Witness Name: Debra Anne Pollard
Statement No. WITN3094129
Exhibit No. WITN3094130-32

WITNESS STATEMENT OF
DEBRA ANNE POLLARD

1. I, Debra Anne Pollard of the Royal Free London NHS Foundation Trust, Pond Street, London, NW3 2QG, will say as follows:

2. I am employed by the Royal Free London NHS Foundation Trust (the Trust) as a Lead Nurse Specialist within the Haemophilia & Thrombosis Centre. I have worked for the Trust as a Clinical Nurse Specialist from February 1992 taking up my role as Lead Nurse Specialist from May 2014. I have therefore worked at the Centre for 31 years. I retired from this full time role in October 2020 and returned to work part time in December 2020. My job title remains Lead Nurse Specialist.

3. The information provided within this witness statement is based upon facts within my knowledge, save for where I indicate the source of information or belief. Where matters are not directly within my knowledge, I believe them to be true.

4. As the Lead Nurse Specialist, my responsibilities included leading and managing a team of specialist nurses and allied health professionals. I was 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. 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.

Scope of this witness statement

5. I have been asked to write this witness statement on behalf of the Trust to respond to matters raised within the witness statement, WITN4653001, dated 30 September 2020, specifically the criticisms in her witness statement at paragraphs 12, 14, 15 and 16.

6. I set out below the criticism and then my comments as follows:

Response to criticism at paragraph 12 of witness W4653's statement which states: "Later, in 2010 and following a review by the Royal Free, Professor Tuddenham confirmed that I had never actually been exposed to vCJD. This was yet another mistake for which the Royal Free apologised."

7. In order to respond to this criticism I set out first some background to the criticism before responding to it. In September 2004 all patients with inherited bleeding disorders who received UK sourced pooled factor concentrates between 1980-2001 were classified as at risk of vCJD for public health purposes. In England and Wales the Chair of the UKHCDO (United Kingdom Haemophilia Centre Doctors Organisation) wrote to all Haemophilia Centres informing them that all patients must be identified and notified. Witness W4653's parents were notified that their daughter was at risk, because she was a Von Willebrand disease "VWD" patient who it was believed had received UK sourced pooled factor concentrates and some donors whose blood was used to make concentrate could have been infected with vCJD.

8. One of the precautions taken to address this risk, was that Bio Products Laboratory, (BPL) who prepared pooled factor concentrate for use in the United Kingdom changed the manufacture of plasma from United Kingdom blood products to blood from the United States. BPL calculated that 2001 was the last possible expiry date of any products manufactured from UK sourced blood products. All patients with bleeding disorders, who had been treated with UK sourced plasma products between 1980 and 2001 were considered to be at risk of vCJD, which is the reason why such patients were placed on a register.

9. All of the US sourced pooled factor concentrate supplied by BPL had batch numbers starting with four letters and ending in an "N".

10. On 3 March 2010, witness W4653 attended the haemophilia centre for a pharmacokinetic study of factor VIII concentrate. In the course of reviewing the medical notes for past treatment I noticed that witness W4653 may been wrongly identified as being at risk of vCJD for public health purposes. This is because I had noticed that witness W4653 had in the past only been given a pooled factor concentrate product called 8Y. BPL makes this product in the UK, but sources its blood solely from the United States, using the batch number "N"

11. Further investigation was carried out and BPL were contacted to confirm my suspicion that witness W4653 had only ever received "N" batch products manufactured from US blood products. These further investigations confirmed that witness W4653 had been wrongly identified as being at risk of vCJD.

12. It was ascertained from witness W4653's parents that they had never informed their daughter that she was at risk of vCJD, because they did not wish to advise her that she was at risk until she became an adult. Witness W4653 alludes to this at paragraph 28 of her statement dated 30 September 2020. Therefore, because witness W4653 was a child at the time it was discovered that she was not at risk of vCJD, an apology was sent to her father by Professor Tuddenham, who was at the time Director of the Haemophilia Centre for the fact that witness W4653's parents had wrongly been informed she was at risk of vCJD. Both I and Professor Tuddenham also met with witness W4653's parents on the 4th March 2010 to discuss the events which led to Tiffany being wrongly classified as at risk of vCJD.

13. As a result, warning labels applied to witness W4653's medical records were removed, the vCJD risk flag was also removed from her computerised clinical records and her name was removed from the UK at risk register.

14. In addition a letter dated 1 April 2010 was sent by Professor Tuddenham to witness W4653's GP and a copy of that letter is attached to this statement as exhibit WITN3094030.

15. On behalf of the Royal Free London NHS Foundation Trust I take this further opportunity to apologise to witness W4653 and her parents for distress and anxiety caused by mistakenly advising that she was at risk of developing vCJD.

Response to criticisms at paragraphs 14 a) b) c) and d) and paragraph 22 regarding testing of blood samples dated 1 July 1993, 4 August 1993, 9 February 1999 and 14 February 2007 without witness W4653 or her parents' knowledge or consent.

16. I note that at paragraph 14 a) of witness W4653's statement a criticism is made that her blood sample dated 1 July 1993 was tested on 4 August 1993 to see if her HBV vaccination had been effective. At paragraph 14 b), c) and d) she complains that blood samples taken on 1 July 1993, 9 February 1999 and 14 February 2007 were tested for HIV and Hepatitis without her or her parents' knowledge or consent.

17. I note that the Trust responded to the fact that this testing was carried out without consent in a letter from Rebecca Longmate, Director of Nursing at the Royal Free London NHS Foundation Trust dated 5 March 2020, a copy of which is appended to this statement at exhibit WITN3094031 Further questions were raised by witness W4653's father following receipt of that letter and the Trust responded to those further questions in a letter to witness W4653's father dated 5 March 2020. A copy of that letter is exhibited to witness W4653's statement as exhibit WITN4653002.

18. In the letter of the 15 April 2020 the Trust explained that it was likely that consent was obtained to take blood on 1 July and 4 August 1993, because witness W4653 would have been 1 year old, and similarly consent to take blood would likely have been given on 9 February 1999 when witness W4653 was 6 years old. This is because witness W4653 would have been attending the haematology centre with her mother who likely consented to blood being taken. Similarly in the letter of the 15 April 2020 it was submitted that consent to take a blood sample would likely have been given on 14 February 2007 when witness W4653 would have been 14 years old and was likely to be able to give consent on her own behalf.

19. However, following review of witness W4653's medical records, no evidence was found that consent had been given by witness W4653's parents for the blood samples taken on 1 July, 4 August 1993 or 9 February 1999 to be tested for HAV, HCV or HIV. Similarly, no evidence was found in the records that on 14 February 2007 consent was obtained from either witness W4653, who at 14 years old may have been mature enough to give her consent, or her parents, for the blood sample taken on that date to be tested for HAV, HIV or HCV.

20. I note that the Trust apologised that consent should have been obtained but was not in the letter from Rebecca Longmate to witness W4653's father dated 5 March 2020. On behalf of the Trust, I reiterate that apology and apologise for any distress caused to witness W4653 or her parents.

Response to criticism at paragraph 15 which states "It can be seen from the Royal Free's letter that they accept that these tests were undertaken without consent but they have refused to tell me who ordered the tests or what reason there was for them being undertaken."

21. I note that witness W4653 has vWD. I confirm that testing of patients with vWD and other inherited bleeding disorders for hepatitis viruses and HIV was standard practice. This was part of a safety initiative introduced because there was a history in those with inherited bleeding disorders of exposure to and contamination with viral infections in contaminated blood products through the 1970s and 1980s.

22. In terms of who ordered the tests, the records for the relevant periods when blood tests were taken on 1 July and 4 August 1993, 9 February 1999 and 14 February 2007 have been reviewed. It has not been possible to identify who requested the testing. The relevant doctor is very likely to have left the Trust given the length of time ago the tests were requested.

Response to criticism at paragraph 30 which states *"As to testing me without consent, I didn't find out about this until recently and I don't understand the reasons for it. At the time I was being tested the products being given to me were heat treated and (I believe) high purity so I can't see why there was any need to do it unless they thought I would become infected with HCV through my dad but even then, that doesn't explain why I was tested for HIV."*

23. Whilst the introduction of heat treating of blood products was effective in purifying them, the practice of testing blood samples for HAV, HCV and HIV continued. It is difficult now to comment on the reason for this, but testing continued probably because it had been standard practice. Due to the passage of time I am not able to confirm when the practice of testing patients' blood samples stopped.

Response to criticism at paragraph 16 which states "*The tests that were carried out on 14 February 2007 are particularly interesting because they were carried out the same day that the Royal Free realised that my Dad was HCV position. My own view is that, as a result of this realisation, they tested me again to see if I had been infected – I do not think that this was a valid reason to test me but even if it was, it was done without my (or my parents') consent which is clearly wrong."*

24. Due to the passage of time I regret it is not possible to state with certainty why blood was taken for testing on the 14 February 2007. The test result of the sample taken on the 14 February 2007, a copy of which is attached as exhibit WITN3094032 only states under clinical details *"VWD on alphanate 6 monthly review"*.

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

Signed…  …….

Debra Anne Pollard

Date…18th December 2023