Witness Name: Frank Hill

Statement No.: WITN3087001

Exhibits: NOT RELEVANT

Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF FRANK HILL

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 12 April 2019.

I, Frank Hill, will say as follows: -

Section 1: Introduction

1.

Name: Frank Hill

Address for contact: c/o Dr Fiona Reynolds, The Children's Hospital, Steelhouse Lane, Birmingham, B4 6NH

Date of Birth: GRO-C 1943

Professional Qualifications:

MB Ch B (Bristol) 1967
MRCPath (UK) 1975
FRCPath (UK) 1987
FRCPCH (UK) 1997

I retired as a Hospital Consultant Haematologist 11years ago.

My experience in haematology is as follows:

1971-1973 Rotational Registrar in Pathology at the United Oxford Hospitals including 11 months in Laboratory and Adult Haematology and 6 months in Blood Transfusion and Immunopathology.

!973-1976 Lecturer in Haematology (Institute of Child Health) and Honorary Senior Registrar in Haematology, Hospital for Sick Children, Great Ormond Street, London. This provided training in Paediatric Laboratory and all aspects of paediatric Clinical Haematology.

1976-1992 Full-time Consultant Haematologist with 2 sessions at The Queen Elizabeth Hospital, Birmingham - responsibilities included attending a weekly haemostasis and haemophilia clinic. I had no patient admitting rights and the haemophilia patients were under the care of the Professor of Haematology. The remaining 8 sessions were at the Birmingham Children's Hospital where I was responsible for the Haematology Laboratory and had joint responsibility with a Consultant Paediatrician for the Clinical Haematology Service including The Haemophilia Treatment Centre.
In 1992 I became full-time at The Children's Hospital.

Past Memberships:
College of Pathologists, College of Paediatrics, Member British Society of Haematology, Member of The International society of Haemostasis and Thrombosis (I attended conference every alternate year if possible)

Membership of Committees:
I was a member of district and regional haematology committees (1976-1989) including The Transfusion and Haemophilia committees.

1993-2005 Member of Biologicals Subcommittee of the Committee for Safety in Medicine.
Membership of the UK Haemophilia Doctors Organisation and attended the annual meeting from 1976

In 1989 UKHCDO was re-organised and The Children's Hospital became a Comprehensive Care Centre (CCC) and from that time I attended the meetings of CCC directors committee.

I was Chairman of UKHCDO 1999-2005.

Chairman UKHCDO Transfusion transmitted infections working party 2005-2007

Member of DoH group for recombinant products for adult haemophilia patients in England 2003-2006

Member of HPA, UKHCDO and DoH Group for blood product vCJD risks and the patient notification.

Section 2: Criticism of Andrew Evans

1. When I received the initial letter from the Inquiry there were no records attached. I requested the records to try and collect more evidence to inform my replies and was sent 37 pages of notes from ward (haemophilia unit) attendance. Pages 1 and 15 appear to be absent and there were no outpatient notes or laboratory results. I know from my transfer summary dated 26 November 1996 at Exhibit WITN 1213004 that there were 9 volumes of notes at that time and so the notes that I have been provided with are only a very small percentage of the whole.
2. I make this statement with reference to my memory and usual practice at the time. As the events are nearly 40 years ago it is difficult to remember any specific details for which I offer my apologies to Mr Evans and the Inquiry.
3. I would also like to point out that whilst I was the consultant haematologist in charge of Mr Evan's case, he was seen by several other members of the team, including junior doctors and specialist nurses. Some of the entries in the records were made by them. However, I did have overall responsibility for his care.
4. I will answer the questions about the hepatitis, HIV and other viruses separately to the best of my ability from what I can remember.

Hepatitis

5. I recall that when a child was first diagnosed with haemophilia I, or sometimes a member of my team, had a discussion with the parents about treatment with blood products and the risk of potential infection with certain viruses. At that time we could test for Hepatitis B and non-A non-B hepatitis, which was later called hepatitis C. At the time that I was seeing Mr Evans (late 1970's) non A non B hepatitis was thought to be a minor, self-limiting condition with no serious long term consequences. Unfortunately this did not turn out to be the case later on. All parents would have been told that we needed to test for viruses that could cause hepatitis regularly as patients could be asymptomatic and the family needed to be careful if the patient had hepatitis B on testing. Parents gave verbal consent for this screening.
   Blood was also checked for the presence of antibodies against the clotting factors used.
6. Most older children were treated at home but they would come to the haemophilia unit for advice and the routine screening of blood. Patient

reviews were done in the outpatient clinic. The blood tests were organised by the haemophilia specialist nurses. Abnormal results would be acted upon otherwise the parents and patient would be informed of the results at the next regular outpatient appointment.

7. Patients also came to the unit with injuries or illnesses.

HIV testing

8. Blood was routinely stored from patients with haemophilia in case further testing became available later on. I cannot recall whether this was discussed with the parents but it was custom and practice for the virology department to store blood at that time.
9. When HTLV-3 (later called HIV) antibody testing became available in around 1985, it was not known what percentage of patients were affected and whether they would develop disease. At that time heat-treated blood products were just being developed with the hope of reducing the risk of transmission to recipients.
10. I discussed the matter with my consultant colleague in Microbiology. After due consideration of the advice I decided that we should test the stored samples of blood. This was for two reasons, firstly to identify those children that tested positive so that we could offer that knowledge to parents and patients if they wanted it and secondly to identify those patients who were negative for HTLV-3 antibodies as at that time haematologists were discussing whether the use of the expected new heat treated products should be used in the first instance for HTLV-3 antibody negative patients as it was hoped that these new products would reduce the transmission of the virus.
11. I contacted parents of all children who were tested for HTLV-3 antibody in this way and arranged appointments to explain that we had tested the stored samples and asked them if they wished to know the results. If they did wish to know. I would explain the results to them. There would then be a discussion about how and when the patient needed to be told and by whom. I would offer further appointments to have further discussions about this. I would offer appointments to see the patient after disclosure to answer the patient's questions.
12. At the time, I felt I was acting in the best interests of the patients, I felt that worrying them about a test which could have been negative was not in their best interests. If the same situation arose in the present day with the present legal and ethical landscape, I would have done things differently

and would have asked for fully informed consent before testing. I am very sorry if this has caused distress to Mr Evans and his family.

Other Viral Testing

13 As stated above, we routinely checked for viruses that can cause hepatitis. In the event of a patient presenting with jaundice (a symptom of hepatitis) hepatitis B and other causative viruses i.e hepatitis B and EB virus would be tested for by way of antibody testing and CMV by way of complement fixation testing.

14 The samples and request forms would have been sent to the Microbiology department at Birmingham Children's Hospital and then referred on to the Virology department at East Birmingham Hospital. I am not sure why other viruses were tested for at East Birmingham but I have no reason to think that these additional tests were done for research.

Statement of Truth

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

Signed GRO-C

Dated 28th May 2019