

ANONYMOUS

Witness name: GRO-B

Statement No: WITN2033001

Exhibits: WITN2033002-005

Dated: 8 May 2019

INFECTED BLOOD INQUIRY

FIRST WRITTEN STATEMENT OF GRO-B

I, GRO-B will say as follows:-

Section 1: Introduction

1. My name is GRO-B My date of birth is GRO-B 1950 and my address is known to the Inquiry. I have been a widow since the death of my husband, GRO-B: H on GRO-B 2005 aged 47. H was an intelligent, highly skilled, and well-respected man, who was extremely good at his job as an industrial roofer. Our industrial roofing business, which we ran together, was awarded major contracts for landmark developments, GRO-B
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GRO-B to name a few. H contracted hepatitis C ("HCV") after a blood transfusion following a road accident in 1987. We had no idea that H had HCV until November 2004, shortly after which H died as a result of liver cancer caused by HCV. I would like to emphasise at the outset that, tragically, H only lived for GRO-B days from when first experienced symptoms and went to his GP. His diagnosis and quick death were devastating for me and my family.
2. I have two adult children – a son, GRO-B who is married to GRO-B and they

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have two daughters, GRO-B and GRO-B and a daughter GRO-B who has a partner, GRO-B. Sadly, GRO-B GRO-B daughter and only child, was killed in a road accident aged 18 years in 2016. Since 2009 I have had to live in rented accommodation. I retired from work in 2011.

3. I make this statement in response to the questions set out in a "Rule 9 Request" letter sent to me by the Inquiry care of my solicitors, Leigh Day. Those question headings are set out below, followed by my responses to them. Save where I state otherwise, the facts and matters set out below are within my own knowledge and are true. Where I refer to matters that are not within my own knowledge, they are derived from the sources stated and are true to the best of my knowledge and belief.
4. I append some key supporting documents to this statement and I state their corresponding Exhibit Numbers in the body of this statement.

Section 2: How infected

5. My husband, H was in a road traffic accident in November 1987. He sustained a number of fractures over his body. While in hospital due to his injuries, he had whole blood given to him. He was given the blood transfusions in Peterborough District Hospital, although I understand this hospital building no longer exists. I can see from H medical records that he had blood transfusions on two separate occasions, and I exhibit to this statement as **WITN2033002** his blood transfusion records. H was given six units of whole blood (unit numbers: 724618g8; 725095g9; 734394g9; 734808g9; 734400g7; and 725474g1) on or around 1 November 1987 under the care of a consultant whose name is recorded as, "JRG". He was then given 2 units of whole blood (unit numbers: 726203g5; 726172g1) on 3 November 1987 under the care of a consultant whose name is recorded as, "Myles".

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6. We had no knowledge at that time or at any point after that that he could be at risk of HCV.
7. As far as I am aware, [H] was only infected with HCV and no other virus.
8. [H] found out that he had HCV by chance. On 14 October 2004 my husband phoned me at our home in [GRO-B] to ask me to make an appointment with his GP, because he had coughed up blood. I recall that he was working that day on the roof of [GRO-B]. We had a contract to do this work as part of our industrial roofing business. He had an appointment that evening at our GP surgery. From [H] medical records, I can see that his GP referred him for urgent care at hospital, stating, "*He has a 3 week history of epigastric and umbilical pain, loss of weight, loss of appetite and also he occasionally vomits with some blood in it. He is normally very healthy. We hardly ever see him in the surgery. He is not on any regular medication*". After seeing the GP, [H] was referred for tests and admitted to the Queen Elizabeth Hospital in King's Lynn the following day. [H] had endoscopy procedures and a CT scan during his inpatient treatment. Initially the clinicians at King's Lynn Hospital could not work out what was wrong with [H]. They saw oesophageal varices when they did the endoscopy and, eventually, [H] was diagnosed with HCV in November 2004, at some point between the 5 and 25 of November. We did not really understand the HCV diagnosis. [H] was referred to Addenbrooke's Hospital for a liver biopsy.
9. On 11 December 2004, [H] had a liver biopsy under the care of Dr Graeme Alexander, a consultant hepatologist at Addenbrooke's. That afternoon my son and I went to pick [H] up and met with Dr Alexander. He informed us that [H] had liver cancer and cirrhosis of the liver and he

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could do nothing for us. He also told us then that [H] only had two to three months to live. [H] indeed died on [GRO-B] 2005 and only lived [GRO-B] days from October when he suddenly demonstrated symptoms. I was completely devastated and shocked.

10. Dr Alexander was very helpful and explained what HCV was and that it was most likely that it had been caused by [H] blood transfusion following his accident in 1987. This was also confirmed by Dr Andrew Douds, consultant physician and gastroenterologist at the Queen Elizabeth Hospital in King's Lynn.
11. In terms of any information that was given to understand how [H] HCV could be managed, this simply did not apply in our case because it was too late; the effects of [H] infection were so advanced, given that he had liver cancer and was given only a few months to live, that there was nothing he could do.
12. I firmly feel that [H] HCV diagnosis should have come many years earlier than it did, in which case, it is likely that he would still be alive today. In particular I feel very angry that there was some kind of "lookback exercise" that took place in 1995, which failed to identify [H] as a person who had had a blood transfusion and was at risk of being infected with HCV.
13. On 18 January 2006 the Peterborough and Stamford Hospitals NHS Foundation Trust, which by that point had become responsible for the Peterborough District Hospital where [H] was given infected blood, put out a media statement entitled "Blood Products" (exhibited to this statement as **WITN2033003**). It referred to the Chief Medical Officer's "look back" exercise in 1995, which had been coordinated in that region by the National Blood Authority's Regional Transfusion Centre ("RTC"). The statement said:

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"This Trust never received any instruction from the RTC to check its records against blood products that would have been relevant to the deceased. The reasons for this need to be taken up with the National Blood Authority's' Regional Transfusion Centre – it is not a matter for the Trust and there is no evidence whatsoever to suggest that the Trust failed to comply with the Chief Medical Officer's guidance."

14. I can see that there is a note on the statement saying that there was a key limitation of the lookback exercise – that it related to donors who had given blood since HCV testing was introduced in September 1991. Therefore, this may have not been relevant to my husband. However, I am angry that there was no lookback exercise at all in our area, which could potentially have identified my husband as someone at risk. I can only assume there was a complete failure and breakdown of communication at the time. HCV is a silent killer and not knowing that you have the virus is what leads to the various serious complications and secondary conditions. My husband was oblivious to the fact that he had HCV for seventeen, nearly eighteen, years. That is unacceptable.

15. In or around February 2006, I contacted my local MP, Malcolm Moss MP, about HCV and the lookback exercise, asking why patients such as my husband were not informed that they may have contracted HCV. Mr Moss wrote to the then responsible minister for infected blood, Caroline Flint MP, pursuing the matters I had raised with him. In a letter she sent to him dated 13 February 2006, she stated that she was sorry that my husband was not identified as part of the lookback exercise and *"unfortunately, the lookback was unable to identify all patients who may have been infected."* She also stated in her letter that the Department of Health was running an HCV awareness campaign for health care professionals and the public. However,

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despite what Ms Flint said, I firmly feel that there should have been more pressure. I do not recall seeing a single public awareness advert about HCV. This compares starkly to other conditions such as AIDS, at the time. This failure, in my view, was crucial. If you are aware that you are at risk of HCV, you can do something about it. It goes without saying that a lack of awareness means you can do nothing to change your situation.

16. I also hold responsible for a failure to diagnose my husband his private GP, Dr Ray Webb. In 1998, my husband lost his driving licence after drinking too much at the pub one evening and drink driving. He wanted to get his licence back, so he went to a private GP. The doctor assumed he was an alcoholic and he had to get a Liver Function Test ("LFT") done. His readings were high and abnormal. I exhibit as **WITN2033004** the medical record showing the tests he had in 1998. One of his LFTs was sent away to the hospital at King's Lynn. The records show that he was tested for Hepatitis A and B but not HCV. I cannot see why he was not given this test, since this was a number of years after a test was available for HCV. Instead, Dr Webb just assumed that [H] was an alcoholic. This made me feel dreadful. [H] was alcohol and drug tested regularly given that he worked on roofs. It was not possible that he was an alcoholic. He had to be responsible at all times carrying out his work. I am not sure if [H] medical records would have shown that he had a road traffic accident in 1987, but in any event I believe that Dr Webb should have been under a duty to investigate after seeing [H] abnormal LFTs. In approximately 2006-2007, I tried to sue Dr Webb for negligence in failing to carry out an HCV test. I instructed Irwin Mitchell to act on my behalf but this claim went nowhere, which was emotionally very difficult for me at a time when I was grieving. I still believe that Dr Webb failed my husband. He did once phone me and admit that, in hindsight, he would have carried out an HCV test on [H] I thought to myself, how dare you? He has since taken me off his practice list.

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17. I can confirm that we were given no information about the risks of others, such as me, being infected as a result of [H] HCV infection. We had to do our own research entirely. Our research suggested that you should be careful doing things like sharing a toothbrush. I had, as to be expected, had sexual intercourse with my husband, or shared razors on the odd occasion. All the time I had potentially been putting myself at risk and I had no knowledge. When [H] eventually received the diagnosis, nobody imparted this information.

Section 4

18. I believe that [H] did not give his informed consent for the blood transfusion in 1987 that was the cause of his infection. He was not made aware at any point of the material risks of the transfusion or that the blood might be infected, including with HCV. He certainly would have attached great significance to the risks if he had known of them, I believe. I do not think that he was not informed at any point if there was any reasonable alternative course of treatment, if indeed there was one.
19. I do not know if [H] was treated or tested for the purposes of research without his consent.

Section 5: Impact

20. As I explained above, by the time [H] and I found out he had been infected with HCV, it was too late. The impact on both of us mentally was unreal and it was difficult to understand. My daughter-in-law, [GRO-B] was expecting her second child at the time. As a family we coped and my husband was as strong as ever. Most of his friends were unaware of HCV

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and its connection with blood transfusions. [H] knew he had only months to live, so enjoyed the time that he had and did not dwell on his illness. I was in despair, however, as I knew nothing about HCV, except that I knew it was associated with intravenous drug abuse, so I did not talk to my friends about it.

21. [H] consultant hepatologist, Dr Alexander, was very caring and helped immensely.

22. [H] was a very proud and private person and so it was difficult for me to tell how he was really feeling about his HCV and liver cancer diagnosis. Everything happened so quickly and he did not want to talk to me about it. He did not want to let on that he was struggling. After his diagnosis, he had to stop working at about the end of October. [H] was the sort of person never to grumble but to make the best of life. He knew that he had liver cancer and was going to die, but that did not matter to him; he got on with life, enjoying his time and even planning things for the future. For example, I remember that the Saturday before he died (he died on a Wednesday), he had gone shooting with his spaniels, which was one of his much-loved hobbies. I recall that he was actually planning for us still to go on a holiday and I remember him looking on Expedia to plan a trip. He was such a strong man, who never gave up. I remember also that we went out for a meal for my birthday, which was between Christmas and his death on [H]. He was jaundiced and he found it very hard, but he really wanted to keep going and do it.

23. I remember that Christmas was surreal. [H] wanted to make the best of it, still carving the turkey for everyone. He truly did not give up living until it was completely necessary. I exhibit as **WITN2033005** two photos of [H] to demonstrate his rapid deterioration physically. The first is taken of the two of

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us in 2000 and the other shows [H] at the end of the table during the Christmas before he died. The difference is remarkable.

24. One thing I find hideous about HCV is that it is a silent killer. As a result of us not knowing about [H] condition, we had made many plans for our future, which, because the end was so quick, we could not change.
25. In terms of the progression of [H] condition, as explained above, we had no idea anything was wrong until he had the symptoms described in October 2005. There are, however, some things that now "make sense" in hindsight, and which I think were early signs something was wrong.
26. For example, in 2001 [H] had an arthroscopy in day surgery because he was having a problem with his knee. His medical records record that, after discharge, his leg became red, hot and sore and he was taken into hospital for a further arthroscopy a few days later. It turned out the knee was full of fresh blood and an old blood clot. It had to be washed out.
27. I also recall that [H] suffered from itching of his skin. [H] was not a "sun worshipper", but he loved to scuba dive, which required him to be outside. I remember, though, that he really did not like to be in the sun and that it made his skin uncomfortable. This started quite a while before he was diagnosed.
28. I do also remember that after approximately 2001/2002, [H] became impotent. This was significant as we had had what I would describe as a healthy intimate life before this.
29. He was also slightly forgetful and did have some ringing in his ears, although I do not know if these were caused by the HCV.

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30. As I have explained, [H] HCV caused a number of secondary complications, including liver cancer, cirrhosis of the liver and varices.
31. The questions about treatment for HCV and secondary conditions are not relevant to me, as [H] did not receive any treatment given his diagnosis was terminal.
32. [H] diagnosis and death shortly after changed me as a person. The impact on me personally was massive. Although I had great support from my son and daughter-in-law, [GRO-B] and [GRO-B] I still had to be incredibly strong and the aftermath of [H] death was extremely traumatic. When I lost my home, I had to get rid of a lot of [H] things. I burnt a lot of them, such as his shirts, as I needed to move on quickly. This was so painful.
33. There were also knock-on wider family effects. My marriage to [H] was his second marriage and he had two daughters from his first marriage, who he did not see very often. When [H] knew he was dying, his daughters were in their early twenties. We sat and talked about what he should tell them and he decided that he did not want to get in touch with his daughters. After he died, I had the extremely difficult task of making a phone call to them to explain that he had died and the cause of his death. They were not happy at all, but those were [H] wishes. It was very traumatic for me. They wanted to see a copy of his will. The whole episode was so stressful and I have not been in touch since.
34. My situation is complicated by the fact that I also support and look after my daughter, [GRO-B] who has suffered from depression and a number of issues. As I explained above, she tragically lost her only daughter in a car accident. I support [GRO-B] financially and emotionally. I am now 68 years old and I live alone. I rent a property from [GRO-B] and [GRO-B] who live next door. I am

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now quite happy with my own company. I have free range hens, four cats and a lovely garden. However, [H] death has really impacted on my social life and I do not go out often.

35. Financially, [H] death hit me extremely hard. There was a real aftermath. Our industrial roofing business, which we ran together, was very successful and had many high value and high prestige contracts. I worked in the office and my husband worked on site. Naturally after [H] died, the business could not run without him. As a result, I lost everything. From the point of [H] death, my life completely changed, and I have struggled for money ever since. We thought that I would be OK because [H] had life insurance, however my experience was that insurance companies would not pay out any money. Only one of our policies paid out. After [H] died, I had my house repossessed and I was made homeless. I also had to give away my husband's three working spaniels, which destroyed me. I was heartbroken. Because I was homeless, I had to live in a hostel for two months in August-September of 2009. There was no accommodation that the Council could offer me and I had to find this hostel myself, with no help from the Council at all. Before this, I also lived with my mother, who was diagnosed with cancer. I lived with her until she died in November 2008. I stayed in that property with my daughter and granddaughter until it was sold.
36. Before [H] diagnosis, we had bought properties in Spain that we subsequently had to sell. We lost a lot of money. The hard thing was that, given we had such short notice that [H] only had months to live, we had no time to change or improve our financial situation.
37. Although I received the stage 1 and stage 2 payments from the Skipton Fund of £20,000 and £25,000 respectively, which I received after [H] died, I never in reality saw that money because it went into trying to save my house.

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It was only the latest additional top-up payment of £25,000, that I really could do anything with. I have used that money to live off, and I have also had to support my daughter, GRO-B since H died. Previously our business had supported my daughter.

38. After H died, I got a job at Asda working in the canteen. I struggled to find employment. By this point I was in my late fifties. I had worked in our business but found that people did not want to employ me at that age. I retired in 2011, as I found I was financially better off taking my pension rather than working. I thought to myself that I had never claimed any benefits and, after all I had been through, I deserved it.
39. I had 14 years of very bad times. I am now slightly better off financially. However, I still am always worrying about money and things are tight. I am unable to go to my husband's grave because I cannot afford to run a car. This is very painful for me. My car allowed me independence and to visit H grave. It also hurts me very much that, if something were to happen to me, I have nothing to leave my son, daughter and granddaughters. I would add that it can often be forgotten that it is not just those who have died that are victims, but also their family and loved ones left behind. I found that there was no real support for me at all.
40. In terms of the stigma associated with a diagnosis of HCV, I found that the most common assumption was that it was caused by alcoholism. My understanding is that alcohol does not cause HCV itself, it causes *cirrhosis*. However, because of this stigma, we told few people, apart from friends and family. I did contribute to a piece in the local paper, the GRO-B Standard, warning people about HCV and the risks of infected blood, imploring people to get tested.

Section 6: Treatment/Care/Support

41. No counselling or psychological support was made available to me or [H] however I feel that this would not have changed anything. We found out about [H] HCV when it was too late to do anything. [H] was more interested in living with the time he had left. I do remember that we had some support from a Macmillan nurse, who came to our house one occasion. It was so emotional for me to sit there and hear that conversation.

Section 7: Financial Assistance

42. Following my husband's terminal diagnosis from Dr Alexander at Addenbrooke's, he sent us a letter advising us about the Skipton Fund. Dr Alexander completed the forms for the stage 1 and 2 payments and I received those payments. Unfortunately, [H] had died by this point.

43. I have received the following payments:

- a. Skipton Fund Stage 1 payment of £20,000 in April 2005;
- b. Skipton Fund Stage 2 payment of £25,000 in May 2005;
- c. A further "top up" stage 2 payment of £25,000 in 2011;
- d. Skipton Fund £10,000 payment to bereaved spouses and partners in March 2017.

44. I have had no difficulty with receiving any payments from the Skipton Fund.

45. I now have regular payments of £500/month from the England Infected Blood Support Scheme ("EIBSS"), which helps to pay my rent, however other wives have had this payment from the beginning. I also get a winter fuel allowance payment every December, which is so useful. It really matters

to me as it pays for my oil. I also receive Pension Credit from the Government.

46. In terms of the adequacy of financial assistance I have received, I have several thoughts and observations. First, as I explained above, although the money from the Skipton Fund was welcome, much of it I lost trying to save my house and trying to continue a business with my son and daughter-in-law. In the end we all lost our money on this venture. All of this was in direct consequence of [H] death. I feel that the approach taken in other countries such as Italy, Japan and Canada to financial assistance was much better than in the UK. These countries took responsibility. By contrast, affected people like me have never been given any form of compensation for the havoc caused, financial or otherwise. Instead, we have been drip-fed money. This means that you can never move on when you have to rely on these hand-outs as you are never really in control of your money. It is better than nothing, but every time you need anything you have to ask for a handout. I cannot afford to go away on holiday, for example. However, I should add that it is impossible to put a price on life.

Section 8: Other Issues

47. My family and I have been involved in some campaigning and public awareness raising. My daughter, [GRO-B] has done an awful lot including demonstrating in London with the Contaminated Blood Campaign ("CBC"). I could not afford to go, which was shame as I would have liked to very much.

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48. I have various questions and observations based on my experiences as set out above. At this stage, I am uncertain as to what will actually be achieved from the Inquiry. I have fears that the divisions between the various groups of victims, particularly between "wholeblood" victims and those with haemophilia will play out in the Inquiry, and I sincerely hope they do not. At the end of the day, HCV and other viruses are a death sentence, whether you have received a contaminated blood transfusion or blood products. I also have lost faith hearing people say that a number of key documents have been shredded.
49. I hope that the Inquiry answers a number of important questions about the whole infected blood scandal. For example, who is to blame for what happened? How long has HCV and the risks of contracting it through blood been known about? Why was the issue of infected blood not pulled up earlier and why was there no effective lookback scheme to identify those who were at risk of infection?
50. I would also like to see as an outcome of this Inquiry that there is a greater public awareness of HCV, its symptoms and causes, including the risk of having been infected by contaminated blood. For example, there should routinely be posters in GP surgeries warning people of this. It feels to me that intravenous drug users are made more aware of HCV than everyday people, who may have contracted HCV through a transfusion.
51. Finally, I would add that whatever the outcome is of the Inquiry, it is too late to help H However, others can still be helped. There should be answers; too many people have died for this Inquiry to fail to get to the bottom of things.

STATEMENT OF TRUTH

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

GRO-B

SIGNED:

DATED: 8 May 2019