Witness Name: Dr Patricia Hewitt
Statement No.: WITN3101002
Exhibits: NIL
Dated: 4 June 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PATRICIA HEWITT

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 01 May 2019, but only received on 3 June 2019.

I, Patricia Hewitt, will say as follows: -

Section 1: Introduction

1. **Name**: Dr Patricia Hewitt
   Address: NHSBT Colindale Centre, Charcot Road, Colindale, London NW9 5BG
   DOB: GRO-C 1951
   Qualifications: M.B., Ch.B., 1975, Fellow of the Royal College of Physicians (England) and Fellow of the Royal College of Pathologists.

Positions held as a Consultant and Roles and Responsibilities

2. I was appointed to a Consultant Haematologist post at the (then) North London Blood Transfusion Centre (NLBTC) in 1984. NLBTC was one of 14 Regional Blood Transfusion Centres which together made up the National Blood Transfusion Service. I occupied a role in charge of donor health and blood collection. One of my first responsibilities was to implement within NLBTC the Confidential Unit Exclusion (CUE) questionnaire, based on one in operation at the New York Blood Centre, designed to encourage blood donors at risk of HIV infection to confidentially indicate to the blood service that their blood donation should not be used. In 1985, on introduction of HIV screening of blood donations, I managed the HIV lookback programme for NLBTC, which covered the area of central and north west London and the Home Counties.

3. Subsequently, I was Lead Consultant in Transfusion Microbiology for the London and South East Zone of the National Blood Service (NBS) from 1995 to 2000, and National Lead Consultant in Transfusion Microbiology from 2000 to 2005. In these positions, I managed the HCV lookback programme for NLBTC (1995) and the national HTLV lookback programme (2002). I contributed, with colleagues, to a submission to the Department of Health proposing a cost-effective method for the introduction of screening of blood donations for Human T-cell Lymphotropic Virus 1 (HTLV 1). I also was Principal Investigator, with Professor Robert Will of the National CJD Research and Surveillance Unit, of a research project (the Transfusion Medicine Epidemiology Review [TMER]) which commenced in 1997 and was designed to investigate whether there was any link between blood transfusion and vCJD.

4. After formation of the National Blood Authority (NBA) and then the current organisation NHS Blood and Transplant (NHSBT), I retained the National (clinical) lead role for Transfusion Microbiology until my retirement from full time employment in June 2018. I continued in the work of the TMER, and also contributed to a study (2012/2013) looking at the blood safety implications of hepatitis E virus (HEV). The results of this study led to the introduction of HEV screening of blood donations.

5. The National (clinical) lead role for Transfusion Microbiology involved overall responsibility for the management of blood donors who were found through the routine screening of blood donations to be infected with blood-borne infections, and overall responsibility for managing reported cases of possible transfusion-transmitted infection. In addition, I was required to ensure that clinical matters relating to transfusion microbiology were represented in any relevant NHSBT initiatives and projects.

6. Prior to my employment with NHSBT and its predecessor organisations, I was employed as a Lecturer in Haematology at Middlesex Hospital Medical School, and was involved in treatment of patients with a variety of Haematological disorders, including clotting disorders.

7. I am now retained by NHSBT to provide occasional assistance and advice as and when required.

Membership of past or present Committees/groups relevant to the Inquiry's Terms of Reference.

- JPAC (Joint UK Blood Transfusion and Tissue Transplantation Services) Specialist Advisory Committee on Care and Selection of Donors
- JPAC Specialist Advisory Committee on Transfusion Transmitted Infection
- UK Blood Services Prion Assay Working Group
- Serious Hazards of Transfusion (SHOT) Steering Group
- CJD Clinical Incidents Panel
- ACDP (The Advisory Committee on Dangerous Pathogens) Transmissible Spongiform Encephalopathy (TSE) Risk Assessment Working Group
- ACDP TSE Risk Management Working Group
- ACDP TSE Sub Group
- Council of Europe Committee of Experts on Blood Transfusion and Immunohaematology
- English Infected Blood Support Scheme (EIBSS) Appeal Panel

Section 2: Response to criticism of Peter Buckland

8. I do not have access to any relevant documents which may exist given the short time available to me and so make this statement from my recollection of events and general knowledge of these matters by virtue of my various roles and responsibilities set out above.

9. I met with Mr Peter Buckland in 2006, as set out in his statement. This was in my role as national clinical lead for Transfusion Microbiology in NHS Blood and Transplant (NHSBT). I am not, and was not, "Head of the National Transfusion Service". I had knowledge of Mark Buckland's case because of the work that I had carried out with the National CJD Research and Surveillance Unit, as described in Section 1 under "Roles and Responsibilities". The purpose of the 2006 meeting was to give a full account of the events which had led to the identification in 2000 of Mark Buckland as the recipient of a blood transfusion in 1997 which originated from a blood donor who was diagnosed with vCJD in 2000. It was my normal practice to offer a meeting with an individual (and/or family) when it had been determined that an infection had been unfortunately transmitted through a blood transfusion.

10. I do not believe that I told Mr Buckland that "they knew Mark was going to die". That is not language which I would use, but in any event, it was not known in 2000, and still remains unknown, whether it was inevitable that people who have received a blood transfusion originating from a blood donor who later developed vCJD will themselves develop vCJD. I am aware of cases where a person who has received blood originating from a blood donor who later developed vCJD has not to date developed any signs of vCJD, many years after the blood transfusion. I could not, therefore, have predicted that Mark Buckland would die, at least up to the point when a diagnosis of vCJD was made some 3-4 years after we first had knowledge about his exposure through blood transfusion.

11. I also did not state that Mark was not told because of a fear of suicide. I note that Mr Buckland has used the same form of words in paragraph 35 in relation to the "Research Committee" taking a decision not to tell Mark. As is made clear in the letter from Caroline Flint, responding to a letter from HM Coroner to Patricia Hewitt, Secretary of State for Health, the initial decision as to whether to inform recipients of blood from a donor later found to have vCJD was made by the Department of Health. The CJD Clinical Incidents Panel subsequently recommended that individuals should be informed, but that appropriate support measures should be made available in case of psychological harm. I expect that I would have explained this aspect to Mr Buckland, but I am certain that I did not suggest that there was a fear of suicide in his, or any other, case.

12. I would also at the meeting in 2006 have explained to Mr Buckland the legal implications of transmission of infection through blood transfusion. This was my routine practice. Although there was no precedent for vCJD, product liability legislation, in the form of the Consumer Protection Act, had been used to bring successful claims against NHSBT for transmission of infection through blood transfusion, and I would have explained this to Mr Buckland. I am aware that a successful claim was made.

13. I think it is important that I comment on paragraph 50 in Mr Buckland's statement. This states that "Mark had been tested and the results made it obvious that he had been donated vCJD and they knew he was at risk of contracting the disease. This was in 2000". I believe this may be a misprint, since in 2000 Mark was unaware that he was at risk of vCJD, and no testing could have been carried out on him at this

stage. It is true that it was recognised in 2000 that he was at risk of developing vCJD, since the blood donor had recently been diagnosed with vCJD.

14. I would like to make two further points.

i. To avoid any confusion, the Secretary of State for Health from May 2005 until June 2007 was Patricia Hewitt (not Hewett as spelt in paragraph 8 of Mr Buckland's statement). Although we share the same name, we are two different people.

ii. Although I anticipate providing further information to the Inquiry at the appropriate stage, it is important from the point of view of public confidence in the UK Blood Services that I address some of the points made in paragraph 33 of Mr Buckland's statement. I have no knowledge of the court case referred to in this paragraph, but it is important that I emphasise that blood donors are assured anonymity, and their names would never be revealed; to a recipient of their blood, to any other person, or made public in a court of law. I cannot therefore understand how or when the sister of a blood donor could have been questioned about the blood donor or any connection made with any recipient of that donor's blood. I have no recollection that the donor in this case was a vegan, or even a vegetarian. I believe I would have been made aware if this was the case. This fact could only be confirmed by referring to the detailed dietary questionnaire on this donor, held at the National CJD Research and Surveillance Unit. I can also state with absolute confidence that: there has never been any case of transmission of vCJD from one person through blood transfusion to a second person who has also then passed it on through blood transfusion.

Section 3: Other Issues

15. I have sought to deal above, in I hope appropriate detail, with the specific matters raised in the Rule 9 Request. As will have been seen I have, given the invitation in the Rule 9 Request to set out other pertinent matters if they arise, sought also to deal with other related matters which seem likely to be relevant. I recognise of course that there will be other areas where I may be able to assist the Inquiry, because of my roles and responsibilities within NHSBT up to the time of my retirement, as specified

in Section 2 of this statement. If so, I look forward to being able to assist the Inquiry further.

Statement of Truth

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

Signed GRO-C

Dated 4th June 2019