Witness Name: GRO-B
Statement No.: WITN2232035
Exhibits: WITN2232036- WITN2232044
Dated: 29th September 2022

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF GRO-B

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 11 November 2021

1. I am providing this statement to give further information following consideration of Dr Ludlam's response to my first written statement. Dr Ludlam's response has the Inquiry Reference **WITN3428045**, and my first written statement has the Inquiry Reference **WITN2232001**.

2. Dr Ludlam has stated that the majority of the blood samples that were taken from me were to measure my plasma Factor VIII level to ensure I was receiving the appropriate level of treatment. I have reviewed my medical records and exhibit the entries in my medical records showing blood tests that were taken between 1979 and 1989 as **WITN2232036**. These show that a large number of blood tests were being carried out throughout the 1980s, including those introduced in March 1983 which were 'lymphocyte' tests. Within these entries, I would highlight two consecutive blood tests one from February 1983, immediately prior to the new test introduction and the one which was the actual first time the test was done in April 1983. In the February 1983 test, 'differential' is not measured. In the next test in April 1983, it is measured, and this test sheet is labelled "AIDS study" for the first time. I know

that this new test was only developed around February or March of 1983. Dr Ludlam was alerted to this new test and its relevance to AIDS at the 11th Hepatitis Working Party Meeting held on 19th January 1983 (Inquiry reference **HCDO0000558**) and The Haemophilia Centre Director's meeting held on 14th February 1983 (Inquiry reference **HCDO0000411**). He then developed these tests, within a matter of weeks, in conjunction with the Virology department at the Western General Hospital in Edinburgh. These are the tests that were labelled 'AIDS Study." These tests required additional blood samples from those that were taken as part of routine patient monitoring. Not long after the first samples were taken, Dr Ludlam submitted these results for publication in The Lancet. The Lancet article was published in May 1983 in response to an earlier letter by Dr Robert S Gordon, National Institute of Health (North America) Working Group on Acquired Immune Deficiency Syndrome (AIDS). My records also show a large number of these tests being carried out in 1984, that is the year it was discovered I had been infected. I do not think it is 'unfortunate' they were labelled "AIDS Study" I think it is 'accurate' they were labelled AIDS study.

3. When reviewing my medical records, I discovered that there are entries showing that blood tests were carried out on my father, mother and sister in 1985. My relatives were not told why these tests were being carried out. I exhibit the relevant entries from my records as **WITN2232037**. There is no logical reason for these tests being carried out other than Dr Ludlam was checking to see if any of my family had become infected through contact with me. He knew at that point I was a risk to them because of my positive HIV status. This again illustrates a lack of candour and honesty by Dr Ludlam and supports my view that he was determined to avoid informing me or my parents of the true state of my health despite this placing them all at risk. Dr Ludlam was also sent a document on two separate occasions by the Public Health Laboratory Service, signed by Dr Craske. One is dated 13th November 1984 and the other is combined as part of a letter specifically sent to Dr Ludlam by Dr Craske, dated 30th November 1984. Attached to both is an Appendix which deals with ethical considerations for doctors who discover a patient has tested positive. It gives two choices for doctors in this situation. These are one, tell the patient or two,

wait for two years. The option of waiting highlights the pitfall of this approach regarding patient trust and the risk it places other people in. At the end of the document, the conclusion is that the only ethical choice for a doctor is to tell the patient. These two copies were sent to Dr Ludlam at exactly the time he discovered I, and the other members of what became The Edinburgh Cohort, had been infected. I draw reference to the letter dated 13th November 1984 (Inquiry reference **HCDO0000273_066**) and to the letter dated 30th November 1984 (Inquiry reference **HCDO0000273_058**) to show Dr Ludlam had the opportunity to make himself fully aware of ethical considerations and risks to other people by not telling patients. This, of course, was at an especially relevant time as he was facing this situation for real.

4. In my first written statement, I refer at paragraph 36 to the number of the infected batch being written out in full in my medical records. I exhibit the excerpt from my medical records showing the batch written out in full as **WITN2232038**.

5. In his response to my statement, Dr Ludlam states that I was offered explanations and that these were accepted at the time. In 1984, I was only fourteen years old. My position is that my parents should have been consulted on such issues and they should have especially been told of the AIDS study tests and the purpose of those. They brought me to my medical appointments and visited me in hospital, yet Dr Ludlam has not detailed any attempts he made to contact them or inform them of my status. There was no allowance made for my age or vulnerability. I question why there was no system in place to include parents when it was known that their child had a serious infectious disease. I also question the legal position of a doctor not informing parents their child has a fatal disease which could infect other people. Dr Ludlam refers to the fact that I did not tell my parents about my HIV status for several years after I was finally told in 1991 about my infection. What I did or didn't do once I was actually told seven years later is irrelevant. Those are events which occurred well into the future. They have no bearing on the decisions Dr Ludlam took in 1984 and 1985 or the ethics of telling me or my parents. If anything was relevant for him to consider about the future, it was the health and safety

of the girlfriends I later went on to have. And what was relevant to the future of any children I may have fathered and the risk to their lives. How he behaved and his decisions are what is relevant. Comments on how I behaved to try and deal with the trauma of being told I had a fatal disease is a cynical attempt to deflect attention from his actions which placed other individuals at risk for many years.

6. My parents have lived at the same property for forty-two years. At the beginning of this year, my father unearthed a crucial letter. The letter is dated 31st January 1985, addressed to me not my parents, and was sent after the December 1984 meeting referred to in my first statement. The letter encloses an advice sheet on AIDS. It states that I should contact Dr Ludlam to make an appointment if I have any questions after reading the advice sheet. The letter does not contain a clear, unambiguous message to patients that a test has been carried out and that they should come forward if they want to know the result. The letter also sets out that Factor VIII is now being heat treated to kill the AIDS virus. As I had not been told differently, I lived under the misapprehension that the threat was over. This letter gave a false sense of security which continued for years. Neither the letter nor the Advice Sheet contain the information that patients in Edinburgh have tested positive for the virus, instead it only refers to Scotland in general. I exhibit the letter and the advice sheet as **WITN2232039**. I was fifteen years old when this letter was sent to me. I do not know why this letter was sent to me directly and not to my parents. Just a week previously, on 23rd January 1985, my parents were sent a letter attaching a survey into the effects of haemophilia on children's schooling. I attach this letter as **WITN2232040**. I do not understand why the 23rd January letter was sent to my parents but a crucial letter – possibly the most crucial letter ever sent regarding my health - was not sent direct to my parents. I made a complaint to the GMC in June 2005 about my treatment by Dr Ludlam. The excerpt of this GMC complaint file has already been disclosed by the Inquiry as **WITN3365029_001**. In the excerpt from my GMC complaint disclosed by the Inquiry at **WITN3365029_001_0044**, Dr Ludlam comments on this letter. He states that "*An explicit invitation was made to anyone who wanted to have more information or to know the result of their anti-HTLVIII test*

to telephone to make an appointment. Mr and Mrs (redacted) did not take up this opportunity." The actual copy of the letter clearly shows that was not an accurate statement by Dr Ludlam as the letter does not contain an explicit invitation. Instead, it includes the suggestion "*If after reading this leaflet you want talk things over with me...*" Dr Ludlam also states in his GMC response at **WITN3365029_001_0045**: "*In summary, Mr (redacted)'s parents were given 'the opportunity to know of their son's HTLVIII result but chose not to enquire*." The letter clearly shows that is also not an accurate statement. The actual letter combined with the Advice Sheet sends a very reassuring message that Factor VIII is now safe and the message conveyed is: '*we your Doctors are on top of this and we are providing extensive information and advice.'* Later in Dr Ludlam's response at **WITN3365029_001_0138**, he makes comment on what was sent out in January 1985 to patients. He states that the Advice Sheet "*alerted recipients to the fact that individuals with haemophilia in Scotland had been tested for anti-HTLVIII and it made an explicit offer of a meeting with myself to discuss individual circumstances.*" As mentioned above, this did not specifically alert people to the fact this was the case in Edinburgh. The Advice Sheet only makes a conditional suggestion "*If anyone wishes further discussion*." I note that in contrast to his earlier GMC response, this second response, which was done under advice from Dr Ludlam's solicitors Dundas and Wilson, does not refer to the 1985 letter at all. Instead, comments are exclusively restricted to the Advice Sheet. I find that very significant because if this letter was so clear in supporting Dr Ludlam's version, his solicitors would surely want its existence fully highlighted to make their client's case to the GMC, not mysteriously 'omitted'.

7. Dr Ludlam states that I was adamant that I did not want to know my HIV infection status. My position is that I always said at appointments "Just tell me if there is anything wrong." Dr Ludlam did know there was something wrong, yet he never said a word. He has been less than clear on what he did ask and the terminology that he used. In his response, Dr Ludlam refers to an occasion when he saw me that I was adamant that I did not want to know. I believe that Dr Ludlam is talking about an occasion that is documented in my medical records and which I exhibit as **WITN2232041**. The handwritten date on this

document is unclear, however I understand that Dr Ludlam's position at the Penrose Inquiry was that this document is dated 13th November 1986. His handwriting came under some scrutiny as it is very unclear especially in connection with the 'year'. I have recently located my mother's appointment diaries from 1986. The diary entry from the relevant week shows that the appointment took place on 12th November 1986 and not 13th November 1986, so the "day" is now in question. I exhibit the diary entry as **WITN2232042**. The fact that the date is wrong leads me to question the accuracy of the entry. Dr Ludlam confirmed during the Penrose Inquiry that this record was part of his "private notes" that were later returned to the principal case records. This again leads me to question whether the record is accurate as these records were in his sole possession and control for a number of years. In 2003, I made a request to have copies of all my medical records. On 21st June 2005, I submitted a complaint to the GMC about Dr Ludlam and his treatment of me. On the 12th August 2005, I received Dr Ludlam's response to my complaint and the evidence he'd submitted to the GMC to support his version. That evidence included **WITN2232041**. In Dr Ludlam's written response to the GMC at **WITN3365029_001_0044** he stated *"I saw him on the 13th November 1986 and asked him whether he wished to know his anti-HTLVIII result. He was adamant that he did not wish to know."* He also stated later in that paragraph at **WITN3365029_001_0044** "*We were concerned that Mr* **GRO-B** *did not wish to know his anti-HTLVIII status, but as a competent adult that was his legal right. Furthermore he told me that neither his parents nor his GP were to be informed.*" The actual record does not speak of HTLV-III result; it uses the term 'antibody result.' Also, it makes no reference to what I did or did not want my parents or GP to know. I had only just left school at this time and was seventeen years old, which was below the age of majority. I made all these points to the GMC in my reply to Dr Ludlam's statement. My reply stated at **WITN3365029_001_0048**, "*As for being adamant I did not wish to know, where does this information come from*?" I also say later in that paragraph at **WITN3365029_001_0048**, "*As for me not wanting my parents or GP to know, I do not know where Prof Ludlam obtained this information from at this time as I see no record in my medical notes.*" In January 2006, Dr Ludlam's solicitors sent a letter to the GMC with a further detailed statement and more 'evidence'

he'd supplied at that time. I exhibit a copy of this letter under **WITN2232043** and the further evidence they supplied under **WITN2232044**. These documents were recovered recently as part of a Subject Access Request made this year for my full GMC complaint file and were not previously provided to me or disclosed by the Inquiry in the excerpt at **WITN3365029_001**, except in the case of **WTIN2232041** discussed below. Part of the further evidence Dr Ludlam's solicitors provided under **WITN2232044** is a letter Dr Ludlam apparently sent me dated the 27th May 2005. In this letter he says he had found a clinical note when he was (for some unknown reason) reviewing a file of his "*especially confidential clinical notes*." The letter states he apologises for it not being given to me two years earlier back in 2003 when I'd requested my medical records. An unstamped Royal Mail Special Delivery Sticker is placed on this photocopy as if this is proof of postage. I have only seen this letter recently for the first time. This note Dr Ludlam had 'discovered in his '*especially confidential clinical notes*' is actually **WITN2232041**. Dr Ludlam had in fact already submitted that to the GMC months before in August 2005 as part of his first set of evidence yet failed to mention at that time to the GMC this record had been stored away from the main medical records for nearly twenty years. I also note, the 27th May 2005 letter was apparently sent to me 'out of the blue' one month before I'd even submitted my GMC complaint. It is from the "Department of clinical and laboratory Haematology'. I have kept all the original communication from my GMC case – original letters, envelopes etc. I do not have this letter Dr Ludlam told the GMC he apparently sent it to me in 2005. Dr Ludlam's solicitors also tell the GMC in 2006 of another occasion that Dr Ludlam has 'realised recently' other clinical records have been held back from me. This time the reason for omission of these documents is explained as: "*The Medical records department may not have sent information stored confidentially on the Haemophilia clinical database on the main hospital computer*." None of this missing information that Dr Ludlam keeps suddenly remembering about was actually given to me at the time. In fact, as with the 27th May 2005 letter, I have only seen this very recently (September 2022) for the first time because of my GMC Subject Access Request. These documents weren't even in the medical records which were issued for the current Infected Blood Inquiry. They are absent from my set of

records and from the set issued to my solicitors. I don't understand how even now, there is no reliable system in place to ensure patients have full access to these legal documents on their own health.

8. I exhibit the entry in my medical records dated 15 January 1991, recording the appointment when I was told about my HIV infection to my first written statement as **WITN2232022**. I would like to add to what I have already said about this entry at paragraph 16 of my first written statement. Within the entry, there is scant reference to me being informed of my HIV status. It is only mentioned at the end of the clinical note, almost as an afterthought. This follows the pattern that I remember where Dr Ludlam would ask me questions at the end of appointments when I was getting ready to leave and all-important things had been discussed. He dealt with the haemophilia treatment first and only at the end, as if it was a minor footnote to the meeting, did he inform me of my result. In the meeting he used the words "It has come to my attention." What he did not say is that this came to "his attention" in 1984. Why did he not give me the full facts? I think this is yet another example of Dr Ludlam withholding salient information to favour himself. It is at this meeting I said I don't want my parents or GP to know. That is recorded in this clinical note as well. I refer back to point 7 regarding Dr Ludlam and what he told the GMC on 12th August 2005 when he stated this happened in the meeting documented in **WITN2232041**.

9. I maintain my position that I was not told about the facts of my infection. I only learned of the fact years later that I had been infected when I was fourteen years old and that I had been part of a research study group.

10. Dr Ludlam states that he did not keep records at home. However, records were kept in a locked cabinet in his office. Therefore, as mentioned above, these "private notes" were in his sole control and possession for decades. Dr Ludlam has given many conflicting versions of where records were and at what time they were lost or returned to files. Dr Ludlam has repeatedly contradicted himself on the history of these records. These are the very records he has stated he actively took steps to ensure were preserved. Even now in 2022, as

detailed in point 8, there are notes which are not in my main medical records and according to his evidence to the GMC are being kept on the main hospital computer. Yet despite being on the main hospital computer are not within access of the official hospital record retrieving system. The purpose of this system should be to ensure full medical records are issued to patients (or parties acting on the instructions of patients) who request copies. I don't believe it is right that even now I have to unearth my own medical history via so many different avenues.

11. In Dr Ludlam's response he states that I didn't hear about the research studies from him. He is correct - I didn't. Nor did my parents hear about them. There are a lot of relevant things Dr Ludlam's patients didn't hear about with regard to their health, treatment and what he did with results. I took an active part in my treatment. I always asked questions. I have demonstrated I wanted to know.

Statement of Truth

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

Signed GRO-B

Dated Sep 30, 2022