Witness Name: Dr Michael Hamblin
Statement No.: WITN3069001
Exhibits: NIL
Dated: 24 April 2019

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF DR MICHAEL HAMBLIN**

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I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 2 April 2019.

I, Dr Michael Hamblin, will say as follows: -

## Section 1: Introduction

1. My name is Dr Michael Hamblin, Consultant Haematologist, Department of Haematology, East Suffolk North Essex Foundation Trust (ESNEFT), Colchester, CO4 5JL. My date of birth is GRO-C 1964. My qualifications are MBBS, BSc,MRCP, FRC Path.

2. The positions I have held are Consultant Haematologist ESNEF – appointed April 2001, Chair of Haematology MDT, Audit lead and Peer Review lead for service, Research lead for Haematology, Primary role – Provision of Clinical and Laboratory Haematology service to ESNEFT and affiliated primary care service.

## Section 2: Responses to criticism made by Kate Ashton

3. I worked at the Mayday Hospital ( now known as Croydon University Hospital) between April 1996 to April 1997 as a junior Doctor in Haematology under the supervision of Dr H Lumley, Consultant Haematologist. As part of that role I would have seen patients under the care of Dr H Lumley in Out Patients.

4. I have been asked to provide a statement concerning an episode 22 years ago without access to the medical records. I have read the 2 clinic letters (exhibit WITN1416009 and WITN1416010) and the witness statement of Ms KA provided to me. Naturally, I have no recollection of the clinic appointments referred to, nor can I remember any specifics of conversations held during any interactions with Ms KA. I do, however, recall some of the details of the patient and case. I have had to rely heavily on the 2 clinic letters provided as evidence to inform my statement.

5. I recall that Ms KA was requiring venesection therapy ( blood letting) as a result of accumulating excess iron - secondary to repeated blood transfusions for apparent delayed bone marrow recovery after an autologous bone marrow transplant, performed in Nottingham during 1989. Whilst there was limited information available about events in Nottingham I recollect that it seemed prudent to screen for the presence of Hepatitis C infection in Ms KA as she would have been the recipient of multiple blood transfusions in the immediate period before donated blood was routinely screened for Hepatitis C. My intention would have been to make sure she had ongoing access to expert Gastroenterological care in case she had been unfortunate enough to acquire the infection. I do not recall expecting the result to be positive (I do not recollect Ms KA exhibiting any features of chronic Hep C infection). I would have perceived the analysis as primarily a screening mechanism that would most likely, and hopefully, exclude Hep C infection. I do not remember taking specific consent for the analysis; this would not have been my usual practice in 1997 and I am not aware of any specific guidance available at that time that might have mandated this.

6. Regrettably the test did confirm Hepatitis C positivity.

7. I have no recollection of the consultation Ms KA refers to in her witness statement but I will rely on the available clinic letter and knowledge of my usual clinical practice. In my clinic letter, dated 15/4/1997, I confirm that investigations from the previous visit revealed that Ms KA was hepatitis C positive. I have stated that I thought this was very likely to have been acquired in 1989 when she was the recipient of extensive blood support following a bone marrow transplant. I don't have access to her medical records to corroborate this statement now but, from memory, this remains a very plausible explanation. I have also stated that I found no clinical evidence of chronic liver disease but I did note mildly abnormal liver function tests.

8. I go on to document that I specifically discussed the broad implications of the infection, including the risk of developing chronic liver disease and the risks of transmission.

9. The purpose of my clinic letters is to provide a succinct and accurate summary of notable results and discussions held with the patient for their GP. The letters also act as an additional record for the medical notes. I note I have added Hepatitis C positivity to the headline 'Diagnosis' list at the top of the letter – this list is always included in all subsequent correspondence thus facilitating the rapid transmission of critical information to other clinicians encountering the patient subsequently.

10. It was not common practice in 1997 to share letters between hospital appointments and GPs with patients, but is now mandatory. This has not influenced how I record events over the years – I have always regarded the clinic letter as the lasting, true and definitive record of the consultation. Whilst I cannot recall the specific consultation, my clinic letter indicates that I did have open dialogue with Ms KA and informed of her of the risk of infection, how it was likely to have been acquired and the potential dangers of transmission.

11. When imparting information to a patient one must be very careful not to extend beyond one's sphere of knowledge or expertise. Whilst I would have had a working understanding of the basics of Hepatitis C I would certainly not have been in a position to discuss all of the issues/implications in great detail, in particular it would have been improper for me to have covered the benefits or risks of liver biopsy, the treatment options nor the specific day to day practical advice about avoiding viral transmission or the quantitative risk of liver cancer – I simply would not have known this detail well enough. I was a Clinical Haematologist – not a Gastroenterologist or Hepatologist – with no clinical experience of the complexities of Hepatitis C infection and thus I would have been careful not to encroach onto these areas where I could potentially give misinformation. I was obliged to make an urgent referral onto experts in the management of Hepatitis C whose responsibility it would have been to provide definitive practical advice and support, cover the prognosis in detail and arrange the relevant investigations/treatment.

12. At the end of the clinic letter I state that I am referring the patient to Dr Theodossi, Consultant Gastroenterologist at the Mayday. I would have been anticipating that the

Gastroenterology department would have thereafter taken Ms KA under their wings and arranged the ongoing care of her Hepatitis.

13. There are no additional letters from the Mayday included in the witness statement but I do note that Ms KA was due to undergo a liver biopsy on 07/05/1997. Again, I do not have access to the Medical notes but this arrangement indicates that the Gastroenterology department did receive a referral from Haematology, presumably reviewed Ms KA and organised the relevant investigations very promptly. I would not have organised a liver biopsy directly myself. I can only speculate, but it would be unusual if the potential seriousness of the situation was not shared with Ms KA by Gastroenterology if an invasive procedure such as a liver biopsy was organised with Ms KA's consent.

14. Ms KA refers to my second clinic letter addressed to Professor Russell at Nottingham. He was responsible for Ms KA's care regarding her bone marrow transplant in 1988/89. I would have felt obliged to share this new information with Nottingham as I thought the infection dated from the time she was receiving care at their unit and it represented a very serious and regrettable complication of her transplant therapy. Where I have written 'ascertained' I simply meant that we had established positive serology for hepatitis C. I did not mean that there were any new additional results available – it seems I was relaying the same information we had found when screening for the Hepatitis C initially. I note I document in that letter that 'we' (the Mayday) only had scanty details about her past treatment at Nottingham.

15. In paragraph 23 Ms KA states that the infection was not picked up again until 2004. I note Ms KA mentions she was lost to follow up between 1997 and 2004. I am not aware of the reasons Ms KA did not undergo the planned liver biopsy in 1997 nor the specific circumstances surrounding her failed follow up.

16. I left the Mayday in April 1997 – seemingly around the time these events were unfolding. My clinic letter indicates I did share the relevant information with Ms KA but I would concede that I may not have discussed all the implications of her infection in great detail as I would have felt my knowledge base would not permit that. Accordingly, I made a referral to the experts in this area and would have, reasonably, expected them to provide all the specialist support that Ms KA deserved. I note I did make a follow up appointment for Ms KA with Haematology 3 months later. It would also have been my normal practice to have shared this new clinical information

regarding Ms KA with her Haematology Consultant, Dr H Lumley, who would have been responsible for her ongoing haematological care.

17. I cannot provide an explanation for how the issue of the Hepatitis C was not pursued further at the time. It would have been incumbent upon the Gastroenterology department at the Mayday to have arranged follow up. Without access to the notes it is impossible to establish why this failed.

18. It seems from the information available that I had made every effort to ensure the appropriate ongoing care of Ms KA.

19. I am very pleased to hear that Ms KA was subsequently treated and has now managed to clear her Hepatitis C infection.

**Section 3: Other Issues**

20. There are no other matters which I wish to raise.

**Statement of Truth**

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

GRO-C

Signed

Dated: 24/04/2019