Witness Name: David Croser
Statement No.: WITN0923001
Exhibits: WITN0923002-3
Dated: X 18 March 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF David Croser BDS LDSRCS MFGDP(UK)

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20th January 2020.

I, David Croser will say as follows: -

Section 1. Introduction

1. My name is David Croser. My date of birth is GRO-C 1947 and my address is known to the Inquiry.

2. I am a Dental Surgeon by profession, I will explain the letters that follow my name at the head of this statement. I qualified as **BDS**; Bachelor of Dental Surgery at University of Birmingham (1971). **LDSRCS**; License in Dental Surgery at Royal College of Surgeons (UK) (1971). **MFGDP(UK)**; Membership of the Faculty of General Dental Practitioners at Royal College of Surgeons(UK) (1992).

3. Many of my professional roles over the years have been concurrent. Upon qualification in 1971, I became a self-employed General Dental Practitioner (GDP) initially as an associate and then in my own practice in Belgravia, London.

4. Between 1971 and 2006, I worked for the NHS, private practice, corporate practice and salaried, special needs dentistry.

5. Between January 2001 and December 2006, I was part of a London based team working for The Medical Protection Society providing risk management advice to dentists facing regulatory and legal challenges.

6. From January 2007 to January 2018, I was employed as the Communications Manager for Dental Protection within The Medical Protection Society, responsible for the creation and production of web-based content, member publications and newsletters.

7. I have been involved in dental journalism since 1980. Between 1988 and 2010 I was on the editorial board of 'Dental Practice'(UK). Between 1989-1997, I was Editor of 'Postgraduate Dentist Middle East'.

8. I have been Dental Advisor to the British Dental Association since 2019.

9. Particularly pertinent to the reason behind me providing this statement; I was co-founder and clinical lead for Chelsea & Westminster Dental Clinic, dedicated to the provision of dental treatment for patients living with HIV between 1986 and 2006, where, in addition to clinical dentistry, I undertook research, clinical and administrative roles.

10. Of relevance also: I have had roles on the advisory panels of hivdent.org (since 1997) and Dental Alliance Aids Care (since 1993). I am one of the authors of 'Principles of Oral Health Management for the HIV/AIDS Patient' published by Dental Alliance Aids Care in 2000, specifically Chapter 2 'Special Considerations for Dental Patients with HIV/AIDS'. I am not sure how relevant this is for the Infected Blood Inquiry but the link for the complete document is below;

https://aidsetc.org/sites/default/files/resources_files/Princ_Oral_Health_HIV.pdf.

11. Additionally, I have worked with the UK Advisory Panel (UKAP) for Healthcare Workers Infected with Bloodborne Viruses, to revise definitions of exposure prone procedures to help infected dental colleagues return to work.

12. I provide my full curriculum vitae as **WITN0923002.**

13. I am aware that there have been other Public Inquiries relating to NHS patients receiving contaminated blood but I have had no input in these. I should also add that I have never been invited to contribute to those earlier Inquiries.

14. I have however provided expert witness testimony on behalf of Dental Protection for two cases of discrimination at the General Dental Council (GDC) and I have given evidence to an All-party Parliamentary Committee reviewing the dental needs of prisoners - referencing the use of methadone in sugar solution that was used as a drug substitution for prisoners with a heroin addiction.

15. I am happy for this witness statement to be published in the public domain.

16. I have been asked a number of questions regarding my work in the field of dentistry and blood-borne diseases, specifically the dental profession's development and state of knowledge from 1970 onwards.

17. I should state now that although I have much experience in the treatment of HIV/AIDS patients within a general dental practice setting, I have had very little contact with patients who were haemophiliac or knowingly with others, who had been infected through contaminated blood. In fact, during my career, I have seen only two patients who

were haemophiliac, only one of whom was known to be HIV and HCV positive and a patient with von Willebrand's disease (with no known blood-borne disease) and a female patient who had been infected with HIV by her spouse who had been the recipient of contaminated blood product.

18. When providing dental services in a setting dedicated to patients living with HIV, I was first employed by Chelsea and Westminster FPC Family Practitioner Committee (FPC) with an NHS General Dental Practitioner contract and subsequently became an employee of the Community Dental Service, operated by Hammersmith and Fulham Family Health Service Authority (FHSA).

19. In relation to Human immunodeficiency virus ("HIV"): Initially, fear led to dental treatment frequently being refused by members of the UK dental profession from the discovery of HIV in 1984 until Highly Active Antiretroviral Therapy (HAART) became widely available in 1996. Similar reactions by the dental profession have been documented in some other parts of Europe, Australia and the USA.

20. In the early days of HIV, there was no simple test for the disease but the presence of certain oral lesions might indicate that a patient had been infected with the virus. (Indeed, Kaposi's Sarcoma was AIDS defining). Further questioning of the patient could be sufficient to recommend the patient attend a Urogenital Clinic for further investigation. A knowledge of these HIV-related oral lesions (when present) provided a simple way for any healthcare professional to interpret the patient's other symptoms and to recommend them to a specialist setting for HIV screening, particularly in the early days before oral testing kits were available, and in more remote settings.

21. The dedicated dental clinic worked alongside the oral medicine facility at Guys and Kings Hospitals. The involvement of academics from the teaching hospitals added rigour to the research we undertook.

Information was shared with the other oral medicine facilities in London who met together as the London HIV Dental Group (hosted at Guys Hospital). This combined knowledge was disseminated to the UK dental profession through lectures hosted by the postgraduate deaneries, an information pack distributed to local dental practices and the British Dental Association monograph on the dental management of HIV patients that was distributed to GDPs in the UK.

There was a lag in disseminating new knowledge to dental colleagues – there was no internet yet and scientific publishing requires time to prepare and verify observations. I was invited to lecture to local dental groups about HIV and infection control. There was also a standing invitation to groups of dentists to come and watch the dedicated clinic in practice, so that they could see for themselves the required standard of infection control and the importance of avoiding needlestick injuries. At this time, use of rubber gloves for every patient was a new precaution and an additional practice expense.

22. The UK dental profession magnificently improved infection control standards in response to HIV. NHS contractors were given modest grants by the Department of Health (DOH) to help with the cost. However, some HIV patients reported that they had experienced some reluctance to treat them. Perhaps it should be remembered that the revised NHS contract for dentists were not universally popular. Some dentists opted to work independently and so finding an NHS dentist was sometimes an issue for patients regardless of their HIV status.

23. By 2000 as more newly qualified dentists came into the profession, who had been educated about HIV and were confident about infection control, it was easier for infected patients to obtain treatment on the first time of asking.

24. In relation to Hepatitis B (HBV): The availability of an effective vaccine after 1985 and good infection control should have made access to dental care a non-issue within dentistry. The offer to patients of the

last appointment in the day, which is what sometimes happened, suggests this was not always the case. Until then and before HIV, the non-routine use of rubber gloves was common amongst dentists who as a group, showed a natural incidence of HBV antigens 6 or 8 times higher than the population at large. Strangely it didn't seem to stop them treating patients.

25. In relation to Hepatitis C (HCV) the undergraduate course included information about the different strains of the hepatitis virus and the associated risks of being infected by a patient. The "Hepatitis alphabet" listed strains from A to K. Non A non B Hepatitis as was (later identified as HCV), had no treatment initially but was recognised as a risk for future liver cancer – It could also terminate a dentists clinical career as they had to stop practice as a precaution against infecting their patients.

26. The subsequent availability of treatment might have been expected to reduce the fear of catching HCV. Over time different varieties of therapy were tried with varying degrees of success. An effective method now exists to eradicate the virus from the infected healthcare worker, affording them the potential to return to work

27. In terms of treating patients with HCV, the standard infection control protocols developed to cope with HIV were also considered effective for HCV. The only issue of significance is that HCV is more easily transmitted than HIV - by a factor of 10. The risk of a needlestick injury remains a problem, since dentists often need to top up local anaesthetic injections using the same needle that is frequently recapped in the surgery until it is safely disposed of at the end of treatment.

28. The efficacy of dental treatments for patients with HIV and HCV remains the same as for any patient without either of these blood-borne diseases.

29. In relation to general infection control precautions; The HIV pandemic in the1980s required a total rethink of infection control in all dental surgeries. This development was duplicated by the dental professions in the other EU countries.

    Guidelines and precautionary bans were introduced for all healthcare workers undertaking exposure-prone procedures if diagnosed with HIV as well as other blood-borne diseases (eg, HBV, HCV). The practise of dentistry is considered exposure-prone.

30. HTM (Health Technical Memoranda) 01-05, published in 2013, was ultimately designed to raise the quality of decontamination work in primary care dental services, covering the use of reusable instruments in dental facilities.

31. It is important to understand that dental practices are small businesses, subject to an initial capital loan to build and equip the surgery, repayment of the loan with interest, indemnity, staff costs, overheads/running costs and one's own salary; the ability to cover these costs is entirely dependent upon the fees paid by patients. The fees paid by NHS patients are defined in an NHS contract with the individual clinician. Private fees vary and are agreed with the patient before treatment starts. In general dental practice, apart from certain obligations over the provision of emergency treatment, the dentist has no obligation to take on new patient for a full course of treatment.

32. My own practice was a mixed practice (NHS and private) and relied on attracting enough patients to cover the business costs. As those costs increased I had reduced the number of new NHS patients that I would accept and moved towards independent practice offering a private patient capitation scheme managed by Denplan Ltd.

33. By the time that the HIV/AIDS crisis 'broke', with dramatic public information films and advertising that referenced the almost inevitable mortality for those who caught the disease. There was a lack of

knowledge about the causal agent and the public were fearful in a similar way to the reaction to COVID19 in 2020.

34. News of the disease jolted the general public into discussing methods of transmission that might involve sexual preferences and recreational drug use. The press liked to talk about this in slightly lurid terms, leading to stigmatisation of those who were afflicted. In spite of their ethical obligations, not all healthcare professionals are free of prejudice, Education can help here of course – but this takes time.

35. People suffering with HIV/AIDS need good quality dental care just like everyone else – indeed, periodontal disease is a significant issue for people with untreated HIV disease, and in the early days there was no treatment apart from AZT, which created its own problems.

36. So, there was now a new dental phenomonen in London - HIV positive patients seeking attention for their acute dental problems. The teaching hospitals were one source of dental care, as were some of the central London dental practices. In our own practice we had a number of existing patients (private and NHS) who were living with HIV as well as some who had died of AIDS and for whom we had provided treatment. It didn't take long for the HIV patient self-help groups to pass round the names of practices where they hoped to find NHS treatment.

37. The management of patients with HIV during the early years, meant that many newly diagnosed patients from other parts of the UK came to the London hospitals that were centres of excellence. The only available treatment was AZT which was being trialled. The majority of this cohort were gay men and some drug users. Being a practice that was known to be gay friendly, many of these new patients were now asking to be seen on the NHS - many of them being eligible for free treatment as they were no longer able to work.

38. The influx of so many new patients seeking NHS treatment for complex dental problems that required time-consuming management would inevitably impact upon the viability of the business at a time when the business required us to recruit higher revenue private patients to balance the books. The alternatives, were to discriminate against HIV/AIDS patients or think of a different way to enable them to find good dental care.

39. In 1986, in order to cope with the disparity between demand and supply, my business partner and I discussed the matter with the local NHS Health Authority as well as with members of the Gay and Lesbian Association of Doctors and Dentists (GLADD). A group of dentists from around London identified themselves as willing to be part of the solution.

40. For this reason, five colleagues resolved to set aside one day a week to run this dedicated dental service. It was altruistic in that we all still had our own practice overheads to cover on the day we were out of the practice. Whilst we were not looking for a salary, we did hope that we could find a way to cover the ongoing business expenses.

41. So it was that over a period of nearly 18 years, a total of seven dentists offered their services to create a rota to provide NHS dental services to patients living with HIV, initially at the sessional rate paid to salaried community dentists. There would be no allowance for practice overheads because the Chelsea and Westminster Family Health Services Authority (FHSA) provided the premises, suitably equipped and with a dental nurse to assist in support. We subsequently obtained approval for a contribution to our own practice overheads that continued to run in our absence with (I believe) support from the Chief Medical Officer (CMO).

Section 2: Dedicated Dental Clinic

42. In relation to my involvement with initiating the dedicated dental clinic, how it functioned and how it was funded; The Croser and McLaren (my partner, Dr Andrew McLaren) General Dental Practice was self-funded with a bank loan as a business venture, providing mixed private and NHS treatment.

43. Regarding the specialist HIV/AIDS clinic; dentists worked in their own practices but were salaried by FHSA for this additional work using a separate contract number. In return, the clinic took all the patient charges and NHS fees and paid for nursing, overheads and supplies. Patients paid the relevant NHS fee if eligible, though in most cases this did not apply because most patients were on sickness benefits and or unemployed.

44. The clinic operated four days a week from its inception late in 1986 and its purpose was to provide NHS dental treatment for those living with HIV, their partners and their families. We didn't refuse others who walked in with an emergency problem, if we could help. (you can't believe how many people lose or break their dentures whilst in hospital – and for part of our existence we were housed in the Chelsea and Westminster Hospital).

45. The dedicated clinic had four locations during its almost 18 year 'lifespan'; In a portacabin in the garden at St Mary Abbots hospital in Kensington, in the basement of a house in Alderney Street in Pimlico, that was used by the community dental service, two rooms within the Chelsea & Westminster Hospital and three rooms within the Violet Melchett Community Clinic in Flood Street, Chelsea, SW3.

46. These clinic locations ran consecutively, not simultaneously i.e. one clinic in one location at a time, ensuring that the patients had continuity of care. To assist the rota of dentists there were two dental therapists

as a job-share, and two dental nurses who were notable for their caring and totally non-judgemental attitude.

47. The main function of the clinic was the provision of dental treatment, a second function was the research undertaken in conjunction with Guys and Kings and the third function was the provision of education for dentists, so that we could share knowledge of how to safely treat patients with a blood-borne disease and not fear doing so.

48. Any fear generally came from the lack of confidence in infection control procedures. If a dentist is infected with a blood-borne disease that was not only effectively the end their career but invariably would have left them with an unserviceable debt associated with establishing their own practice.

49. After a period of almost ~~the~~ ten years following HIV being named, effective medications were developed to control the disease (HAART).

50. In relation to my knowledge of discrimination generally against dental patients and my own experiences as a dental practitioner: I have never witnessed any discrimination. Anecdotally I understand patients have said otherwise. I recognise we all have preferences but as a monopoly supplier, the dental profession is regulated by the GDC to ensure that the public are protected in this respect.

51. In relation to the use of any anti-clotting blood products by the dental profession; Such blood products were simply not used by dentists. The Dental pages of the British National Formulary (BNF), sets out drugs that can be prescribed by dentists. Factor VIII and other similar products are/were not included. If for instance a haemophiliac patient (with or without HIV) had required Factor VIII prior to a dental procedure, it would have been necessary to liaise with that patient's GP or specialist so that a prophylactic coagulant could be administered. I have never had experienced this personally.

52. The projected duration of the clinic in the original business plan was 12 years I believe, allowing time to for continuing professional education via the Deaneries and upgraded standards of infection control to give dental profession the confidence to accept HIV patients. By 1996, it would probably have been possible for any patient with HIV taking HAART, to be seen safely in general dental practices – but the science proving the efficacy of antiretroviral therapy did not materialise until 2006. The need for a dedicated service was no longer necessary. I was invited to stay on in the Community Dental Service but by then had sold my own practice and was looking at other professional interest, including dento-legal work.

Section 3: The Treatment of Patients with HIV or HCV at the Clinic

53. All NHS dental treatments were provided at the clinic. At the start of the pandemic, patients with HIV/AIDS, typically had difficulties accessing dental treatment and would possibly have had to ask several times to find a willing dentist. I was aware that some self-help groups advised patients to say nothing about their diagnosis.

54. I believe that in addition to our own clinic there were four other dedicated HIV dental clinics in London (between 1986 and 2008), Myatt's Field Community Clinic, UCL Tottenham Court Road, Maurice Wohl Centre Kings College. After 2000, GDP practices were increasingly confident to provide treatment. STD departments and HIV/AIDS self-help groups helped provide the information about where NHS dental treatment could be obtained.

55. One has to remember that when AIDS/HIV was first recognised, the internet was embryonic nothing like it is now, it was only just really starting in the mid 1990s and so access to and methods of distribution and the publication of advice was much more limited.

56. I have been asked about any stigma suffered by patients. I am not personally aware of any specific patient feeling stigmatised, I didn't ask about stigma and they didn't mention it to me. I do know that in general terms it was documented elsewhere such as within articles in gay press.

57. The Terrence Higgins Trust (THT) was I believe particularly active in campaigning against stigma. However, I think that the Inquiry is seeking information on stigma suffered by HIV/AIDS patients who were infected through being given contaminated blood or blood products and I am afraid that I cannot assist with this specific area as I had almost no patients who fitted this category. The dedicated dental service didn't differentiate between patients according to the route by which they had been exposed to the disease. All patients were welcome and treated in the same way.

58. I have been asked about any meetings that I may have attended that were relevant to HIV or HCV. I attended the following Biennial International AIDS Society meetings; 1989 in Montreal, 1991 in Florence,1993 in Berlin, 1996 in Vancouver and 2000 in Durban. Sponsorship was funded by the health authority as well as from private resources.

59. Additionally, I attended and spoke at the World Workshops on Oral Health and Disease in AIDS every 5 years; 1993 in San Francisco, 1996 in London, 2000 in Skukuza, South Africa, 2004 in Phuket, 2009 in Beijing, 2014 in Hyderabad and 2019 in Bali. Funding was supported by my employers as well as from private resources.

60. In terms of decision-making regarding the treatment of patients with HIV and HCV; Apart from the dental press and the British Dental Association, I would say that the All Party Parliamentary Committee on HIV, the Chief Medical Officer and Chief Dental Officer were the biggest influencers on UK health service attitudes towards the dental

treatment available to HIV patients. Beyond that I cannot really comment.

61. I received most of my early guidance by observing a group of dental colleagues in New York who by 1986 were treating HIV patients and subsequently in the UK by writing a book on infection control and from microbiology lectures, Department of Health videos, British Dental Association lectures and professional journals.

62. Standard infection control procedures were applied for every patient whether they were diagnosed with an infection or not. These procedures would include wearing gloves, when previously this may not have always been the case.

63. I remember that in any case, when the routine use of gloves was first recommended and before the current infection control protocols had evolved, they were invariably not of the 'one use' disposable type and that dentists would wear the same pair for several treatments, only washing the gloved hands in between patients. These multiple-use gloves were designed to be washed and were of a better quality than the batch tested single use gloves that often had holes in them and so did not provide a proper barrier.

64. It is actually quite difficult to transmit HIV in the dental setting other than by a puncture wound. A mask and gloves were recommended for the personal protection of the dental team (hygienist, dentist and dental nurse). I am aware that some dentists would wear two pairs of gloves and others might only treat HIV patients at the end of the day so they could do "extra" cleaning after the patient - forgetting that the same decontamination protocol had to be used after every patient, since many patients had yet to be diagnosed and so would not be identified as being infected. Because these two practices were not applied to all patients they could be considered discriminatory and the dental registrant involved, risked prosecution by the Regulator. I

should add that the routine of double gloving for every patient would not be discriminatory – simply rather restricting.

65. Another change in the standard of infection control related to the use of the drill – after HIV was discovered, dentists were obliged to purchase additional handpieces that could be sterilised between patients rather than being flushed through and wiped with alcohol between appointments whilst the diamond drill tips were sterilised between patients.

66. Handpieces were routinely sterilised for surgical procedures but not for simpler less invasive fillings and polishing routine. This upgraded infection control procedure was more costly but eminently nicer. Was it safer? No transmission of HIV from a dental handpiece has ever been demonstrated- it remains a theoretical risk however.

67. I remember on one occasion early on, the senior dental officer for the local health authority visited the portacabin we were working in. He wouldn't come inside, remaining outside the door (speaking from under an umbrella when it was raining). An indication of the prevailing fear of HIV/AIDS, even at senior leadership level.

68. I have been asked about HIV testing: Up to now, Oral swabs or pin prick tests have not been offered in a dental setting, however I understand that the prospect is currently being explored both here in the UK and elsewhere.

69. In my experience to date, the presence of oral lesions, allows anyone (doctors and dentists) to make a provisional diagnosis that could prompt them to ask patient about their HIV status and if they could be at risk – and possibly signposting them to their own doctor or an HIV clinic if a risk is identified. Patients have to consent to testing provided by either the dentist or the doctor .

Section 4: The Treatment of Patients with Factor VIII and other Blood Products

70. I treated one patient with Von Willebrand's disease privately and two haemophiliac patients on the NHS without incident, but then no invasive surgery was undertaken at the time.

71. I have never attended any meetings related or relevant to treating patients with blood products and I have no knowledge of any factors that may have influenced decision-making regarding the treatment of patients with blood products. Most routine dental treatment does not cause bleeding – surgical procedures would be done in consultation with the patient and if necessary their treating physician do establish the patient's clotting time.

72. This is similar to the decision-making needed with patients on anticoagulant therapy (eg. atrial fibrillation) when there is a need to balance the risk of excessive bleeding against risk of stopping anticoagulation, before doing invasive surgery.

73. I am not personally aware of any particular patient having difficulty obtaining dental treatment but I am aware from studies published in the British Dental Journal (BDJ) that some patients reported difficulty in obtaining NHS dental treatment – but, as I mentioned, this was not exclusively a problem for people living with HIV, in some parts of the country members of the general public have had difficulty in obtaining NHS dental treatment.

74. With regard to treating patients with blood products, the only guidance I am aware of receiving was through my undergraduate degree course and subsequently from postgraduate lectures and my own reading of journals and books.

75. There are tens of thousands of dentists registered in the UK and approximately 7,000 haemophiliacs. About 50% of the population do not attend a dentist in any given year. So, in the unlikely event that a haemophiliac came to me, I would start by taking their medical history including if they knew their prothrombin time i.e. how long it takes their blood to clot. If necessary I would then liaise with their physician if surgery had to be undertaken, referring them to a specialist centre if necessary.

Section 5: Further Information

76. When reviewing this statement please be aware of my difficulty in reflecting a situation that started to evolve almost 40 years ago when fear of the disease was created by:

1) its potential to kill
2) the absence of any cure
3) delay in identifying the causal agent and developing an effective test.

The ability of healthcare providers to respond to HIV/AIDS and HCV improved as these three hurdles were subsequently removed or diminished.

Statement of Truth

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

Signed GRO-C

Dated 18.3.20