** Not in advance but when they came to the clinic, and
 8 so on, when they had blood tests we would have told
 9 them then. You see, also at that time there was
 10 a very strong pressure that they must be counselled
 11 before they had a test. So we had a counsellor, we
 12 had the clinic, so we would have arranged for them to
 13 be seen, counselled and then have the tests.
 14 **Q.** So you weren't testing off stored samples, you were
 15 testing off samples you took in clinic?
 16 **A.** Yes.
 17 **Q.** You were informing patients when they came in that the
 18 blood test was going to be used for an HIV test?
 19 **A.** Yes. Memory is vague but it wouldn't even surprise me
 20 if we got them to sign a piece of paper that they had
 21 been counselled and they are having the test. There
 22 was a lot of pressure at that time from Terrence
 23 Higgins Trust about -- that they shouldn't be tested
 24 at all in Bradford. There was a lot of -- there was
 25 a movement that you mustn't test people. People

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1 mustn't come forward.
 2 **Q.** Because? Did you understand what the reason for that
 3 was?
 4 **A.** Well, their reasons was it was to do with freedom of
 5 individuals and if you're going to have a test that
 6 you can't do anything about then it's discriminatory
 7 to pick out people for the test. But that's not why
 8 we were doing it for haemophilia, that was a different
 9 reason.
 10 **Q.** Do you recall any of your patients saying they didn't
 11 want to have the test?
 12 **A.** No.
 13 **Q.** Everybody wanted to have it or --
 14 **A.** Yes. Yes, everyone who had blood products had the
 15 test, I think, initially.
 16 **Q.** When you say the advice was that you should be
 17 counselled before you had the test, what did you
 18 understand that to mean and what was the practice that
 19 you put in place?
 20 **A.** The counselling would have been in -- you are saying
 21 why were we doing it?
 22 **Q.** Yes, what did you understand you were supposed to be
 23 doing and what did you actually do?
 24 **A.** Well, when the test was there people knew about HIV so
 25 it was almost a routine test not to show that they've

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1 got AIDS but to do the antibody test whose
 2 interpretation wasn't totally clear at that time but,
 3 in the same way as we did other tests, but that we
 4 wanted to know whether they had been exposed to the
 5 virus, you know, which was important for us to know
 6 but it might be important for them to know, you know.
 7 But also there was a question of advising about
 8 how they go about with people nearby, you know, what
 9 their relationships are like and --
 10 **Q.** So that was counselling before they had the test. You
 11 would give them some information about --
 12 **A.** That's right.
 13 **Q.** -- infecting partners, and so on?
 14 **A.** Well, I think we would have talked about that probably
 15 but, you know, we didn't know the significance, total
 16 significance of the antibody test. That was one of
 17 the reasons why there was objection to the test, you
 18 know. I mean, I could see some sense in it but
 19 obviously now we can see better sense, you know.
 20 **Q.** So having got the consent of your patients, sent the
 21 tests off, the results come back, what do you do then
 22 in terms of informing patients about the test results?
 23 **A.** People who would have had the test were the ones that
 24 would have come every three months. These were
 25 starting with the severe haemophiliacs, et cetera, and,

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1 you know, we tried to have proper clinics where the
 2 counsellor would be there, you know, or social worker,
 3 and Pauline Sharp, and so on. So they would have been
 4 seen but they would be first seen by me to give the
 5 test and then Sister Sharp would probably be there
 6 with me and then passed on next door, or whenever, to
 7 spend some time with Andrea.
 8 **Q.** Do you remember that, can you actually remember that?
 9 **A.** Yes, I can remember.
 10 **Q.** You can remember that process. Can you recall
 11 whether --
 12 **A.** Difficult times, you know.
 13 **Q.** Yes. Can you recall whether you brought people in for
 14 special appointments or whether you did it in your
 15 regular three-monthly appointment?
 16 **A.** It depended on -- it was a time factor thing. If the
 17 clinics were going to be very busy we made extra time.
 18 Andrea could see them in her own time, in her own
 19 environment, you know, but my work was done in the
 20 clinics. Patients were spaced out, you know, quite
 21 reasonably and plenty of time given. But they were
 22 followed up whether by Sister Sharp or by Andrea. It
 23 wasn't just a five-minute thing that finished, you
 24 know.
 25 **Q.** Just before I come on, because I want to ask you some

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1 questions about the follow-up and the counselling and
2 so on, can we just return back to this document on the
3 screen. It's the same paragraph, Henry. The last
4 sentence there -- so this is Dr Swinburne telling you
5 that the tests are available, and she says
6 "interpretation of the test [is unclear]" and you've
7 given evidence about that, and "the results should
8 remain confidential".

9 Do you know what she meant there?

10 A. I don't know what she means but the results were
11 confidential. They remain in the domain of the
12 hospital records. But the results came from public
13 health laboratories.

14 Q. But you have just told us it doesn't mean it remained
15 confidential from the patient?

16 A. No, no, no. Not at all, no. That's why I don't know
17 what she means. It certainly shouldn't remain
18 confidential from the patient. The ownership of all
19 results are with the patient, it's their results.

20 Q. Then I interrupted you, you were talking about the
21 counselling that was available to patients. So you
22 have described how they had some pre-test counselling,
23 and then there was counselling available when they
24 were given their results, and then you were talking
25 about follow up. Can you just explain to us what

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1 follow-up was available for your patients who had been
2 infected by HTLV-III?

3 A. Well, it often raised more questions than answers.
4 That was the problem. So they needed support. They
5 needed more explanation sometimes, and they were fed
6 with information in the media all the time. There
7 was -- as you know, the popular press was full of all
8 sorts of speculations and accusations and -- you know,
9 there were some groups that really felt paranoid about
10 what was said about them, you know.

11 Q. So were you able to -- were people able to have, say,
12 a course of psychotherapeutic counselling through your
13 centre; was that available to them?

14 A. Yes, but we also had a psychologist called Dr Dawson,
15 who was doing some research where the university was
16 also supported with the counselling. He was
17 a psychologist.

18 But we tried to get proper psychologist,
19 hospital psychologist, for them to support us and that
20 was very intermittent and it didn't go anywhere.

21 Q. You did some research, I understand, or at least you
22 had ethical approval for a study into people with
23 haemophilia to identify their emotional and
24 psychosocial needs in October 1985, do you recall that
25 with, Dr Hunt?

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1 A. That was with Dr Dawson the psychologist.

2 Q. Okay. So that is who you are referring to?

3 A. There were quite interesting findings which haven't
4 been explored that much, as they should have, because
5 what we found was people who had psychometric testing
6 when they got HIV or HTLV-III, that the psychometric
7 testing was affected, that it did affect their mental
8 performance. We found this with leukaemia, with
9 chemotherapy and all sorts, but Dr Dawson -- I don't
10 know whether he became ill or he had to leave.

11 Q. So you did complete that research and produced a paper
12 did you?

13 A. Only abstracts. It never got published as a paper
14 but, I mean, it applies as much now with Covid, you
15 know, that you do psychometric testing now and then
16 after Covid people are finding big differences, you
17 know, that it actually does reduce your IQ, et cetera,
18 you know.

19 Q. So your patients had access to a psychologist and
20 counsellor through --

21 A. Counsellor primarily but we also had support from
22 a psychologist.

23 Q. -- your service? Did you test partners and family
24 members?

25 A. Not routinely, no --

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1 Q. So what circumstances --

2 A. -- but if we were requested.

3 Q. If it was requested you would test?

4 A. We would test, yes. Interestingly, when we did test
5 we didn't find any partners that were positive.

6 Q. Just on numbers that were infected, we've only got one
7 document and I don't know if you can help me interpret
8 it, it's BHT0000002. So this is the covering letter
9 and it's enclosing statistics for patients treated
10 between April 1991 and March 1992 inclusive, so
11 a little bit after these years we're talking about
12 when the tests took place. If we scroll through the
13 document at page 2 please, Henry -- maybe page --
14 that's better.

15 You can see here it says "HIV/AIDS cases", then
16 it sets out the period, "In-patient summary by
17 District of Residence/Consultant", and then it has
18 "Airedale" and then your name and "2". Then if we go
19 over two pages it has "Bradford", and we can see there
20 "Minford 1", and your name, 48. District total for
21 Bradford is 53, and so on. So you go through the
22 document with all the different areas and the
23 consultants with the numbers of HIV patients is set
24 out there.

25 Is that a document you are familiar with?

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1 A. No. But because when HIV tests came along and we had
 2 counselling and testing, and so on, there were no HIV
 3 experts in the district. There were none appointed
 4 for obvious reasons, and the largest population that
 5 was positive was haemophilia and because we had a full
 6 setup we attracted non-haemophiliacs, non-bleeders who
 7 came for testing.
 8 Q. To the centre?
 9 A. To the centre, yes, we were referred. And because
 10 they didn't have anywhere else to go, we were testing
 11 them, et cetera, but also in the private sector people
 12 used to come for testing, you know, at Yorkshire
 13 clinic, and I used to see them.
 14 So these are mixed up.
 15 Q. Because I couldn't make sense of the numbers because
 16 the numbers, according to this document, of your
 17 patients with HIV between '91 and '92 is 71, and
 18 you've told us that actually you had 40 patients with
 19 haemophilia, so ...
 20 A. These are mixed up with all of these from other --
 21 Q. Sorry. Were you treating these patients for
 22 their HIV?
 23 A. No.
 24 Q. You were the consultant who was testing them?
 25 A. Yes. It was counselling and testing them. So we

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1 offered that facility. But if they were positive they
 2 would be referred on. And it mentions the
 3 GU specialist, Mohanty. For some reason he's only got
 4 one there, I can't understand that. But we used to
 5 refer -- there was another GU specialist, and there
 6 was obviously -- there were also people in Leeds who
 7 were considered experts, that were actually appointed
 8 for that function.
 9 Q. So you never prescribed anyone AZT, for example?
 10 A. No, no. But we did have patients with AZT then but
 11 I didn't -- no, it was something that I tried to
 12 avoid, is -- trying to become an HIV specialist.
 13 Although I was the only one at the time. But within
 14 a few years they appointed specialists, you know.
 15 Q. Were any of your patients who had the rarer blood
 16 disorders that you were speaking about this morning,
 17 were any of them infected?
 18 A. No.
 19 Q. Only people with haemophilia that you were treating?
 20 A. And von Willebrand's, I think.
 21 Q. And von Willebrand's.
 22 A. And kids. But no, none others. Which is interesting,
 23 because they all -- a lot of them used NHS material
 24 for one reason or the other.
 25 Q. Did you do any work to try to establish when

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1 seroconversion happened, i.e. on previous stored
 2 samples?
 3 A. We didn't check stored samples but I think there are
 4 documents which says they could -- they might have got
 5 infected in '78 to '79. Some other people had done
 6 this work. I think it was Peter Kernoff who had
 7 looked at previous samples, to old samples, and found
 8 infected people in '78/'79 samples.
 9 Q. You never did that with your patients?
 10 A. No.
 11 Q. Did your patients know that their test results were
 12 being shared with UKHCDO? Is that something they were
 13 aware of? Do you think you discussed that with them?
 14 A. Well, they were anonymised if they were shared. They
 15 were just numbers. So it wasn't that we shared the
 16 patient details. We shared numbers but we didn't
 17 share any patient details. So it wasn't their
 18 information that was being shared, it was just
 19 statistical numbers. As far as I remember.
 20 Q. Then moving on then to HCV testing, when that came in,
 21 again, can you recall when you undertook HCV testing,
 22 hepatitis C testing, for your patients?
 23 A. As soon as it was available from PHLS, Public Health
 24 Laboratories, in Leeds, we started testing them.
 25 Would it be '91? I don't know.

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1 Q. Probably '91. We don't have the precise date.
 2 **SIR BRIAN LANGSTAFF:** There were tests which were
 3 available from 1990 onwards. Though it was regularly
 4 used to screen transfusion -- blood for transfusion --
 5 from September 1991, there is some evidence I think
 6 that one test or another was used on a trial or *ad hoc*
 7 basis at various centres in between those two dates.
 8 That's not much help.
 9 A. No, but as soon as it was available to us -- you know,
 10 as soon as Public Health said yes, you know, we
 11 started -- initially antibody test but the more
 12 important was the combined with the PCR. You know,
 13 whether there was active virus or not.
 14 **MS SCOTT:** Again, in terms of the process, what was the
 15 process that you went through when you were testing
 16 your patients for HCV? Did you inform them or ask
 17 them whether or not they wanted to have a test?
 18 A. Well, they were regularly having liver function tests,
 19 because if they had abnormal liver function, they knew
 20 that I was monitoring them. So when this test came
 21 along, this was just an added test to the -- as it was
 22 for liver function, you know.
 23 I can't honestly remember whether -- you see,
 24 quite often they would have the test before seeing me
 25 in the clinic. So they had the blood test done and

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1 I saw them in the clinic, I would tell them what was
 2 done. So -- you know, I can't remember which way it
 3 was. But certainly as the results came in, they were
 4 all discussed, including the liver function tests.
 5 **Q.** So it may be that their consent wasn't obtained before
 6 having the test specifically to the hepatitis C test?
 7 **A.** That's a possibility. But it was in combination with
 8 the liver function tests. You know, but when we had
 9 the results, the results were never kept from them.
 10 **Q.** Then as soon as you got the results back, you shared
 11 those with the patient, presumably at their next
 12 appointment?
 13 **A.** Oh, yes. As soon as we had the results.
 14 And I never had a single person who objected, by
 15 the way.
 16 **Q.** Who objected to?
 17 **A.** Having had the antibody test done, for the
 18 hepatitis C. Not one. Like I said, it's -- sharing
 19 information was one of our strengths, of the clinic.
 20 **Q.** Did you test all of your patients for hepatitis C?
 21 **A.** I think ultimately we -- all the patients who received
 22 blood products we did, because there was also this
 23 question that if they converted, if any of them
 24 converted, then the implication would be the batches
 25 of Factor VIII that they were getting.

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1 So, yes, if you were looking for abnormal liver
 2 functions and a positive hepatitis C test, that was
 3 because we were looking for -- to diagnose hepatitis.
 4 But if they were negative, then it said that the
 5 products they received did not contain the hepatitis
 6 virus. So there was benefit in having both, you know.
 7 **Q.** So, following the tests, were you carrying out sort of
 8 look-back exercises almost to look at the products
 9 they have used over the years?
 10 **A.** Immediately, if -- if there was an element where it
 11 would help them to trace which products. Sometimes it
 12 was impossible because if they'd had blood products
 13 for ten, 15, 20 years, there's no benefit. But if
 14 they only had one or two products, then we can --
 15 **Q.** Then you would have gone back and done --
 16 **A.** Oh yes. That's -- that's quite serious.
 17 **Q.** You did do that? Do you recall doing that?
 18 **A.** We would do that, yes, absolutely.
 19 **Q.** Because in your witness statement -- I only ask you
 20 that question about whether you tested all your
 21 patients because in your witness statement you suggest
 22 that only ten of your patients, you think, as
 23 a guess -- your best guess, best estimate -- that only
 24 ten of your patients were HCV positive?
 25 **A.** Yes, there weren't that many really. There may have

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1 been more. I can't -- I really can't remember.
 2 **Q.** It's a slightly surprising evidence because I think --
 3 is it right that you had approximately around sort of
 4 20 to 25 regularly treated severe patients?
 5 **A.** That's right.
 6 **Q.** Do you think that some of those tests came back
 7 negative for hepatitis C?
 8 **A.** It's possible. But ten seems quite low, doesn't it,
 9 if they had a lot of Factor VIII, you know?
 10 **Q.** So you don't recollect being surprised when the
 11 results came back and thinking: oh, somebody who has
 12 had a lot of factor product in their life has come
 13 back negative. That's not something you remember?
 14 **A.** I can't recall that actually. But I think
 15 heavily treated haemophiliacs, all of them had become
 16 hepatitis -- had non-A, non-B, and then hepatitis C
 17 positive, you know. I think there may have been
 18 a mistake in typing or whatever, but ten seems very
 19 low.
 20 **Q.** Again, did you treat -- or, did you test, sorry,
 21 family members for hepatitis C? Do you recall doing
 22 that?
 23 **A.** No, no, we never had to. Certainly we wouldn't do it
 24 routinely but we -- we never had a relative that was
 25 ill, somebody that was ill that we had to test, you

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1 know.
 2 **Q.** Can you recall what advice was given to patients if
 3 they tested positive, about lifestyle and transmission
 4 of the virus and so on?
 5 **A.** They had to be warned that it could be transmitted
 6 sexually. You know, body fluids or whatever. That
 7 was very difficult actually because -- you know, when
 8 you've got life-long partners and they have had
 9 relations for many years and then to be told --
 10 I think that was hard, actually.
 11 But as far as -- I think we tried to tell people
 12 that this was -- we were obliged to tell, you know.
 13 **Q.** Would you have recorded those sorts of discussions in
 14 medical notes?
 15 **A.** I don't think we would have recorded in full. Maybe
 16 it would have just said "discussed" or "counselled".
 17 And this was also supported by our staff by the way.
 18 **Q.** Was written material given to patients about lifestyle
 19 and transmission and so on?
 20 **A.** We had written material, printed material.
 21 **Q.** For hepatitis C?
 22 **A.** Yes.
 23 **Q.** And for HIV?
 24 **A.** Yes. We had -- as far as possible, whenever we got
 25 printed material available from whatever source,

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1 including Haemophilia Society, that -- we made that
 2 available. It made our job easier.
 3 **Q.** Henry, can I have PARA000006.
 4 This is a note again a letter from Dr Swinburne
 5 to you, dated 13 May 1985, headed "AIDS". And it
 6 starts:
 7 "The Regional Medical Committee has set up an *ad*
 8 *hoc* working party on AIDS."
 9 We can just see there the membership does not
 10 include you but it does include Dr Swinburne and
 11 Dr Tovey.
 12 And then going back to the letter:
 13 "Recommendations based on the interim guidelines
 14 are being formulated and documents produced by other
 15 bodies such as the Royal College of Nursing and
 16 Haemophilia Society are being taken into account."
 17 Just pausing there, do you know what the interim
 18 guidelines she's referring to there are?
 19 **A.** Well, I can't remember but you are going to show them
 20 to me, I think.
 21 **Q.** I'm not actually, but I am just going to show you
 22 what -- she says:
 23 "I have made notes on those proposals which have
 24 a bearing on haemophilia and suggest that before any
 25 of these proposals is incorporated into guidelines,

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1 Directors should make their own views and policies
 2 known ..." and then says where to forward them to.
 3 Then, Henry, if we go over the page, she sets
 4 out the ones that are relevant to haemophilia, and we
 5 have:
 6 "1. General practitioners should be notified of
 7 the results of tests of anti-HTLV-III."
 8 Do you recall what your practice was in relation
 9 to informing GPs of diagnoses of HTLV-III and/or
 10 hepatitis C?
 11 **A.** Whenever any patients came to the clinic we did
 12 a letter to the general practitioner and giving
 13 results and, you know -- so we didn't keep things back
 14 from general practitioner.
 15 **Q.** Is that something, particularly in relation to
 16 HTLV-III, that you would have spoken to the patient
 17 about and explained what you were doing or sought
 18 their consent or come to an agreement about or is that
 19 something you just did anyway, as a matter of course?
 20 **A.** No, patients knew that we wrote to the general
 21 practitioner each time. We sent a letter with the
 22 results. Quite standard practice and they knew that,
 23 you know. There's no problem there at all.
 24 **Q.** Then secondly:
 25 "During counselling patients should be advised

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1 to inform their dentists of their anti-HTLV-III
 2 status."
 3 Again, was that your practice to advise your
 4 patients to inform the dentist?
 5 **A.** A lot of them didn't have dentists because dentists
 6 wouldn't come anywhere near, so we had our own
 7 dentist.
 8 **Q.** Your own dentist would have known about their status?
 9 **A.** That's right. It's interesting it mentions Mr Mason,
 10 oral surgeon. He was very happy to -- not very happy,
 11 that's the wrong thing, but he would treat our
 12 patients if the need arose, you know, but after they
 13 had seen Hugh McCarthy, the community dental surgeon.
 14 **Q.** Then slightly out of turn on this subject but, anyway,
 15 a point on this document, if we go to the second half
 16 of paragraph 3, where it starts:
 17 "The question of labelling case notes was
 18 controversial but there should be a clear indication
 19 of the patients' anti-HTLV-III status in the case
 20 notes. External labelling, wording specifically
 21 mentioning AIDS or hepatitis could give rise to
 22 problems from loss of confidentiality."
 23 What was your practice in relation to any
 24 external markers on someone's file about their
 25 infected status?

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1 **A.** There's a lot of discussion on this because what we
 2 were required was to put not "HTLV-III" or anything
 3 but "infection risk" labels on all laboratory
 4 requests, laboratory bottles, on the green cards, and
 5 we were asked to put it on the case notes, as well,
 6 but not HTLV-III, just infection risk, and that
 7 infection risk could have applied to anybody in the
 8 hospital, with even hepatitis carriage or any other --
 9 a lot of debate on that but this is what we were
 10 required to do and the reasons are obvious, especially
 11 in the laboratory where they are handling samples.
 12 They had to know.
 13 **Q.** So that's in relation to samples but, in relation to
 14 the actual case notes, so recommendation is obviously
 15 inside the case notes there must be a record of the
 16 infection status but external labelling, what was your
 17 practice for external labelling on someone's notes?
 18 **A.** No, I think it said -- I think it wasn't danger of
 19 infection, I think it said something in the area of
 20 "infection risk".
 21 **Q.** On the actual hospital notes?
 22 **A.** Yes. But that applied not just to -- that applied
 23 right across the hospital.
 24 **Q.** Yes. Then returning then to those infected with HCV,
 25 you've described the counselling available for those

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1 that are infected by HIV. By the time we get to
 2 testing in the 90s what counselling, if any, was
 3 available for people that got back positive diagnoses
 4 for HCV?
 5 **A.** We followed patients with HCV regularly with blood
 6 tests because I think -- I don't know when the PCR
 7 came in that was quite important and we had to sort of
 8 work out, you know, how -- what sort of HCV they had.
 9 At that sort of time we would refer it to the
 10 infectious disease consultant or the pathologists, you
 11 know, one of the two.
 12 **Q.** If there was a positive test they would go off and be
 13 treated by somebody else?
 14 **A.** If the PCR was positive.
 15 **Q.** So would any counselling and --
 16 **A.** That department would then have to look at the liver
 17 side of things.
 18 **Q.** Would any counselling and psychosocial requirements
 19 that the patients had as a result of their HCV status
 20 then be dealt with by that department rather than by
 21 your own?
 22 **A.** We'd pass it on, yes, because their own, obviously,
 23 departments and staff, and so on.
 24 **Q.** So the centre wasn't providing any counselling for HCV
 25 patients at that time?

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1 **A.** It depends what you call counselling. We did talk, we
 2 did talk to them about it.
 3 **Q.** You did talk to patients. But in the way you
 4 described the more formal psychologist and counsellor
 5 for HIV, that wasn't available in the 1990s?
 6 **A.** We probably don't -- I don't think we did that.
 7 **Q.** So, again, you have described that anyone that had
 8 a positive result was treated elsewhere. So do
 9 I understand from that you wouldn't have ever
 10 prescribed any medication for HCV like interferon or
 11 anything of that sort?
 12 **A.** Never. Although, I mean we used interferon on
 13 haematological malignancies but I never treated
 14 hepatitis C.
 15 **Q.** In your witness statement you describe some of -- you
 16 describe -- you were asked some questions about the
 17 relationship between pharmaceutical companies and
 18 clinical centre directors or clinical staff, and you
 19 describe some of the hospitality given by the
 20 pharmaceutical directors as extravagant. Can you just
 21 describe for us what you meant by that?
 22 **A.** When we went to conferences, meetings and so on
 23 which -- pharmaceutical companies were very important
 24 for us to attend meetings, for all the directors, but
 25 obviously there were different grades. So the

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1 directors that were most closely associated with
 2 companies would stay in the conference hotels and have
 3 five-star, et cetera, et cetera, and you could see
 4 that they were -- then there were gradations and you
 5 could see that as you went lower down the usage of
 6 Factor VIII in numbers or type of centre you were,
 7 then you may have to go into three-star and four-star
 8 hotels, and you could see the dinners, et cetera,
 9 et cetera. There was quite a big difference on
 10 hospitality that people got.
 11 I don't know how far do you want me to tell you
 12 about these things?
 13 **Q.** Well --
 14 **A.** What do you want to know?
 15 **Q.** Is that the extent of the extravagant hospitality you
 16 were talking about or were there more extravagant
 17 hospitality that you had in mind when you said that?
 18 **A.** Well, I'm sure there was. The bigger -- the centres
 19 that were more -- were nearer working with
 20 pharmaceutical companies and so on, people who used
 21 more of the product had a lot of support for their
 22 departments. And there were individuals being
 23 employed as consultants. I know at least one who is
 24 still working as a consultant to one of the
 25 pharmaceutical companies. There were research grants.

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1 There was all sorts of available monies from
 2 pharmaceutical companies.
 3 But in terms of meetings, we all needed the
 4 meetings, whether it was local, national or
 5 international, whatever, because that was the only way
 6 we could send our staff. There was no money in the
 7 NHS. There was money for me, as a consultant.
 8 I could ask for the post graduate funding. You know,
 9 I could get money. But if I wanted our nurse or
 10 people to go, laboratory staff, I had to ask around to
 11 try and get backing, you know.
 12 Now, it's sad that, it's unfortunate, because
 13 I think even now things haven't changed that much,
 14 although now they would have to declare it. And some
 15 things would be unacceptable now. What -- if the
 16 gifts went above a certain level, you know, it
 17 wouldn't be acceptable at all. But at that time it
 18 was accepted practice. It was normal practice.
 19 **Q.** Did that at the time cause you any concern? Were you
 20 ever concerned about how close some directors were to
 21 the pharmaceutical companies?
 22 **A.** Only in that this was -- some of them were the same
 23 directors who were advising the Government, or on
 24 reference -- there were reference directors who were
 25 in committees that, you know, were recommending.

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1 I mean, we wanted honest advice and, you know,
 2 it sort of made us think: well, you know, is this
 3 purely unbiased or not? You know. I think it was
 4 unbiased. I think we got very good guidelines from
 5 UKHCDO. But it wasn't pleasant visibly to see people
 6 not declaring their interest, you know. Which they
 7 would have to now. You know, they wouldn't be allowed
 8 to do it. It would be scandalous. But at that time
 9 it was -- seemed acceptable practice to be --
 10 a Reference Centre Director to be on committees that
 11 recommended the use of Factor VIII, and they would be
 12 the advisers to the Government. And these are people
 13 are paid by the National Health Service, employed by
 14 the National Health Service.

15 **Q.** Meanwhile taking --

16 **A.** It's a bit strange, you know.

17 **Q.** Meanwhile having extravagant hospitality and gifts and
 18 so on from the very companies that they are
 19 potentially putting forward as to the Government.

20 **A.** Yes, it was -- it felt a bit strange but I -- we took
 21 hospitality too, you know, but obviously not -- I --
 22 we took it largely for our staff.

23 But remember, things are still most -- if you
 24 look at all the educational meetings and so on for
 25 general practitioners and so on, they are still backed

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1 by pharmaceutical companies to promote their own
 2 products. So they must have been doing it to promote
 3 their products.

4 And I think I've mentioned that we had to talk
 5 to representatives and so on, and we had more visits
 6 from the pharmaceutical companies representatives than
 7 we ever had from BPL, which was, again, very sad,
 8 because they should have been acting -- if they were
 9 going to act like a pharmaceutical company, they
 10 should have had a budget for it and, you know, promote
 11 et cetera, et cetera. If they were to be, like,
 12 a part of Blood Transfusion Service, then they should
 13 have been in the same place as the way you use blood
 14 transfusion, et cetera. But I don't think they had --
 15 they were not business-like enough to be able to
 16 promote themselves. It felt very strange and sad for
 17 them. I felt sad for them that they were not able to
 18 compete on equal footing, you know, with
 19 multi-national companies.

20 **Q.** Did anyone from a pharmaceutical company ever try to
 21 seek to influence your decisions about which products
 22 to buy?

23 **A.** Well, they were all trying to market their products,
 24 so obviously they had to say nice things about their
 25 products, but we had to prod and find out the

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1 actual -- and seek reassurances, you know, seek what
 2 the products were about, you know.

3 **Q.** So they were marketing themselves to you during
 4 visits. But would it ever go beyond that?

5 **A.** No, because we would not be influenced, because at the
 6 end of the day it was our head, you know -- it was our
 7 necks. No. But I would have liked more discussions
 8 with BPL, which -- there was very -- I complained
 9 officially that: why am I not getting visits from BPL?
 10 That I want to discuss things. Because they were not
 11 only doing Factor VIII, they were doing
 12 immunoglobulins as well as a few other products, you
 13 know, NTDs.

14 **Q.** I have had some questions from Core Participants to
 15 ask you. They are going to be dotting around a bit on
 16 subject matter.

17 The first one is in relation to -- it's really
 18 the sort of culture of the UKHCDO, that organisation,
 19 and particularly to get to your perspective, as
 20 someone who wasn't in the inner circle and wasn't --
 21 was in a relatively small Reference Centre.

22 There was clearly a hierarchy, because there was
 23 the inner circle, as you described it, of Reference
 24 Centres and so on. Was it a forum in which, at annual
 25 general meetings, for example, you could challenge

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1 authority figures, Professor Bloom, for example, and
 2 it was -- was there a culture of open debate there?

3 **A.** It's open debate with over 100 people there, so you
 4 couldn't call it -- it would be very difficult to
 5 debate anything.

6 **Q.** Yes.

7 **A.** I think -- I mean, me being quite young and early,
 8 I found it -- I would have found it intimidating to
 9 try and speak out. But they were very good -- quite
 10 a few of them were very, very good, very -- full of
 11 integrity. They were people I could listen to. You
 12 know, especially people like Charles Rizza,
 13 Peter Kernoff and so on, you know.

14 But the culture of -- I do not know of any
 15 illness/disease where you got to hit a number to be
 16 a Reference Centre. I mean, do we have a system that
 17 you have got to hit 40 Coviids to be a Covid Reference
 18 Centre? You know, here you had a system where -- we
 19 had a full comprehensive centre, we had more Asian
 20 bleeders because of the practice of consanguinity and
 21 so on, because we didn't have 40 haemophiliacs --
 22 I think it was 30 or 40 -- we can't be a reference
 23 centre. Do we know of anywhere where it's organised
 24 in the same way and it's -- you could predict which
 25 first places were going to be the Reference Centres,

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1 mostly in the south-east?
 2 People had to move. Haemophiliacs had to move
 3 towns. A lot of them tried to live near Oxford, you
 4 know. Do you have to move town to get a Reference
 5 Centre? Half the patients, haemophiliacs were treated
 6 outside the Reference Centres. A system based on
 7 districts and areas would be far better. And it was
 8 all about resources and it's, like I said, the inner
 9 circle. It was a club. Like Geoff Savidge said, it's
 10 a club. You know, he called it a club.

11 **Q.** You would agree with that?

12 **A.** Well, they did a lot of good work. I'm not trying
 13 to -- but I think it could have been organised a bit
 14 better but I've never known anywhere where it says you
 15 have got to hit a number and, bingo, you know, you can
 16 apply. Because if you're one short, you don't have
 17 enough experience. You know, it's crazy.

18 And that system is still there by the way, you
 19 know.

20 But I think now we've moved on. We've got --
 21 all right, haemophilia was very important, was one of
 22 the first bleeding disorders. But now we've got other
 23 bleeding disorders far in excess, and we've got
 24 thrombosis and so on. You know, we need to move on.
 25 And Resource Centres that are good, that are

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1 excellent, but call them by something else. Perhaps
 2 "Centres of Excellence". You know, if you have renal
 3 dialysis centres -- you know, you have cardiothoracic
 4 centres, et cetera, you should have haemostasis and
 5 thrombosis centres, you know, to be more equitable.
 6 But not based on hitting a number and, you know,
 7 having friends in the right places and the right
 8 people to -- sorry, I'm going on a bit.

9 **Q.** And Government money following that decision?

10 **A.** That's right. That's what it was about: resources.
 11 It was all about resources, either from Government or
 12 companies or research or whatever, you know.

13 But, like I said, they have done -- there are
 14 some people of absolute integrity and they have done
 15 some good work. But a lot of divided opinion, a lot
 16 of divided interests in there. But I think we should
 17 learn from all this, you know.

18 **Q.** Going back to the discussion we had earlier about
 19 informing patients about the risk of AIDS, arising
 20 from treatment with factor products, you said that you
 21 weren't offering that information to patients but if
 22 patients were coming to you with concerns about it
 23 then you think you would have discussed it with them.
 24 The question is whether you would expect to have
 25 recorded those discussions in their medical notes. Do

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1 you think that that's the sort of thing you would
 2 record in medical notes, in their clinical notes?
 3 **A.** I think that at first patients seemed to be very
 4 knowledgeable. They knew what -- the risk of AIDS,
 5 et cetera. So when they came we made time to talk to
 6 them and so did Sister Sharp, and so on. So it wasn't
 7 a question of them having to ask, specifically. The
 8 information would be shared. So before AIDS, we were
 9 testing for it, the topic would have arisen, after
 10 testing definitely we would have talked, you know,
 11 there would be counselling and testing.

12 **Q.** Would you have recorded that in the notes?

13 **A.** I think that -- either it would be recorded by me or
 14 staff or -- but there could be also in the nursing
 15 notes. You know, Sister Sharp kept the nursing notes
 16 which may have been more complete than -- and
 17 obviously if they did see the counsellor, and so on
 18 they would be there but she left many years ago. But
 19 we were not allowed to do HIV testing without
 20 counselling and then to sign that, you know, they have
 21 been counselled and they agreed to the test.

22 **Q.** But before the testing, if you were having
 23 a discussion about AIDS and the risk of AIDS, would
 24 you personally, in your practice, would you have
 25 expected yourself to record in the notes a record that

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1 that conversation's taken place?

2 **A.** Well, they couldn't have the test without signing that
 3 they were counselled.

4 **Q.** No, this is not the test, not the test.

5 **A.** No, not this -- I can't remember whether, you know --
 6 I honestly can't -- I mean, I think good medical
 7 practice would be to record it. That would be good
 8 medical practice. I think I might have, I might not
 9 have. I can't remember. But good medical practice
 10 would have said that you should record.

11 **Q.** Another question related to this topic is to ask you
 12 this, would you accept that by not informing patients
 13 about the risk of AIDS from blood products that the
 14 patients lose the opportunity to take steps to prevent
 15 onward infection of their families of HTLV-III, HIV
 16 virus, if they had it?

17 **A.** I've never deliberately not told patients about risks
 18 of AIDS from blood products. Like I said, most of
 19 them were well informed anyway and if we knew that
 20 there was risks then that would have been discussed at
 21 the clinic. That would have been discussed at some
 22 point.

23 But, you know, haemophilia care it's very live.
 24 There's interactions going on all the time. There are
 25 comings and goings all the times, there's meeting

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1 nurses, doctors, treatments and these are happening
2 all the time. It would be very unusual that we would
3 have kept knowledge that we had from patients
4 deliberately. No, we wouldn't.

5 **Q.** So I had understood your earlier evidence to be that
6 before the test came online, as it were, for HIV you
7 weren't routinely telling patients about the risk of
8 AIDS from factor concentrates?

9 **A.** No, we wouldn't have been telling, because it was
10 still in flux. There were conflicting views but if it
11 was brought up, we would certainly -- I would
12 certainly tell the state of the art knowledge.
13 I would tell the patients, you know. But I wouldn't
14 give a false reassurance, as you saw in the letter
15 from Society, you know.

16 **MS SCOTT:** I think those are all the questions that I have
17 and I have had from CPs, from Core Participants, as
18 well.

19 Sir, unless there's --

20 **SIR BRIAN LANGSTAFF:** Yes, well let me just ask one or two
21 questions, if I may.

22 I wonder if we can go back to 0020293_0009.

23 This is the diagram showing the comprehensive care
24 model from 1987, I think it is. It's HSOC0020293.

25 Can we go to page 9 of that? It's the wrong reference

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1 I've got here, I'm sorry. My apologies.

2 **MS SCOTT:** Try page 8.

3 **SIR BRIAN LANGSTAFF:** Thank you. Could we just have
4 a closer look at the diagram, thank you. Now, this is
5 your centre in 1987?

6 **A.** Yes.

7 **SIR BRIAN LANGSTAFF:** In the case of anyone who was known
8 to be infected with HIV, there is no reference here to
9 there having been a GU consultant or someone expert in
10 AIDS, apart from yourself, perhaps; where would they
11 go?

12 **A.** There was no GU. There was no HIV expert at that
13 time. I was the first one who suddenly inherited or
14 had all these patients with HIV.

15 **SIR BRIAN LANGSTAFF:** So that would be you?

16 **A.** Yes, it would be. But only for a short while.

17 **SIR BRIAN LANGSTAFF:** If you understood that they were
18 suffering if we non-A, non-B hepatitis, or for that
19 matter, one of those very few who suffered from
20 hepatitis B still, there is no reference to a liver
21 specialist in the boxes in the middle. Where would
22 they go?

23 **A.** If there was a liver -- I would have to refer them.
24 They didn't come to the clinic.

25 **SIR BRIAN LANGSTAFF:** So this would not be a clinic that

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1 was comprehensive in the sense of including those
2 specialties, apart from saying your only knowledge
3 which you picked up -- of AIDS -- from the most
4 practical way of all, of dealing with it.

5 **A.** If you said that a liver specialist should be included
6 in there then, yes, it's not comprehensive then. But
7 how can we have a liver specialist, where would the
8 resources come from? All these people have given
9 their own time.

10 **SIR BRIAN LANGSTAFF:** The reason I ask is that in some
11 other centres we have had evidence that there were
12 joint clinics arranged. So did you ever arrange
13 a joint clinic of that sort in Bradford?

14 **A.** No. As I stated, we had to make do with the staff.
15 There were no extra resources. There were only two
16 consultants and, you know, I took on this project.
17 All the people gave their time from their own
18 employment. There just wasn't enough resources or
19 rooms in the clinic, you know, because all the rooms
20 are occupied in out-patients, we just couldn't have
21 fitted any more people in there, we just couldn't have
22 done it.

23 **SIR BRIAN LANGSTAFF:** The next question is this: you
24 started as a consultant and then acting director and
25 then director of the haemophilia centre in 1982 in

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1 Bradford. Do you have any reason to think that any of
2 your patients at that time in 1982 were then suffering
3 from the effects of HIV infection?

4 **A.** In 1982, I didn't think there were any patients with
5 HIV, although not haemophiliacs. On the ward, I had
6 a young gentleman who was gay, had pneumonia, but he
7 might have had AIDS but we didn't -- I did not have
8 the knowledge or specialism to take it further than
9 that because even the blood test may not have been
10 available then -- not with haemophilia. But I didn't
11 think anybody -- any one of my patients had AIDS,
12 rather than HIV. AIDS is different.

13 **SIR BRIAN LANGSTAFF:** The gay man would have had signs
14 that you recognised at the time might be AIDS but you
15 didn't know, I see.

16 **A.** He disappeared and I couldn't trace him. But having
17 said that, the first death with AIDS in Bradford was
18 in a haemophiliac and that might have been in 1985,
19 I think -- '84/'85. Sorry, '85. I think it's in the
20 records. It's '85 and it's interesting because I gave
21 him high dose immunoglobulins and he responded very
22 well and we wrote a letter and he had seen a list of
23 my publications, and he responded very well to that.
24 My last sentence on that was that immunoglobulins
25 should be tried in viral infections, and it's

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1 interesting because it's gone round in a circle.
 2 Mr Trump had immunoglobulins, didn't he, so --
 3 and I don't know why they don't try high-dose
 4 immunoglobulins, because that's quite pooled, you
 5 know. They are going for specific immunoglobulins but
 6 it sort of came out in a circle, but that was the last
 7 sentence I wrote. It was printed in the BMJ that it
 8 should be tried.

9 I think the other interesting thing, by the way,
 10 I'm surprised you haven't asked me, which is still in
 11 this healthcare management, was we were the first in
 12 the world to use Monoclate, which was -- that patient
 13 is still alive, has a family, he is not positive for
 14 hepatitis and he doesn't have HIV. It was a different
 15 way of making Factor VIII, it was using antibodies
 16 which bound Factor VIII in von Willebrand, and then
 17 you added calcium chloride. You let everything else
 18 go through, all the impurities then you added calcium
 19 chloride and got Factor VIII. It was such a small
 20 amount and so soluble that they had to mix it with
 21 albumin because it was so small, to make it enough
 22 volume to be able to inject. But that was taken off
 23 the market, but Monoclate went on for a long time.
 24 But that patient never got hepatitis or HIV, which was
 25 a great success, which was a great thing.

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1 **SIR BRIAN LANGSTAFF:** Thank you. Roughly, how many
 2 patients do you think you had going through between
 3 1982, in the usual sort of number 1982 through to say,
 4 1986?

5 **A.** Going through?

6 **SIR BRIAN LANGSTAFF:** Those four years, 1982 to 1986.

7 **A.** How many patients -- sorry, I missed the question?

8 **SIR BRIAN LANGSTAFF:** Roughly how many patients with
 9 haemophilia did you treat in the years 1982 to 1986,
 10 roughly?

11 **A.** Well, first the returns, I think, started about
 12 18 patients but they were gradually increasing because
 13 we were getting patients from outside Bradford, as far
 14 as Huddersfield and Halifax. I think in that period
 15 severe haemophiliacs that we treated might have gone
 16 to 26, something like that, 26/28 something like that.

17 **SIR BRIAN LANGSTAFF:** Roughly how many of the 26 or so
 18 tested HIV positive?

19 **A.** I cannot remember the figure.

20 **SIR BRIAN LANGSTAFF:** What sort of percentage?

21 **A.** I don't think there were that many, actually, but
 22 Adrian Minford mentioned four. I don't know, maybe
 23 another six, seven, eight, something like that
 24 possibly.

25 **SIR BRIAN LANGSTAFF:** Per cent or number?

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1 **A.** Number. There weren't that --

2 **SIR BRIAN LANGSTAFF:** So that would be about 30 per cent?

3 **A.** I honestly couldn't -- I can't remember, I can't tell
 4 you, I'm sorry.

5 **SIR BRIAN LANGSTAFF:** Why do you think, from patients who
 6 began in 1982, and you have no reason to think that
 7 they had any infection with HIV, through to, say, 1986
 8 when tests were regularly freely available, why do you
 9 think it was that about a third began to have
 10 infections with HIV?

11 **A.** I honestly don't know but we were using commercial
 12 Factor VIII, we were using a lot of NHS Factor VIII,
 13 the usage is going up all the time. I don't know
 14 exact numbers how many were actually infected but they
 15 probably got infected with those materials, you know.
 16 There was one particular -- I think it's in the
 17 material I've given you, where a patient with
 18 von Willebrand got infected with just one batch of
 19 Factor VIII and I informed promptly and all the
 20 batches were withdrawn, and subsequently they started
 21 withdrawing the batches from two or three other
 22 hospitals very quickly. The message there was that if
 23 you used the same material on the same patient, in
 24 this one there was a change and that helped to
 25 withdraw all the rest, but they got infected like all

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1 other patients and I think it was we found out too
 2 late, didn't we, really?

3 **SIR BRIAN LANGSTAFF:** You must have asked yourself: here
 4 am I responsible for the treatment, which they are
 5 giving, they are having, about a third end up with
 6 infection from the treatment, one way or the other,
 7 how did it happen?

8 **A.** Well, I know how it happened and I feel very guilty
 9 about it. It's the fact that I changed practice when
 10 I got appointed, I started getting commercial
 11 Factor VIII in, started using more concentrate, even
 12 NHS, and without knowing it, I'm responsible for
 13 infecting them but without any knowledge, you know,
 14 like so many directors, the best intentions -- you
 15 know this happened and all I can say is I'm sorry.

16 **SIR BRIAN LANGSTAFF:** So it was the product that you were
 17 given to use that was, as you saw it, causing the
 18 problem.

19 **A.** Yes, unknowingly, obviously.

20 **SIR BRIAN LANGSTAFF:** When people were infected, did you
 21 check back the batch numbers to see whether they
 22 probably had it from batches of concentrate?

23 **A.** As far as -- well, as we knew the batches were
 24 infected, they were withdrawn, they were brought back,
 25 they were given back. This information as it came

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1 through, whether it came through Blood Transfusion
 2 Service or pharmaceutical companies or wherever, it
 3 was actioned immediately.
 4 So yes, they were withdrawn. We didn't continue
 5 using them. We knew all the batches. It was all
 6 recorded. We had all the records in our blood bank,
 7 but we moved on with the products as well because this
 8 is where knowledge came and said, okay heat treatment
 9 is better than unheat treatment, heating at, was it 60
 10 or 80 degrees, is better than 40 degrees, but the
 11 treatment is better -- and so we kept on withdrawing
 12 the previous products that had been used up and
 13 getting newer products, and then when then we used the
 14 Monoclote, which produced very good results. But that
 15 was withdrawn as well, for some reason. I don't know.
 16 **SIR BRIAN LANGSTAFF:** You have mentioned a number of
 17 occasions that you were desperate for information
 18 during the time, '82, '83, '84.
 19 **A.** Reliable information.
 20 **SIR BRIAN LANGSTAFF:** Reliable information. To what
 21 extent do you think the lack of information may have
 22 contributed to what happened?
 23 **A.** I think it may not be about lack of information. It's
 24 about delayed information. As we found out that --
 25 the Americans had a lot of information. There was

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1 a lot of actions being taken there. The problem was
 2 bigger. But somehow there was reluctance in Britain
 3 to accept that.
 4 I think that that delay might have cost lives.
 5 I think the delay in the Government recognising how
 6 good the -- how good British donors are, how good is
 7 the NHS stuff, not investing money.
 8 I mean, I've often thought about it. If it was
 9 a commercial world, if they were now in the stock
 10 market and you had BPL, what they would say is: Invest
 11 in them, you've got a free supply of donors, free
 12 plasma. Invest in them because our costs will be
 13 lower and our profits will be higher.
 14 And those profits could have been ploughed back
 15 into getting new manufacturing plants, et cetera,
 16 et cetera. The pricing should have been in
 17 competition with commercial factor. There should be
 18 an element built in for research and development.
 19 But what would we have? They are part of NHS,
 20 a monopoly. Government doesn't want to invest, not
 21 enough anyway. They cannot go to the City for money
 22 or investment. They cannot ask NHS staff to invest.
 23 And so I think the future was sealed, you know. It
 24 was a -- when the reps came, you could see they didn't
 25 have enough -- enough of anything, really. There were

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1 only two reps, I think, for the whole of England,
 2 while the commercial companies had a lot more
 3 material, you know, a lot more muscle. So I think
 4 their fate was sealed actually, that they would not
 5 succeed as a non-commercial concern within the NHS.
 6 But if they had that independence, if the
 7 Government said, "We're going to float you out",
 8 people would have invested crazily, because here was
 9 good, solid supply of good material, you know.
 10 **SIR BRIAN LANGSTAFF:** I suppose another way of putting the
 11 same point would be that it would be cheaper to have
 12 invested and developed the BPL Elstree product than it
 13 would to buy the commercial product, allowing for all
 14 the profit and the uses to which the profit was put,
 15 such as marketing and commercial return?
 16 **A.** A lot cheaper. The commercial companies were
 17 making -- it was an absolute fortune. The profits
 18 were incredible through Factor VIII. Which I'm sure
 19 you are aware of, you know. You are talking millions
 20 and millions, and you are talking worldwide.
 21 If Elstree had produced, they had invested and
 22 made products, and if they were allowed to -- had been
 23 able to sell, a lot of the world would have bought it,
 24 because it was good British product, with good British
 25 donors, clean. But British donors, they give their

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1 blood -- if there was hepatitis, they soon trace it.
 2 If somebody got it. They're withdrawn. That donor is
 3 gone. You know, well tested.
 4 You don't need a blood test because you have
 5 been tested by giving 50 units, 30 units or -- I mean,
 6 it's a great thing that the Great British have, is
 7 their charitable generosity that they have with the
 8 blood transfusion, the National Blood Transfusion
 9 Service.
 10 But I think it was what I called a missed
 11 opportune -- you know, I invest a lot in shares and
 12 things and, you know, I -- and I just felt that the
 13 BPL were not commercially minded, they didn't have
 14 proper backing, they were not supported, and all
 15 because they were in a sort of nationalised industry.
 16 **SIR BRIAN LANGSTAFF:** Yes, I see.
 17 Turning to a new subject, you spoke quite a bit
 18 about the way in which, as a haemophilia centre, you
 19 would operate as a family in many ways, or a friend,
 20 because you saw your patients so often, those who were
 21 severe haemophiliacs, who attended the clinics
 22 regularly. So you would get to know what they were
 23 thinking or what they picked up, and presumably,
 24 I think this is what you said, that whatever was in
 25 the press or in the media they might reflect back to

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1 you by asking you questions about it, and you say they
 2 knew quite a bit about their condition.
 3 **A.** They do. And I also support them because some wrote
 4 very -- articles that I had supported them to write,
 5 in Sunday Times and -- I've always backed their cause.
 6 I think as a society we have failed them.
 7 **SIR BRIAN LANGSTAFF:** They came to you presumably
 8 because -- it must have been because -- you were the
 9 expert in haemophilia.
 10 **A.** I had to learn on the job a lot. As I said, my
 11 training wasn't particularly great. I think that's
 12 something that -- I don't know whether the Inquiry is
 13 looking at -- is such a responsible post, would you
 14 have people appointed by accidental training? Surely
 15 UKHCDO should have given guidance about how people
 16 should be trained and accredited and so on. And it
 17 was really in that there were just few centres that
 18 produced the directors for themselves, for their own
 19 centres, et cetera.
 20 **SIR BRIAN LANGSTAFF:** Let me change the question then.
 21 You were in a position which they would
 22 naturally look up to as being the source of definitive
 23 advice.
 24 **A.** Yes, they were actually. And I had to be honest with
 25 them. But as you said, in the conditions, inherited

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1 blood conditions, and conditions like haemophilia, you
 2 do become -- and leukaemia, by the way, they were very
 3 close to me.
 4 **SIR BRIAN LANGSTAFF:** So you said you took your lead from
 5 information because you didn't have a lot of it from
 6 the UKHCDO --
 7 **A.** And elsewhere.
 8 **SIR BRIAN LANGSTAFF:** And so you can't remember, I think,
 9 any specific conversation, but if somebody suffering
 10 from severe haemophilia had come to talk to you
 11 raising media concern in May 1983 or June 1983, do you
 12 think you would have told them, as being the person
 13 they were looking to for definitive advice, what the
 14 HCDO were saying, or do you think you might have said
 15 something different?
 16 **A.** I think that's a bit too specific because -- I think
 17 what they would use a Director for is to get
 18 information from several sources, try and summarise
 19 it, and bring it to a language that we could converse
 20 in. You know, that we could actually talk. So we
 21 were like a filter, you know, a filter for all the
 22 information we got from various sources. But my
 23 patients were my friends.
 24 **SIR BRIAN LANGSTAFF:** So what do you think you might have
 25 said -- if you can't remember, please don't try and

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1 remember -- to someone who came and raised -- in, say,
 2 May 1983, said, "Right, I've been reading the Mail on
 3 Sunday and I've seen this thing about a killer
 4 disease, AIDS, from which haemophiliacs are at risk,
 5 am I really at risk here? Am I going to get AIDS?"
 6 What would you have said?
 7 If you can't remember, please say?
 8 **A.** Oh no, I think we're all used to the headlines that
 9 come from Daily Mail and so on. It's -- like I said,
 10 I think one has to play it down or play up, depending
 11 what's said in the papers, but they are -- what they
 12 are looking for is interpretation by somebody who has
 13 empathy for them, who understands.
 14 I think it really depends what information
 15 Daily Mail had, because I think sometimes the
 16 newspapers have done a grand job. I think they've
 17 done a grand job trying to highlight haemophilia and
 18 the plight, you know. But sometimes it's the other
 19 way round, they cause problems, you know.
 20 I'm sorry, I might not be answering your
 21 question.
 22 **SIR BRIAN LANGSTAFF:** You aren't, but you've given an
 23 answer of a sort.
 24 **A.** Maybe I can't answer it. I don't know.
 25 **SIR BRIAN LANGSTAFF:** I think perhaps you can't remember

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1 specifically, so I shall forgive you for that, if I
 2 may.
 3 The only other matter which I want to raise with
 4 you is -- if we can have UKHCDO0000270_004, what
 5 I want to ask you about was this: this is the
 6 Reference Centre Directors sending out a report. It's
 7 recommendations which counsel took you to. It refers
 8 to a meeting of the Reference Centre Directors
 9 on May 13, 1983. As far as you can recollect, was
 10 this a time when there was quite a lot of concern
 11 about the risk of AIDS, the problem of AIDS?
 12 **A.** Sorry, can you repeat that?
 13 **SIR BRIAN LANGSTAFF:** Yes. Was this a time, 1983, around
 14 the middle of the year, that there was a lot of
 15 concern in the popular press, amongst those who were
 16 your friends who came to speak to you in the
 17 haemophilia clinics and so on, about the possibility
 18 or the risk of AIDS?
 19 **A.** 1983 ...
 20 **SIR BRIAN LANGSTAFF:** If we just have a look at the
 21 heading, Henry, it may give a clue, I think.
 22 This is a long-ish letter all about it.
 23 **A.** I think 1983 -- I mean, it's difficult --
 24 **SIR BRIAN LANGSTAFF:** To think back?
 25 **A.** No, I think there was -- obviously things were

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1 happening in America.
 2 **SIR BRIAN LANGSTAFF:** Let me tell you what my question is
 3 here.
 4 The meeting is 13 May. The letter -- if you go
 5 back and down a bit further, Henry, if we may --
 6 sorry, up. I'm in the wrong direction. That's it.
 7 24 June. So it's, what, six weeks in 1983
 8 where, if the American experience was right, there may
 9 be something which is labelled an epidemic which is
 10 happening. Do you have anything to say about the
 11 slowness of this letter being written after a meeting
 12 of 13 May to which the substance of it was agreed?
 13 **A.** There is slowness. I mean, you know, we have said
 14 there's -- do you mean the slowness to take into
 15 account this letter afterward?
 16 **SIR BRIAN LANGSTAFF:** The delay in writing it.
 17 **A.** Mmm?
 18 **SIR BRIAN LANGSTAFF:** The delay in writing it.
 19 **A.** I think that that's what I meant, that there has been
 20 delay. There has been delays all the time, every
 21 year.
 22 **SIR BRIAN LANGSTAFF:** That's what I was going to lead
 23 on -- that's where this question was leading. There
 24 were further delays, were there, in giving out
 25 information?

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1 **A.** Yes, there was delays. But we were looking for
 2 leadership, and I think in some way it would have been
 3 good for UKHCDO, whichever organisation or
 4 Government-appointed or whatever, to have collated
 5 this and taken things quicker, further, faster.
 6 Because we did have a choice -- because in this
 7 country we did have a choice, because there was an
 8 alternative company that they could have taken
 9 corrective measures with. You know, they could have
 10 reassured the population in Britain that: yes, we have
 11 a British company, with the right backing, right
 12 research, right investment, may reduce the risk.
 13 I do not know again if I'm answering it, but the
 14 delay I think is critical.
 15 **SIR BRIAN LANGSTAFF:** Well, thank you very much.
 16 **A.** I think in many ways we're talking about -- comparison
 17 would be like with Covid. The delay, for whatever
 18 reason, may actually cost lives. Delaying
 19 vaccination, delaying whatever. There are parallels.
 20 **SIR BRIAN LANGSTAFF:** Thank you very much.
 21 That's all that I ask, Ms Scott.
 22 **A.** I'm sorry, I was getting a bit tired.
 23 **SIR BRIAN LANGSTAFF:** You don't need to apologise. You
 24 have been there all day and you have been most
 25 helpful.

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1 **MS SCOTT:** Professor Parapia, is there anything you would
 2 like to say?
 3 **A.** I would, but I don't think I can.
 4 **MS SCOTT:** Okay.
 5 **SIR BRIAN LANGSTAFF:** If you want to I'm not stopping you.
 6 **A.** No, it's ...
 7 I think it's just sad what's happened. It
 8 shouldn't have happened. And I think we should ...
 9 **SIR BRIAN LANGSTAFF:** Just take a moment, please.
 10 **A.** I've lost a lot of people I knew. I'm sorry.
 11 **SIR BRIAN LANGSTAFF:** You have absolutely nothing to
 12 apologise for in saying what you've just said.
 13 Can I thank you? In your gentle way you have
 14 illuminated what life was like for a consultant and
 15 director in one of the smaller units treating those
 16 with haemophilia in the early 1980s and through to
 17 1990, and given us quite a practical insight into how
 18 you saw things and how things might have been seen in
 19 other places, and the relationship between a smaller
 20 unit and perhaps some of the bigger players, if I can
 21 call them that, in the field. That's been really most
 22 helpful.
 23 Thank you very much indeed for coming, despite
 24 all the current challenges, to which you have made
 25 a number of references. So our gratitude to you.

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1 **A.** Thank you.
 2 **MS SCOTT:** Sir, we're not sitting tomorrow. I think we
 3 are back on Monday with evidence being given remotely
 4 by Professor Hay.
 5 **SIR BRIAN LANGSTAFF:** Preston, I think.
 6 **MS SCOTT:** Professor Preston.
 7 **SIR BRIAN LANGSTAFF:** Professor Preston. That may be less
 8 than a day, I think, for those who are coming but
 9 spread over two days, possibly, as I understand it.
 10 **MS SCOTT:** Yes.
 11 **SIR BRIAN LANGSTAFF:** Then later in the week we hear from
 12 Professor Hay, do we?
 13 **MS SCOTT:** Yes.
 14 **SIR BRIAN LANGSTAFF:** Until Monday then, those of you who
 15 are coming back then. In the meantime, please stay
 16 safe and I look forward to seeing you again, those of
 17 you who return next week.
 18 **(4.48 pm)**
 19 **(Adjourned until Monday, 2 November at 10.00 am)**

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