08/11/19

Witness Name: Robert Adamson
Statement No.: WITN0992001
Exhibits: **NIL**
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF ROBERT ADAMSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 30 May 2019.

I, Robert Adamson, will say as follows: -

Section 1. Introduction

1. My name is Robert Adamson. My date of birth is GRO-C 1937 and my address is known to the Inquiry. I intend to speak about my position as Principal Pharmacist at Walsgrave Hospital, Coventry in the 1970's and the supply of Factor 8 concentrate during my tenure as Principal Pharmacist.

2. I have not been involved in, nor have I given evidence to, any other public inquiries, investigations, criminal or civil litigation in relation to HIV and/or Hepatitis C virus (HCV) infections in blood and blood products.

3. I qualified as a Pharmacist in 1958. At the time, the Pharmaceutical Society of Great Britain was both the examining and awarding body for the profession. My qualification was that of Pharmaceutical Chemist and Member of the Pharmaceutical Society (Ph.C., MPS). I attended the school of Pharmacy at what is now the University of Bradford. After I obtained my qualification, I completed two years of national service in the Army before I began working as a Pharmacist. In 1973, I completed a Master of Pharmaceutical Science at the

University of Aston, Birmingham and in late 1973 / early 1974 I commenced my role as Principal Pharmacist at Walsgrave Hospital.

4. Walsgrave Hospital comprised a District General Hospital, which had 600 plus beds, a Maternity Hospital with 200 plus beds, a 200 plus bed Psychiatric Hospital and a Geriatric Hospital. In my role as Principal Pharmacist, I was the head of the pharmaceutical department and was responsible for the management and the supply of pharmaceutical products to Walsgrave Hospital. I was also responsible for the pharmaceutical department's budget.

5. There was very little direct input from the Department of Health and Social Security (DHSS) as to what pharmaceutical products were supplied. We did buy products and materials against what were called regional contracts. We complied with regional contracts but, as responsible professionals, reserved the right to buy elsewhere if necessary, and if we could make a good case for doing so. I was never called upon to justify making purchases outside of these contracts, and would have resented any such interference in the management of my own department. Furthermore, these contracts only applied to a small portion of the product range, and with the rest of the product range we were left to our own devices, and we could buy whatever we wanted.

6. In addition to managing the pharmaceutical department of Walsgrave Hospital, I had responsibility for the pharmaceutical departments of two offsite hospitals, these being Gulson Road Hospital and High View Geriatric Hospital.

7. When I commenced my role as Principal Pharmacist, Factor 8 blood products were supplied by the Hospital Pharmacy for the treatment of haemophilia and bleeding disorders. At the time, cryoprecipitate was the standard treatment for bleeding disorders as commercial quantities of Factor 8 were not yet available in the UK. As far as I am aware, the only commercial Factor 8 concentrate that was available at the time was imported and I understand it was mainly supplied by the American pharmaceutical company, Baxter/Travenol.

8. I was not involved in the supply of cryoprecipitate as it was not considered a pharmaceutical product and therefore did not fall under my department. The supply of cryoprecipitate, whole blood and all other blood products, which were obtained from the National Blood Transfusion Service (NBTS) remained a responsibility of Haematology Departments. It was only the availability of Factor

8 concentrate as a 'longer-life' blood derivative that supported the argument that it might be considered as a pharmaceutical product.

9. As I mentioned previously, cryoprecipitate was supplied through the NBTS which relied upon voluntary donors. When patients suffered a bleed they would attend the hospital to receive the cryoprecipitate treatment which was provided by the hospital's haematology department.

10. Though cryoprecipitate treatment was effective, it wasn't always pleasant for the patient. The treatment carried a risk that the patient would have an anaphylactic reaction. This risk required the patient to be monitored by the hospital when the treatment was administered.

11. Cryoprecipitate was considered impractical by many as the treatment required a day away from school or work to attend hospital for treatment. For this reason, there was pressure at the time for the adoption of prophylactic Factor 8 use to eliminate the need for hospital attendance. This pressure was, to a large extent, exerted by the Haemophilia Society, not the DHSS. The Haemophilia Society emphasised that the inconvenience of emergency cryoprecipitate administration could be obviated by daily injections of Factor 8 concentrate.

12. I believe the Haemophilia Society's press campaign made a number of misleading claims about the benefits of Factor 8 use. The Society implied that the costs of the Factor 8 injections would be insignificant as patients would only need a few units each day, at a cost of only a few pence per unit. However, in reality the treatment cost around 10-12 pence per unit and, dependent upon final product analysis, single doses had 200-250 units of activity with a daily cost per patient of between £20-30.

13. As Factor 8 was considered a pharmaceutical product, the decision regarding the supply to the Walsgrave Hospital fell to my department.

14. I had not been in my post for long when one day I was visited by Dr Bruce Shinton, the Consultant Haematologist for the area. Dr Shinton had come from a meeting with the Regional Health Authority where a proposal was made to treat haemophiliac students at the Hereward College with Factor 8 concentrate. He said that in the very near future a number of Haemophiliacs would be

admitted to the College and would require routine treatment with Factor 8 concentrate.

15. The Hereward College was established as a joint venture between the local education committee and the Area Health Authority, whereby the Area Health Authority had responsibility for matters such as the College's drug costs. The College was designed to provide students with disabilities, as well as haemophiliacs, with secondary education and vocational training. The school was designed for students to be self-sufficient, and I was very impressed with the facilities such as hoists in the bathroom which students could operate independently.

16. I was seriously concerned by the proposed use of Factor 8 concentrate on haemophiliacs attending the Hereward College. While I had no reservations regarding its use to control bleeding, I recognised that, although prophylactic use would be expensive initially, costs would escalate much further once inevitable antibodies (or inhibitors) developed. As these appeared, more and more concentrate would be required to provide the required clinical response.

17. Dr Shinton told me that if I considered the cost of supplying the Factor 8 to be prohibitive, then he would accept my decision, but he advised caution. He said that the DHSS had failed to reach any conclusion over cost and supply of Factor 8 use, leaving the Regional Health Authorities to make the decision on their own. In turn, the Regional Health Authorities delegated responsibility to local Area Health Authorities who agreed that local policies should be determined by individual Consultants.

18. With Factor 8 becoming a political 'hot potato', and so many within the DHSS dodging the issue, Dr Shinton told me that he was not going to 'stick his neck out' and was not prepared to become a scapegoat. Dr Shinton recommended that we supply the Factor 8 to Hereward and that my response be similar. He suggested I accept the cost as an inevitable charge against my drugs budget without asking too many questions.

19. The proposal to supply Factor 8 to Hereward was not discussed with anyone else in the hospital. The only discussions that took place were between Dr Shinton and myself. After this, we commenced the supply of Factor 8 to Hereward College.

20. Around 1978, I left Walsgrave and started a new role as an Area Pharmaceutical Officer for Redbridge and Waltham Forest Hospitals in London's North East Thames region. In the role, I oversaw the management of seven pharmaceutical departments and seventeen Hospitals.

21. My role as Area Pharmaceutical Officer was entirely managerial in nature and I no longer had immediate responsibility for the supply of pharmaceutical products and therefore had no exposure to discussions regarding the supply of Factor 8. The decisions in relation to the supply of pharmaceutical products, including Factor 8, were left to the heads of pharmaceutical departments and the Area Consultants, who had free range over what was supplied.

Section 2. Knowledge of Risks

22. As far as I am aware, when Factor 8 concentrate was introduced at Hereward College it was understood and accepted that Baxter/Travenol relied upon paid donors, rather than volunteers, for their blood products. At this point in time, there was no suggestion of any risk of infection associated with Factor 8 concentrate or blood products. Hepatitis C and HIV had not yet been identified.

23. During my time at Walsgrave, Hepatitis B had been identified as a transmissible virus for some time. However, it was thought at the time that it was the patient themselves, rather than blood or blood products, which carried the risk of Hepatitis B infection.

24. Toward the end of my time at Walsgrave, a number of measures were taken to reduce the risk of patients infecting others with Hepatitis B. Nursing practices were tightened up in response to the Hepatitis B risk in order to protect the nursing staff. There was no knowledge of the risk of other infections, such as Hepatitis C or HIV, being transmitted through blood products.

25. You can't have a contaminated product unless you identify a contaminant, and the contaminants (being the HIV and Hepatitis C viruses) were not identified until the mid 1980's. My view is that anything supplied in the 1970's cannot meet the definition of a contaminated product. It was therefore not possible to advise patients about the risk of infection associated with the products.

26. I am confident that if there were known risks associated with blood products, these would have been communicated. In practice, if the DHSS became aware of the risks associated with a particular product, the information would be disseminated between regions and areas, and instructions would be given to hospitals to sequester stocks.

27. As far as I am aware, the DHSS had a network at the time (referred to informally as 'the grape-vine'), where if a problem was identified with a particular product or batch of a product, there would be a network of telephone calls between regions and areas, and I imagine that in the space of a couple of hours, that information would be known to the DHSS, and every hospital in the United Kingdom would become aware of the problem.

28. As I mentioned previously, there would then be an instruction to sequester stocks of the product until they knew what the problem was, and consultations would take place between regional and area authorities, who would then decide what to do about it. However, during my time at the Walsgrave Hospital no risks of infection became apparent with Factor 8 or cryoprecipitate. There was just nothing to say about them.

29. During my time at Walsgrave, the consideration of the risk of transmission of infections associated with blood and blood products did not affect any of the decisions in relation to the supply of Factor 8 over cryoprecipitate, as the risks were not known at the time.

30. By the mid-1980s when the risks of HIV and Hepatitis C infection associated with blood products became well known, I was no longer working at Walsgrave, and no longer had a role in the supply of blood products.

Section 3: Policy and decision-making

31. As a Pharmacist working within the NHS, as Principal Pharmacist and later on as Area Pharmaceutical Officer, I was never aware of any DHSS policy relating to the supply of Factor 8 and cryoprecipitate or the treatment of haemophilia/blood disorders.

32. As far as I am aware, the policy of supplying factor 8 was not a clinical policy, and it was not promoted by the DHSS. As I mentioned previously, the use of Factor 8 was heavily promoted by the Haemophilia Society. I do think it is strange that the Haemophilia Society started promoting the use of Factor 8 when Baxter made it available in the UK.

33. My experience was that the DHSS took a laissez-faire attitude towards the supply of pharmaceutical products, leaving day to day decisions on operational matters to those on the ground. As the DHSS could not agree on a policy in relation to the supply of Factor 8, and there was in fact a refusal to make a decision on its use by the relevant hierarchies within the DHSS, the responsibility was pushed down the chain first to Regional Health Authorities and then to area authorities who also failed to formulate a policy. Ultimately, responsibility was left to individual area consultants to formulate policies for their hospitals and regions. It was entirely the discretion of individual area consultants.

34. Although the work of consultants was usually restricted to area health authorities, one of the anomalies at the time was that all were appointed by regional health authorities.

35. I do think, however, that it is easy to overestimate the impact that prescribing policies had on individual clinicians, most of whom ultimately insisted upon the right to prescribe whatever they considered to be in their patient's best interests.

36. In the case of Walsgrave, Dr Shinton, the senior Haematology Consultant for the area, had the responsibility to decide on the use of Factor 8 that would apply to his area and staff.

37. I don't think there was any specific reason for the failure of the DHSS, regional and local authorities to make a decision regarding the use of Factor 8. I believe it was just ineptitude. Given the high cost associated with the product, I think that the supply of Factor 8 became a political 'hot potato' meaning individuals at the various levels of authority were reluctant to make any policy decisions.

Section 4: Other Issues

38. I believe that at the time I worked at Walsgrave in the 1970's, Factor 8 products were supplied in good faith, and nothing was known about the risk of infection that they posed. I believe that the NHS should not be expected to assume responsibility for clinical conditions that did not exist at the time and that the criticism of the NHS is therefore unjust.

39. From my own experience, I know that Factor 8 was supplied to an increasing number of patients from the 1970's onward, long before AIDS emerged as a major health problem. Nearly a decade passed between the introduction of commercially available Factor 8 and the identification of transmissible HIV and Hepatitis C viruses. The NHS and the Haemophilia Society therefore cannot be held responsible for the effects of blood products supplied during this period.

40. I do, however, think that if the Haemophilia Society had not called for early introduction of Factor 8 concentrates, especially for prophylactic administration, widespread use of the product in the UK might have been delayed, and fewer patients would have been exposed to HIV infection.

Statement of Truth

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

Signed GRO-C

Dated 08/11/19