Witness Name: Helen Susan Burton

Statement No: WITN1128003

Exhibits: WITN1128004

Dated: June 2021

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF

HELEN SUSAN BURTON

I, Helen Susan Burton will say as follows:-

My name is Helen Susan Burton. My address and date of birth is known to the Inquiry. I make this statement in response to a second Request under Rule 9 dated 26 May 2021 concerning my time working at Lord Mayor Treloar college/school for boys ("Treloar's").

Q1 In relation to your comments at Paragraph 3, did you have any knowledge, prior to your application for employment, of either the Lord Mayor Treloar College / School or of its Headmaster at the time, Mr Alec' Macpherson? If so, please detail.

1. I had no knowledge of either the Lord Mayor Treloar College / School or of its Headmaster at the time, Mr Alec Macpherson prior to my employment

Q2 Regarding paragraphs 4 & 39, did you personally 'follow' either the Archer or Penrose Inquiries, and if so, for what purpose, e.g. were you directed to do so on behalf of the school / college? If not, how are you able to state (P.39) that *"...this was about the time of the Archer and Penrose Inquiry?"*

2. I did not follow either the Archer or Penrose Inquires but I was aware of them through personal interest and as a result of a comment made by Dr Aronstam as mentioned in paragraph 39 of my first statement.

Q 3 Concerning the various new policies and procedures brought in by Mr Macpherson, where there were none before, as mentioned within your paragraph 5, was or were there any particular events which caused these initiatives to become necessary?

3. As far as I am aware no particular events caused new policies and procedures to be introduced. New policies were introduced but I was not part of the group who determined why they were introduced. My recollection is that many of the existing practices were just formalised and put into writing.

Q 4 Additionally, as the "complex establishment" that was 'Treloar' evolved during the period of your tenure, how, if at all, did policies, procedures and training alter, e.g. what new training elements for staff were brought in, if any, as regards dealing with male pupils with haemophilia, with HIV, and / or with HcV and in particular what, if any training and support became necessary to assist non-medical personnel (care staff, educational staff, others)?

4. As previously mentioned in my first statement, Child Protection, Care Staff Training with appointed Trainer, etc. I can now only really remember new training elements regarding the spillage of blood as referred to in my first statement. I do recollect there was a full staff meeting where HIV and safety issues were discussed; it could have been during the annual Staff Conference held each year before the September term or it may have been an Extraordinary staff meeting.

Q 5 In relation to your paragraph 6, what was the make-up of the Treloar Trust board of governors / trustees in relation to the particular requirements of the pupils of the college / school, e.g. did any have specific medical knowledge regarding the ailments / disabilities which pupils had and any special requirements which may have been necessary in their regard?

5. There was the usual complement of Stockbrokers, Architects, Solicitors, Headteachers and Media. Yes, there usually was a medical person; Dr Judith Darmady, Consultant Paediatrician (I believe) at Basingstoke District hospital was a Governor (recently deceased). Latterly other medical personnel may have been GPs but I think more senior, mainly women but I cannot recall names.

Q 6 In response to your comment at paragraph 6i, what was the nature of the "NHS involvement (finance)" on the Froyle (Lower School) site - and was this replicated in any manner or form at the Upper School (Holybourne)?

6. I can't answer specifically but Dr Rainsford and Dr McHardy were NHS personnel and they worked on the Froyle site prior to amalgamation in 1978. Once the Haemophilia Centre was built at Holybourne, treatment was held at Holybourne so there was no NHS involvement at the School (Froyle) site.

Q 7 Concerning the content of paragraph 6ii, for clarity, where were Messrs. Rainsford, McHardy, Dick Summers & Summers, Sneddon and Weaver engaged to work? In the hospital, in the college / school, or across both sites?

7. Dr's Rainsford and McHardy were NHS staff who worked at Froyle; Dick and Weaver only worked at the School. Mr David Summers, Mrs Summers and Duncan Sneddon moved to the College at Holybourne to work and were formerly in the medical centre. Duncan Sneddon was based in the boarding houses.

Q 8 Additionally, by whom were the above individuals employed (NHS / College / School / Trust)?

8. Technically all staff working at school and college were employed by The Treloar Trust and then appointed to either school or college. That is apart from the Haemophilia Doctors who were employed by the NHS. Our Medical Officer for Health (local GP) who saw all other students was employed by The Trust and worked at both the school and college.

Q 9 Also as regards paragraph 6ii, what role did Sister Turk undertake at college / school having left the hospital for the same?

9. Sister Trish Turk was the Haemophilia Sister; she may have had responsibilities to the other children, but I think not. This was at the Medical Centre at Holybourne Haemophilia Centre. I recollect a conversation with Sister Turk when she wondered how the blood/blood products could possibly be clean if the blood was obtained from prostitutes and drug addicts.

Q10 In relation to your statement paragraph 6iii, why was the NHS Haemophilia Centre located within the college / Upper School grounds in Holybourne and not within either the nearby Lord Mayor Treloar Hospital or Basingstoke General Hospital?

10. I have no idea! Presumably because there was such a large cohort of boys with haemophilia at the College; maybe the Treloar Hospital had other future plan. Having the boys treated on site saved them having to be transported away from college for treatment. The Haemophilia Centre saw out-patients as well as Treloar students. Perhaps the Headmaster at that time Alec Macpherson, or someone from The Trust can clarify.

Q 11 Concerning the content of your statement at paragraph 6.iv, can you please expand upon your comments as to the manner in which personnel of the Haemophilia Centre were appointed and paid, i.e.

a) By whom were the centre staff recruited, the college or the trust or the NHS?

11. (a) I don't know; I think it was a result of discussions between the Headmaster and NHS staff.

b) By whom were the centre staff appointed, the college or the trust or the NHS?

11 (b) The Trust (college). See 8. Above.

c) By whom were the centre staff paid, the college or the trust or the NHS?

11 c) The Trust (college).

Q12 Additionally, what was the "reimbursement" arrangement between the school / college / trust and the NHS?

12. The Haemophilia Doctors were the only ones employed by the NHS, although as previously said, I believe the NHS gave some monies towards the employment of the Haemophilia nurses. You would have to ask The Trust for further details.

Q13 By "NHS," in paragraph section (6.iv), of whom were you speaking, e.g. the Lord Mayor Treloar Hospital / Basingstoke General / Local Health Authority / Regional Health Authority / other?

13. I presume the Local or Regional Health Authority. I have no knowledge of any 'domestic' financial arrangements.

Q14 In relation to paragraph 10, what is the title of the film to which you refer as being a "... short Vimeo film?"

14. I cannot now remember but a Trust film about that time was called A Dream Come True produced by Margaret and James Hall (who did most of our films) is a similar one:

https://vimeo.com/412440603?fbclid=IwAR3Lt_2XDuD7ZKIXBwhNhgICF1mIL5O1FISQm_vPhIOwOe67xX4IwPOHW-8

Q15 As regards paragraph 14, and concerning the clergyman's son - did he pass away whilst a college pupil or once he had left? Additionally:-

15. The Pupil passed away after leaving college

a. **Do you recall this boy's name? If so, what is it?**

15(a) His name was GRO-A and I believe he lived in GRO-A.

b. **Do you recall the names of any other boys with haemophilia who passed away whilst pupils of the school / college as a result of their having become infected using contaminated blood / blood products?**

15(b) I don't think there were any; maybe GRO-A but I think he had already left as he was quite poorly.

c. **If so, who were they?**

15(c) A member of staff who was an ex-student died when I believe he was still employed by us; his wife has given her testament. He was GRO-A GRO-A

Q16 Continuing as regards paragraph 14, do you recall the names of any other boys with haemophilia whom, having left the school / college, passed away as a result of their having become infected using contaminated blood / blood products?

16. Yes, I certainly remember lots of boys who died as a result of being given infected blood. I prepared a list in or about April 2004 which is appended together with a list prepared in about 2017 at the request of Ade Goodyear as **WITN1128004**. Those highlighted in Bold on the Goodyear List are ones who

have died that I can remember personally and put a face to each name except where stated. Those not in bold are either students before my time or I cannot be exactly sure if they have passed.

Q17 In relation to paragraph 15, what, if any, training or other assistance was available to non-medical college / school staff to prepare them for addressing issues which may have arisen as a result of the death of a pupil, be that dealing with the death of someone themselves, or being able to support other staff or pupils in the event of a pupils death?

17. There was always a memorial service held in our hall, led by our Chaplain after a death of a student. Usually the Housemaster (Care Manager) would inform the students in a more private setting in their 'House' rather than having an Assembly which was the norm in the early days. Staff supported each other and students as was their job. We had a large counselling team and students could always make an appointment to see them. Students were of great support to each other too. I cannot help any further.

Q18 In relation to the "badge system," please describe the nature of the 'badge,' how it was worn and by whom it had been introduced.

18. It was a little round tin badge (like an old milk monitor badge!) in either green or red, worn on the lapel of the blazer or on the jumper. I think it was introduced after discussions between staff and Haemophilia staff but I do not know the specifics of its introduction.

Q19 Was this form of individual labelling accepted by the pupils it impacted upon or others (including staff) or was any opposition to its use raised?

19. I believe the badge system was accepted by the pupils and was thought to be useful by both staff and students. I do not remember any issues of dissent.

Q20 Was a "badge system" used for the identification of any other pupils, such as children with different ailments or disabilities to haemophilia, or was it in use as regards boys with haemophilia only?

20. There was no badge system for any other students; Other students' disabilities were obvious whereas haemophiliacs' ability changed according to whether they had a bleed or not. It was primarily for their safety and also to allow them to participate in activities when they were able.

Q21 In relation to your paragraph 16, for whom did Dr Mounir Wassef work - the college / school / haemophilia centre or another?

21. Dr Wassef worked at the college Haemophilia Centre and I believe Basingstoke Hospital.

Q22 Additionally, for whom did the Basingstoke General Hospital doctors Aronstam and Roy (as they are described in this paragraph) work and when referring to the "College Medical Centre" in this paragraph do you mean the NHS Haemophilia Centre or the separate school medical centres often referred to by others as 'the sick bay?'

22. Yes, I meant the NHS Haemophilia Centre – we usually just referred to it as the Haemo centre or the Medical Centre. It was based at the college hence we also said college medical centre.

Q23 What were the roles of Dr. Aronstam and Dr Roy?

23. Both were the Haemophilia Doctors.

Q24 Concerning Dr Aronstam, are you aware of his having been or become the Director of the Haemophilia Centre located at Holybourne? If so, when did this occur and did the college / school / trust have any involvement in his appointment (please also see paragraph 6.iv).

24. I knew Dr Aronstam was the 'top man' at the Haemophilia Centre and at Basingstoke hospital, I am not sure that at the time I was aware of him being the Director but later I did. I was aware he attended various conferences; I think I remember him going to one in South/Latin America. I cannot remember if he was in situ at the beginning in 1978. I do not think we (Treloar's) had anything to do with his appointment, in fact I am sure not. He worked for the NHS.

Q25 As regards paragraph 17, for clarity, by 'medical centres' are you referring to the college / school medical centres (sick bay), or the Haemophilia Centre as the place in which boys were taught self-administration?

25. Prior to 1978 it was the Froyle (school) Sick Bay, latterly called Medical Centre. After amalgamation in 1978 when we had the Haemophilia Centre on site adjacent to the College Medical Centre (Holybourne) it was the Haemophilia Centre.

Q 26 Also, if within the school / college medical centres, who delivered the boys' training, medical employees of the school / college / trust or staff of the haemophilia centre?

26. Prior to 1978 at the School it would be Treloar medical staff – unless it was a Haemophilia Doctor. After 1978 it would again be Treloar medical staff at the College Haemophilia Centre, unless it was the Haemophilia Doctors.

Q27 As regards paragraphs 21 and 23d, and concerning school / college personnel acting in loco parentis, what, if any, records of a parent / guardian having given permission for staff to act on their behalf were created or kept?

27. There were forms signed by parents kept in the main office file and in the medical files in the Medical Centres.

Q28 When were they created, by whom, where were they stored and who had access to them?

28. I do not know who had access. They were in situ before I arrived in 1976. Any member of staff could peruse a student's office file. They were not allowed to take it away from the office; latterly they were but it had to be signed for. I am unsure what policies were in place for medical files.

Q29 Can you recall the extent or parameters associated with any in loco parentis consent so provided, if so, please describe?

29. Certainly, there was a form for medical emergencies; you would need to check with Treloar's as I am sure they probably still use the a form, or similar one. One of the forms said that they would not hold the college (Trust) responsible for damage however caused (I think this was more to do with activities etc.) This was in the pre-admission papers: The Medical Secretaries were very keen to ensure that the parents had signed the 'medical emergency form' prior to admission to ensure students' safety.

Q30 Did any consent provided by written authority for college / school staff to act in loco parentis extend to NHS personnel employed at the haemophilia centre?

30. I expect so but I do not know.

Q31 Concerning paragraph 26 and the mother who was apparently considered to have been 'over protective' of her sons, by whom was she so considered?

31. It was just a feeling by staff – mainly Treloar's not Haemophilia staff.

Q32 Can you please name the two boys mentioned, and if known the name of the pupil from the Channel Islands who only ever received British blood.

32 GRO-A and GRO-A . GRO-A was from the Channel Islands.

Q33 In relation to paragraphs 27 and 34 of your statement, please name the two brothers you refer to (now deceased), together with the name of the pupil from Birmingham whose family were subject to abuse.

33. The brothers referred to are GRO-A (who visited me) and his brother GRO-A I think their mother or father was GRO-C so I think GRO-A was also known as GRO-A and GRO-A maybe GRO-A but can't be sure of the latter. They lived in GRO-A. The family from Birmingham were the GRO-A family. GRO-A was at Treloar's (now deceased) and I am sure GRO-A was too but maybe he was suspended but I cannot be sure on this.

Q34 As regards your paragraph 38a, please name the pupil to whom you refer as being an 'ex-pupil from Birmingham,' now deceased.

34 GRO-A

Q35 In relation to your paragraph 39, on what basis was Dr Peter Jones known at the college as "... an expert in haemophilia ..." and what, if any, was his relationship with the college / school / trust?

35. I cannot say why Dr Jones was considered "an expert in Haemophilia" other than that was the view at Treloar's. We often referred parents to Dr Jones' book on 'Living with Haemophilia' which we thought was a useful aid. I am sure he visited the College and the Headmaster had discussions with him. I think it was just about haemophiliac students' education; I believe it was an unwritten rule that he would refer severe haemophiliacs to Treloar's otherwise he tended to refer to Percy Hedley School in Newcastle.

Q36 On what basis was the "...Oxford Haemophilia Centre, run by Dr Rizza..." considered to have been a "...centre of excellence..." within the college / school / trust and what, if any, was its or his relationship with the college / school / trust?

36. I know of no relationship between the College and the Oxford Haemophilia Centre/Dr Rizza. Again, I cannot say why the "Oxford Haemophilia Centre was considered to be a "Centre of Excellence" other than It was the belief/view at the time.

37. I have been requested to clarify certain parts of my initial witness statement, signed by me on 21 May 202 which I will now do even though I consider my statement is clear and "readily understandable".

38. In Paragraph 10 I had been asked to provide details of any medical staff engaged within the school, their positions, responsibilities and how they engaged with the pupils and /or myself and other staff regarding pupils' health, and where possible, to describe any hierarchy which I may have been aware of as regards medical staff.

39. As regards the content of my paragraph 13, I had been asked what medical information in relation to each pupil was held, and where.

40. Paragraph 26 refers to a question I was asked regarding pupils with bleeding disorders who had become infected with hepatitis or HIV and any knowledge I may have had as regards the circumstances in which their parents or guardians were advised of their infections, including by whom they were told, by whom and how.

41. As regards paragraph 27, I had been asked if I was aware of any other infections which pupils of the school with bleeding disorders contracted (other than Hepatitis or HIV).

42. Paragraph 31 referred to a question put to me asking what action, if any, was undertaken to manage any risk posed by those who were known to have been infected or who may have been infected, of their infecting others.

43. Paragraph 32 referred to action taken once a diagnosis of HIV or hepatitis had been made in order to accommodate pupils with either of these conditions which I had already answered (within paragraph 24).

44. In relation to paragraph 33, I had also answered this point in paragraph 24. It concerned the actions taken and any policies which were subsequently put in place by the school following pupils having been diagnosed as having hepatitis or HIV.

45. As regards paragraph 35, here I had been asked of any knowledge I may have had of any specific processes in place for consent being obtained as regards the blood testing or treatment of pupils with bleeding disorders, of which I had no knowledge of.

46. I had additionally been asked if I had any knowledge of pupils of the school having been subject to blood tests or treatment without their consent or that of their guardians.

47. Paragraph 36a referred to the school, including its staff, having played any role in clinical research. 36b concerned any steps taken to obtain a pupil's consent, or that of a parent or guardian for participation in research.

48. In relation to paragraph 38, this concerned questions as to my knowledge, if any, of media coverage in which pupils having become infected through use of contaminated blood and / or blood products featured. Subsections b. c. d and e referred specifically to questions as to:

b. when the article(s) aired
c. what the content was
d. who appeared or was quoted within it
e. what steps were taken following any coverage

49. Item 'f' referred to adverse publicity and its impact upon pupils, the school / college / trust / staff.

50. I would also like to correct a minor error in Paragraph 5 (a) of my statement in that the date should be 2012 and not 2010.

I do not wish to give evidence and I do not require anonymity.

Statement of Truth

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

Signed GRO-C

Dated 11 June 2021