Witness Name: Alison Bennett
Statement No: WITN0553/003
Exhibits: WITN0553/004-006
Dated: 28 June 2019

**INFECTED BLOOD INQUIRY**

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**SUPPLEMENTARY STATEMENT OF ALISON BENNETT**

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I, Alison Bennett, have recently been provided with access to some of the medical records which relate to my son, Alistair Bennett's treatment, at the Oxford Haemophilia Centre (OHC) between 1982 and 1986. In light of these records, and further to my previous statement dated 22 November 2018, I will say as follows: -

**Additional points I want to make: -**

*Hepatitis B diagnosis*

1. The records from the OHC show that both Alistair and I developed acute Hepatitis B at the same time in 1976 (antigen positive). I notice that the medical notes make mention of the fact that I was Hepatitis B positive, and that they draw a connection with my work as an anaesthetist at the time. They seem to suggest that I was the cause of my son's infection (WITN0553/004). I think this is nonsense. It is a clever way of saying that his infection had nothing to do with them.

2. Having regard to the relatively long incubation period from date of infection to the development of symptoms it is more likely that we contracted the disease at the same time from the same source, i.e. Factor VIII, rather than me having been infected in the workplace, going on to develop the disease after the incubation period and subsequently passing it on

to Alistair. Medical notes reflect that we both were infected with Hepatitis B at the same time (WITN0553/005) Alistair was aged only 3 years at that time and was treated with cryoprecipitate sourced from the regional blood transfusion service. We have never been informed whether or not any of the cryoprecipitate doses he was given were shown to be infected with Hepatitis B or whether such tests were routinely available in 1976.

3. Further, when I was ill with Hepatitis B, we were not told that he had developed acute Hepatitis B at the same time. I have only discovered this having seen the records from the OHC (WITN0553/006). We had previously known, from about 1986, that he was Hepatitis B antibody positive, in other words that he had been infected in the past and had cleared the infection. We were not told then when the infection had occurred. If I had known that Alistair had been diagnosed as Hepatitis B positive in 1976, I would have been able to say then that it had nothing to do with my work, and that it had to do with the products that he had been given.

*Treatment products*

4. In my Statement I mentioned that Alistair was admitted as an inpatient at the Oxford Haemophilia Centre (at paragraph 2.5) for severe synovitis of his knees and ankles. The medical records include a treatment sheet (WITN0553/007) which shows what material Alistair was treated with at the time. It mentions Koate, which was produced by a manufacturing company called Cutter. It was later thought to be suspect, and I know that there were lots of questions raised in the Penrose Inquiry concerning this product.

5. The medical records I have been shown include a Treatment sheet from 1986 which indicates that Alistair was being given 8Y in August 1986 which was British produced. But then by September 1986 he was given Hemofil, which Dr Rizza refers to as Travenol in his notes, which was produced by Baxter, a US company (WITN0553/008).

*Hepatitis C*

6. We did not learn that Alistair had chronic Hepatitis C until he went up to University in Newcastle in 1990 in September or October. He had only recently been to see the RMCH clinic and nobody had said anything about it.

7. We have no evidence to confirm when he was infected but, as shown in my Statement at paragraphs 2.10 and 2.11 I believe it was in late 1984 shortly before I was confirmed as having Non-A Non-B Hepatitis in January 1985. I understand the incubation period is anything from 2 weeks to 6 months. For the same reasons as I have already discussed with regard to Hepatitis B, I believe we were both infected at the same time and for the same reason.

*HIV testing*

8. I believe that Alistair was infected with HIV at the same time as he had become infected with Hepatitis C. As I say in my Statement at paragraph 2.12, we received a letter informing us of Alistair's infected status. There had been no counselling prior to the test which revealed his status as HIV positive, and we had had no idea what he was being tested for at the time. I have no idea when the samples were taken for testing.

9. What they told us was that they had not been able to get the tests done before because when the test for HIV had become available, there were lots of groups of people who were given priority, like ambulance people, police and so on. We were left with the impression that the test was done on Alistair's blood after these other groups of people had been tested as a priority. So I have no idea when the samples of blood were taken which revealed that Alistair was HIV positive.

*Referring to accurate causes of death on death certificate*

10. Government guidelines on what should be recorded on a death certificate state that it is extremely important that the certifying doctor provides clear, accurate and complete information about the diseases or conditions that caused the death.

11. Information from death certificates is used to measure the relative contributions of different diseases to mortality. Statistical information on deaths by underlying cause is important for several reasons including planning health services, and assessing the effectiveness of those services. Death certificate data are extensively used in research into the health effects of exposure to a wide range of risk factors including medical care.

12. In Alistair's case the immediate cause of death was acute renal failure due to septicaemia, due to immunosuppression caused by HIV/AIDS. This is not accurately reflected on his death

certificate (WITN0553/009). I think this was obfuscation really. I think it was left off because the authorities did not want to admit that my son acquired HIV from his NHS treatment. I am aware that some families did not want HIV mentioned because of stigma and difficulties with funeral arrangements etc. Maybe the hospital was influenced by this. I have no wish to criticise the medical and nursing staff who provided exemplary care in Alistair's final illness but I was surprised that the true cause of death was not certified. I do think there was some attempt to obscure the truth. I feel this is likely to have been due to Government, Regional or Hospital policy decisions and instructions to certifying junior hospital doctors. I cannot prove it, but it is my suspicion.

*Advice provided to us on HIV/AIDS diagnosis*

13. When Alistair was diagnosed as HIV positive, we were sent a letter together with a pamphlet extract, which I provide to the Inquiry at WITN0553/010. This extract together with Dr Evans' AIDS diagnosis letter (exhibited previously at WITN0553/002) was the only information we received from the Royal Manchester Children's Hospital about the nature and management of HIV. We felt the pamphlet was distressing, inappropriate and not suitable for discussion with a boy of Alistair's age (13 years).

*Further comments*

14. I would like to emphasise that I am not suggesting that the medical staff were not doing their jobs properly. The problems I believe were with government, some local and regional health authorities and some haemophilia centre directors. The people we dealt with were always kind and sympathetic, and were not making decisions to deliberately harm us. My hope is that this Inquiry will bring to the government's attention that short-termism is costly in the long term.

**Statement of Truth**

I believe that the facts stated in this witness statement are true.

Signed GRO-C

Dated 28th June 2019