Witness Name: Dr Patricia Hewitt
Statement No.: WITN3101019
Exhibits: Nil
Dated: 13th December 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PATRICIA HEWITT

I provide this statement in response to the request under Rule 9 of the Inquiry Rules 2006 dated 24 November 2023.

I, Dr Patricia Hewitt, will say as follows: -

Section 1: Introduction

1. My name is Dr Patricia Elizabeth Hewitt. My date of birth is in 1951 and is known to the Inquiry. My professional qualifications are MB ChB (Leeds), FRCP, FRCPath. I trained in medicine at Leeds University and qualified in 1975.

2. My employment history is set out in previous statements to the Inquiry, including my statement of 25 October 2021 [WITN3101006]. Relevant to this request is that I was appointed as a Consultant Haematologist at the (then) North London Blood Transfusion Centre in 1984. In 1985 on the introduction of screening blood donations for HIV, I managed the HIV lookback programme for NLBTC.

3. I was subsequently the Lead Consultant in Transfusion Microbiology for the London and South East Zone of the National Blood Service from 1995 to 2000

and from 2000 to 2005 I was National Lead Consultant in Transfusion Microbiology. I continued in that role for NHSBT until my retirement from full-time employment in 2018.

4. My role involved overall responsibility for the management of donors who were found through screening to have blood-borne infections and overall responsibility for managing investigation of reported cases of possible transfusion-transmitted infection.

Section 2: Responses to criticism by Witness W2768

5. I have been able to access the North London Blood Transfusion Centre investigation file for the witness's son, with the witness's consent, for which I am grateful.

6. My involvement in the investigation of transfusions to the son of W2768 began in September 1987, when Dr V Chowdhury, of the Haematology Department at Hammersmith Hospital, wrote to me to report that a patient, who had been an in-patient at the hospital in 1983 while undergoing a bone marrow transplant procedure, had been diagnosed with HIV infection by his local hospital in Wales.

7. The blood supply to the North West Thames Regional Health Authority, which included Hammersmith Hospital, was the responsibility of the North London Blood Transfusion Centre. I would like to make clear that the son of W2768 was never under my care, and that I did not commence employment with the North London Blood Transfusion Centre until June 1984. I therefore had no personal involvement in the events of 1983. My role at the Transfusion Centre included responsibility for the investigation of cases where transfusion with blood components provided by the North London Blood Transfusion Centre could have been responsible for transmission of infection; in this case HIV. This is why Dr Chowdhury reported the case to me in 1987.

8. It is clear from the letter provided with the witness statement that W2768's son had originally been treated in Wales, at Singleton Hospital, for acute leukaemia, and whilst there had undergone red cell and platelet transfusions. He was then referred to Hammersmith Hospital for a bone marrow transplant procedure, where he underwent further red cell and platelet transfusions. The platelet transfusions, in particular, had been extensive and over a prolonged period. As it was suspected that the HIV infection had been transmitted through transfusion, clinicians at Singleton Hospital reported the case to their local blood centre for investigation of the blood components supplied in Wales, and also reported the case to the clinicians at the Hammersmith Hospital, so that the blood components supplied in London could also be investigated. Dr Chowdhury therefore reported the case to me, and I initiated an investigation.

9. It is important to understand that W2768's son's HIV infection was diagnosed in 1987, but the transfusions had taken place in 1983. The clinicians at the Hammersmith Hospital traced the transfusion records and established that there had been extensive red cell and platelet transfusions in that hospital. It is also clear to me from Dr Chowdhury's letter that blood samples had been obtained from W2768's son during the period of treatment at Hammersmith Hospital in 1983 and had been retained in archive storage in the laboratory there. This was good practice, in case the samples were needed at a later date for further investigation, as in this case.

10. When notified of the HIV diagnosis in 1987, the clinicians at Hammersmith Hospital arranged for these samples from 1983 to be recovered from storage and tested retrospectively for evidence of HIV infection. This testing was an attempt to pinpoint the possible date in 1983 when infection was acquired, so that the number of blood components requiring investigation could be narrowed down.

11. The testing revealed that, retrospectively, the case tested HIV negative on samples obtained in February, March and April 1983, but positive on a sample dated 10 October 1983. Blood components transfused after that date

therefore did not require investigation. Unfortunately, the majority of the transfusions took place before October 1983, so the retrospective testing did not reduce the number of components requiring investigation by a significant amount.

12. As there was no HIV test available to test the donations in 1983, the investigation in 1987 commenced with tracing the records of all 309 donors of the 1983 donations. It was then possible to establish how many of those donors had been tested for evidence of HIV infection on a subsequent blood donation, made after October 1985, when HIV screening of blood donations was introduced. This allowed the elimination of a proportion of donors, whose HIV status was known to be negative.

13. It is important to note that if any donor had been subsequently identified as HIV positive, a lookback investigation would have already taken place, to identify previous donations made before the commencement of HIV testing, and to trace, and arrange notification, of the recipients of any untested blood components originating from that donor.

14. Unfortunately, the number of blood components transfused to the patient in 1983 was so large that it was impossible to investigate completely. There were a number of donors whose records could not be traced. There were also a number of donors whose records were traced but who had lapsed from donation before the commencement of HIV screening of blood donations, and whose HIV status was therefore unknown to the blood centre. The transfusions took place very early in the course of HIV in the UK, before the commencement of screening of blood donations for HIV infection in October 1985, and also before the institution of donor education and encouragement of self-exclusion from donation of individuals who recognised themselves at risk of HIV infection, which commenced in September 1983.

15. This was therefore the highest risk period for transmission of HIV infection through transfusion, although such transmission was still rare. Some of the donors involved could have subsequently, after September 1983, self-

excluded themselves from donation because they recognised themselves as at risk of HIV infection.

16. Because of the difficulty in tracing all records, I decided to concentrate the investigation on any male donor for whom records had been traced and whose HIV status was unknown because there was no donation made after October 1985. There were 7 donors in this category, and they were all contacted by letter and asked to contact the blood centre. Three of these individuals responded and provided blood samples for testing. All were HIV negative.

17. The remaining 4 individuals did not respond to the communication. At that time, the only means of communicating with donors was by letter to the last recorded address held on the blood centre records. There was no facility to trace individuals by other means, such as through NHS records, a facility which became available at a much later date and made a huge difference to the ability to trace individuals who had moved house and changed address.

18. It was thus not possible in 1987 to investigate these individuals any further, other than to note that any, or none of them, might have ceased blood donation because they recognised themselves as at risk of HIV infection.

19. The final conclusion of the investigation was that exhaustive investigation had proved impossible, but that HIV transmission by transfusion was highly likely, given the time period involved, which was early in the course of HIV infection in the UK, and pre-dated any measures taken to reduce the risk of HIV transmission through blood components. As the number of HIV infections was higher in London and the south east than elsewhere in England and Wales, it was also likely that the infection had been transmitted during the period when treatment was taking place at Hammersmith Hospital.

Section 3: Other Issues

20. Any case of transmission of HIV infection through transfusion is a matter of deep regret, and measures taken from September 1983 onwards were highly effective in reducing the risk of such transmission, even before HIV testing became available in October 1985. This is, however, no comfort to the witness, or to the small number who were infected through transfusion, and their families, and I deeply regret that such transmission occurred.

21. I am also very sorry that, despite extensive work, we were unable to reach a definite conclusion and could not positively identify the source of the infection in this case.

Statement of Truth

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

Signed GRO-C

Dated 13th December 2023