Witness Name: Debra Pollard
Statement No.: WITN3094056
Exhibits: WITN3094057-64
Dated: 2023-08-10

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DEBRA ANNE POLLARD

I provide this statement on behalf of The Royal Free London NHS Foundation Trust in response to the notification under Rule 13 of the Inquiry Rules 2006 dated 20 October 2022 and the request under Rule 9 of the Inquiry Rules 2006 dated 10 May 2023.

I, Debra Pollard, will say as follows: -

Section 1: Introduction

1. I am employed by the Royal Free London NHS Foundation Trust ("the Trust") as Lead Nurse Specialist within the Haemophilia and Thrombosis Centre ("the Centre"). I have been in this role since May 2014. Prior to that I worked for the Trust as a Clinical Nurse Specialist since February 1992. I have therefore worked at the Centre for 29 years. I retired from this full time role in October 2020 and returned part time in December 2020. My job title remains Lead Nurse Specialist.

2. As Lead Nurse Specialist, my responsibilities include leading and managing a team of specialist nurses and allied health professionals. I am also responsible, together with the Centre Director, for the strategic development and management of the department. In my role as Lead Nurse Specialist, I have been responsible on a number of occasions for answering questions from the Infected Blood Inquiry ("the Inquiry"). As a result I am aware of some of the issues surrounding the Inquiry and know how to investigate matters arising within our archives and systems.

3. I have been asked to write this witness statement on behalf of the Trust to respond to certain criticisms raised in the witness statement of W5350 dated 4 November 2021, in which she raises criticisms regarding the care her late father received by the Trust.

4. For the purpose of preparing this witness statement I have reviewed the records held by the Trust in relation to W5350's father and provide this statement on the basis of those records. Where matters within this statement are not directly within my own knowledge, I believe them to be true.

5. I attach to this statement exhibits [**WITN3094057-WITN3094064**]. These are extracts from the Trust's records detailing various aspects of W5350's father's care which are relevant to his criticisms.

Section 2: Background Information

6. **W5350's** father was diagnosed with Haemophilia A in February 1971. On 17 January 1977 her father underwent a surgery at The Royal Free Hospital to remove the gallbladder, during the course of which he was treated with Lister Blood Products and Elstree Factor VIII Concentrate.

7. After the surgery, W5350's father's skin became discoloured and he became much less energetic. On 18 July 1977 W5350's father was readmitted to the Royal Free Hospital in order to investigate whether he was suffering from jaundice. On 20 July 1977 W5350's father was diagnosed with Hepatitis B.

8. The Royal Free Hospital launched an investigation into how W5350's father contracted jaundice, including an investigation of W5350's father's car garage for any potential causes. Though there is no written evidence of the results of this investigation into the cause of this, W5350 states that a member of staff at The Royal Free Hospital informed her father verbally.

9. In 1997 W5350's father was admitted to hospital due to difficulties passing urine. Two days after admission, W5350's father was diagnosed with prostate cancer. He continued to attend The Royal Free Hospital for treatment in respect of this, but sadly W5350's father passed away two years and nine months after receiving his

cancer diagnosis. Neither Hepatitis B nor C was listed as a direct cause of W5350 father's death.

Section 3: Response to Criticism of W5350

10. The Inquiry has requested that the Trust respond to the following comments made by W5350:

11. At paragraph 17, W5350 recalls how the gallbladder surgery was performed using a laser knife, and that the surgery was recorded on film. In relation to this, W5350 states:

> "*The laser knife was being flown in for just one day from Israel. Through my personal speculation, the fact, it was for one day only, we now wonder whether the wish to ensure a trouble-free filming of the trial influenced the decisions to include, at a late stage, the use of Factor VIII concentrate, in conjunction with cryoprecipitate. Records show that, in the course of this surgery my father was administered Factored VIII concentrate for the very first time. Please see* ***Exhibit WITN5350002****. This decision was not discussed with my father nor with the family."*

12. While the Trust has not been able to provide evidence as to whether written consent to the use of Factor VIII concentrate, it is likely that a conversation took place about the surgery, including the use of haemostatic products.

13. Similarly, while there is no evidence of a discussion on the relationship between the decision to use a laser knife and the choice of haemostatic products, it is highly unlikely that the former decision influenced the latter.

14. The Trust's treatment record and operation notes indicates that W5350's father received his first dose of Lister/BPL Factor VIII pre-operatively on 17 January 1977, rather than during the course of surgery. Please see **[WITN3094058].**

15. At paragraph 40, W5350 states that there were deficiencies in the level of information provided to her father and their family relating to the management and consequences of W5350's father contracting Hepatitis B and C:

"As a family we believe that significantly greater information should have been provided regarding the implications and management of my father's infected status and the steps that should have been taken to safeguard other members of the family, for example, on one occasion, at Royal Free Hospital, my husband assisted by clearing away my father's congealed blood from a hand basin, using his fingers, only realising that it posed a risk when he saw that the doctor was 'gloved up'. Nothing was said. The doctor did not issue any warning advice."

16. W5350's father did not receive home treatment in respect of his haemophilia and therefore neither W5350's father nor their family would have received training sessions about infection prevention and control in relation to needles, syringes and Factor bottles.

17. There are no records of what information was given specifically to W5350's father, however, I would expect there would have been conversations about hepatitis, safe sex through the use of barrier methods of contraception, and how to safely manage blood spillages at home.

18. Additionally, there is evidence to suggest that W5350's father was having conversations about testing and transmission. For example, during his yearly review on 3 June 1986, there is evidence of a discussion about AIDS, which included discussing Heat Treatment, which suggests that the conversation also covered the safety of clotting factor at that point. The doctor also noted that he was accompanied by Riva Miller, the Centre counsellor and social worker. Please see **[WITN3094060]**.

19. At paragraph 53, W5350 recalls how in 1993 her father and his wife had been tested for HIV and Hepatitis C by The Royal Free Hospital as part of a research project on Hepatitis and HIV transmission via sexual contact. Reflecting on the necessity of the testing, W5350 states:

"It is clear that the testing of my father with my mother in April 1993 for HCV and HIV was purely for research purposes. It was extremely late in the day to have been of any benefit to my mother. By that point she had been at risk of

infection for sixteen years! This was part of the research project mentioned earlier, in relation to the sexual transmission of HIV and HCV. Again, totally inadequate information was given about the implications of these tests which I shall touch on later in my statement."

20. The first tests for hepatitis C were not available until 1991. In a review with Dr Goldman on 10 February 1993, there was a discussion with W5350's father regarding the anti-HCV positivity. Please see **[WITN3094063].** The review documents show, while there was no longer a risk of sexual transmission of Hepatitis from W5350's father to her mother, there had been such a risk in the years after he first contracted Hepatitis. I assume this is why W5350's mother subsequently attended for Hepatitis C testing, and why the two of them had been invited to participate in the sexual transmission study.

21. At paragraph 79, W5350 discusses how her father had been turned away on two occasions from dental appointments at The Royal Free Hospital:

"*He had never been pre-warned of the stigma around Hepatitis and so it came as a shock to him to be turned away at the dental appointments, especially being located at The Royal Free Hospital. I later became aware that the dental practitioners were given a freehand to refuse patients if they wished, and so they did. I think this all links with the fact that Hepatitis patients were ill informed about risk, not only in terms of initial warnings regarding the risks posed by the blood products, but, just as importantly, they lacked the warning that, once infected, they would be perceived as posing a risk to others.*

22. Patients with haemophilia have always been encouraged to regularly attend the dentist as poor gum health is associated with unnecessary bleeding. I am not aware of any patients being refused treatment by The Royal Free Hospital's dental service. At the time, many patients were unable to access their community dentists and were in fact specifically referred to the Royal Free Hospital's dental service as they accepted all patients. I believe there may have been special sessions for those who had Hepatitis or HIV, but not that treatment was refused altogether. Refusing patients altogether because of their positive status was not an acceptable standard of care, and I am deeply sorry if this indeed took place.

23. At paragraph 92, W5350 reflects more generally on the standard of care and information provided to her father and their family, and the level of knowledge held by healthcare providers about the blood products:

> "*I hope very much that, in the future, this type of thing will never happen again; I hope lessons will be learnt. I do find it quite difficult to criticise the doctors because, as mentioned previously, many members of the Royal Free Haemophilia department were first class. However, I do feel that some of my father's doctors were extremely remiss in terms of giving him adequate information and allowing him to make an informed choice. I also feel that they were in a very difficult situation. It is with the benefit of hindsight, but perhaps they had an inkling of what was going on but did not speak up? To me, the crux of the matter wasn't only that they knowingly gave patients blood products that carried the risk of harmful infection, it was that they neglected to warn people of those risks beforehand. Therefore, they did not allow for informed choice. This example of neglect could be construed as negligence*"

24. At the time of W5350 father's first exposure, there was very little known about the risk of transmitting Hepatitis through blood products. The Hepatitis C virus was first discovered in 1989 with the first tests being available in 1990 and 1991. Until then, it was classified as non-A non-B hepatitis and no treatment was available.

25. Since then, I believe that the relationship between clinician and patient has transformed significantly. Now, a much greater emphasis is placed on shared decision making, where patients collaborate with their healthcare professional to reach a joint decision about care through considerations of the risks, benefits and potential consequences of alternative treatment through discussion and information sharing.

Section 3: Other Issues

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26. At paragraphs 10-11, W5350 refers to a serious haemorrhage suffered by her father in 1964 at Chase Farm Hospital. It was only on 11 February 1971, following referral to The Royal Free Hospital and registration under the care of Dr Katherine Dormandy that W5350's father was diagnosed with Haemophilia.

27. There are no available records of the admission to Chase Farm Hospital in 1964, so I am unable to comment on neither the interpretation of test results nor the delay leading up to W5350 father's referral to Dr Dormandy at The Royal Free Hospital in 1971. There is evidence available of his original testing at the Royal Free Hospital following his referral. Please see **[WITN3094057]**.

28. In 1964, Haemophilia Centres did not exist in the way they are known today. Dr Dormandy was considered a pioneer in Haemophilia care in 1964 when she moved from Great Ormond Street Hospital to set up a service at the Lawn Road Hospital in 1964, transferring 4 patients from Great Ormond Street Hospital. I include this information for context as to the standard of care at that time.

29. The current international classification of Haemophilia would place W5350's father as "Moderate Haemophilia A", the range for moderate Haemophilia being >1iu/dl (1%) - <5iu/dl (5%) (see Blanchette *et al* 2014), however there have been changes of the classification over the years (see Preston *et al* 2004).

30. At paragraph 27, W5350 comments on the enquiries made by The Royal Free Hospital into whether her father may have contracted Hepatitis while working in his garage, stating that:

> "*It seemed to us absolutely ludicrous that, having used the same products for the past thirty years in the course of his business, they could be to blame. Nothing was found and eventually he was told that contaminated blood products were to blame for the infection. It seemed that the hospital was almost disappointed to not find my father's garage to be the cause. My father was very relieved that it was not linked to anything from the garage, as he wished to continue working in order to support the family financially and he also loved his work. With hindsight, the investigations were a very thorough attempt to exonerate the infected blood products. I have seen entries within my father's medical notes, detailing the thoroughness of the investigation.*"

31. It is clear that during W5350's father's admission a number of causes for jaundice were investigated. This included Mr Lewis assuming that the cause could be obstruction. However, the most likely explanation would have been Hepatitis related to blood products.

32. Based on the results available in the records, W5350's father was tested for Hepatitis B on a number of occasions. However, the results of the Hepatitis B antigen test were initially reported as negative on 19 July 1977, 3 August 1977 and 8 August 1977. A subsequent letter from the Haemophilia registrar Dr Ruth Warwick to the GP states that by the "radio immune assay" the result was positive after all. Please see **[WITN3094059]**.

33. I have also found a reference during the admission from 8 July 1977 to "*inhalation of cellulose paint*". It appears from the records that this was considered as a possible cause of the jaundice as it is referred to as potentially hepatotoxic, and on 18 July 1977 they had investigated the contents of the paint, which I must assume was when somebody had visited the garage. Although the blood products were a likely cause there was enough reason given the history prior to admission to investigate another cause, as there are many reasons for someone to have acute Hepatitis. Please see **[WITN3094059]**.

34. Although it can be assumed that he contracted Hepatitis C at the same time, it was not a known virus at this point and was referred to as non-A non-B Hepatitis.

35. At paragraph 31, W5350 states, having reviewed her father's medical records, that the following infected blood products were used during the gallbladder surgery:

> "*'Lister Blood Products' administered from 17 to 25 January 1977, please see a record of this at* ***Exhibit WITN5350007****. 23655 units of 'Elstree Factor VIII concentrate' with batch numbers: 8CRV857, 8CRV858, HJ1209 and 1232 administered from 20 January 1977 to 31 January 1977, please see a record of this at* ***Exhibit WITN5350008***"

36. Please see **[WITN3094058]** for documentation of the blood products given to W5350's father pre-operatively and post-operatively.

37. At paragraph 34, W5350 refers to **Exhibit WITN5350009**, which is handwritten note by Dr P Kernoff stating that "*as of 01/09/85, this patient should not normally be treated with Factor VIII* concentrate", and directs any decision on use to "*a senior member of staff*". I can confirm that **Exhibit WITN5350009** is typical of handwritten notes by Dr Kernoff in treatment records of the time.

38. It is believed the direction from Dr Kernoff was because W5350's father had been found to be HIV negative, and that by this stage British Blood Products were heat treated and considered safe from HIV. The plasma used in "commercial" blood products was sourced from the United States and were considered a greater HIV transmission risk at this time.

39. The "senior member of staff" would have been the Haemophilia Centre Consultant on call. The Consultant would have been familiar with the patient and aware of the issues relating to blood products at the time. In 1985 this would have been Dr Kernoff, Dr Christine Lee or Dr Eleanor Goldman. Patients attending in an emergency would have initially been assessed by junior medical staff unfamiliar with the products.

40. At paragraph 37, W5350 states that she believes that no discussions took place between neither her father nor her family and the healthcare team regarding the risks associated with receiving Factor VIII concentrate. While there is no record of such discussions taking place, the risk of Hepatitis transmission was not as well-understood as it is now.

41. At paragraph 38, W5350 states that:

> "*Little or no information was given regarding the actual infection but rather the emphasis was on looking for sources of infection, other than the blood products. There was a lot of conversation about other sources, which were disproved, as mentioned previously.*"

42. As discussed previously, a number of causes were being investigated at the time. This included the inhalation of potentially hepatotoxic cellulose paint during the course of W5350's father work at his car garage, which was considered in the records to have been a possible cause of the jaundice. Please see **[WITN3094059]**.

43. At paragraph 44, W5350 reflects on how she had been informed by The Royal Free Hospital about W5350's father's cancer diagnosis over the phone. On 5 February 1998, the haematology registrar who was co-ordinating W5350's father's care as the emergence of the cancer diagnosis and revised prognosis became clear wrote

in the medical record to "discuss with daughter at work so she knows." Please see **[WITN3094063].**

44. I agree with W5350 that this is an unacceptable way to inform her family about such sensitive news. I would expect family members to be called in for a face-to-face discussion with a senior member of the team in these circumstances, and I am very sorry for the distress this must have caused W5350and her family.

45. At paragraphs 51-52, W5350 states that she does not believe W5350's father was provided with sufficient information about the use of Factor VIII concentrate in the course of his gallbladder surgery, nor on the use of a clotting factor other than cryoprecipitate. Consequently, W5350 states that her father did not have the opportunity to make an informed decision and provide informed consent to the use of Factor VIII concentrate.

46. Our records indicate that W5350's father consented to the surgery. However, there is no evidence of discussion about any risks associated with the use of either cryoprecipitate or Factor VIII concentrate. As discussed previously, the risks of transmission of Hepatitis through contaminated blood products was not as well understood then as it is today.

47. At paragraph 62, W5350 discusses how in 1997 her parents were invited by the Royal Free Hospital to participate in a research project on Hepatitis and HIV transmission via sexual contact. She discusses how neither of their parents fully understood that there was a risk of transmission of Hepatitis through sexual contact after her father first contracted Hepatitis, nor the implications of being tested for HIV.

48. As discussed above, there is evidence to suggest that W5350's father was having conversations about testing and transmission. This included during his yearly review on 3 June 1986, where W5350's father had discussed Heat Treatment, which suggested that conversations involved discussions about the safety of clotting factor. Please see **[WITN3094062]**.

49. At paragraphs 73-74, W5350 discusses how her father did not receive treatment for Hepatitis B or C, and that they were not aware of any treatment for Hepatitis C.

50. Initially, tests for Hepatitis C in 1991 were only antibody tests. W5350's father tested positive for Hepatitis C, which indicated that at some point W5350's father had been in contact with Hepatitis C. Later, PCR tests became available. This test is able to determine the level of Hepatitis C in the blood and the extent of viral activity. This test result was consistently negative and why W5350's father was considered to have been naturally cleared of Hepatitis C. This is documented in his annual reviews, and in his clinic letters which followed. As W5350's father had cleared the virus and had normal liver function test results, treatment of any kind was not needed for Hepatitis. Please see **[WITN3094064].**

51. At paragraph 82, W5350 states that she was invited to participate in a research project on testing for Haemophilia in women, and to attend a lecture at the Royal Free Hospital on family planning for Haemophilia carriers. W5350 reflects on how, despite her family being frequently invited to participate in research or attend lectures, she had never been invited to any such lectures on Hepatitis in relation to her father .

52. The Royal Free Haemophilia Centre took a prominent role nationally and internationally in the investigation of Hepatitis and HIV infections. Members of the team at the time were involved in giving public lectures through the Haemophilia Society and wrote about Hepatitis and HIV in the Haemophilia Society's magazine. We are not aware that at any time the staff at The Royal Free Hospital were told to conceal, suppress, or downplay the risks posed by W5350's father contracting Hepatitis.

53. At paragraph 83, W5350 states that neither her father nor her family were offered any psychological support following her father's Hepatitis diagnosis. Our records indicate that W5350's father was seen by Riva Miller, the Centre's social worker and counsellor, during his medical reviews.

54. At paragraph 84, W5350 states that her father was never provided a dietary plan in relation to Hepatitis C. This would be because there are no dietary plans for the treatment or management of Hepatitis C.

55. At paragraph 85, W5350 states that she believes that "there is a lack of training for doctors in regards to empathising with patients." As stated earlier in my statement, I

agree that the standards of communication between W5350's father, his family, and the healthcare professionals working on his treatment was inappropriate at times. Training provided to healthcare professionals in recent times has included a much greater focus on the provision of psychological and emotional support to patients.

56. At paragraph 86, W5350 states that her father was invited by the Haemophilia Society to attend a Hepatitis C information evening on 8 December 1999. There were events held at the Royal Free Hospital, but I do not have any record indicating whether or not W5350's father was invited, especially as by the time full tests of viral load/activity (PCR tests) became available in the mid-1990s, W5350's father was found to be testing negative.

57. At paragraph 90, W5350 discusses the collection of her father 's medical records she received following her engagement with the Infected Blood Inquiry. She notes that the section of the record relating to the period of time during which her father was treated with contaminated Factor VIII had been torn away, and made available to the inquiry at **Exhibit WITN5350012**

58. I agree that the page exhibited has been torn. This is a cumulative handwritten record and those results would have been filed in the notes in their original form. The results are of clotting factor assays, which measure Factor VIII levels before and after treatment. Other clotting results are also recorded. What remains on the right hand side of the page are 3 negative/negative results and the rest are blank. This suggests Factor VIII inhibitor tests took place before and after treatment. There are some other numbers in the final visible column which appear to be similar to those in column 3 (dose/units). This suggests a local haemostatis laboratory comparison of the units stated on the bottle of Factor VIII, and what was actually found to be present or calculated based on the Factor VIII levels in the blood.

59. I have not found any evidence of the Royal Free Hospital's Haemophilia patients' notes being deliberately destroyed. All notes were kept, even though there was no legal requirement. I believe that the damage caused to the record was accidental.

60. At paragraph 91, W5350 states that hospital staff did not provide her father with any information about financial assistance available to him following his diagnosis of Hepatitis.

61. All patients who were Hepatitis positive were told when the Skipton Fund was announced in 2003, and the Centre supported patients in their application. Sadly, W5350's father passed away before the Skipton Fund was announced, and before the first payments under the Fund were made in 2004.

Statement of Truth

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

Signed GRO-C

Dated 10th August 2023

Table of exhibits:

Notes/ Description	Exhibit number
W5350 father's original testing results at Haemophilia Centre, Royal Free Hospital	WITN3094057
Royal Free Hospital Trust treatment record and operation notes	WITN3094058
Bundle including letter from registrar Dr Ruth Warwick to W5350 father's GP	WITN3094059
Doctor's notes dated June-July 1986	WITN3094060
Doctor's notes dated Feb-1998	WITN3094061
W5350 father's yearly review notes dated 3 June 1986	WITN3094062
W5350 father's review with Dr	WITN3094063

Goldman on 10 February 1993	
Results showing W5350 father's cleared the virus and had normal liver function test	WITN3094064