Witness Name: David Phennah
Statement No.: WITN3359001
Exhibits: Nil
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DAVID CHARLES PHENNAH

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 June 2019.

I, David Phennah, will say as follows: -

Section 1. Introduction

1. My name is David Charles Phennah. My date of birth is GRO-C 1951 and my address is known to the Inquiry. I retired 3 years ago from my role as a Contracts Manager for the North and East London Commissioning Support Unit.

2. I intend to speak about a District Health Authority meeting I attended in the 1980's, during which discussions took place in relation to heat treatment and infected Factor 8 products from America.

3. I confirm that I have chosen not to be legally represented and that I am happy for the Inquiry to assist me with my statement.

Section 2. Professional Background and career history

4. Prior to 1983 I worked as a Higher Scientific Officer within the Operational Research Unit of the Department of Health & Social Security (DHSS).

5. Between 1983 and 1986 I worked for West Lambeth District Health Authority (DHA) as the Head of Operational Research, based at St. Thomas's Hospital. My job involved the analysis of hospital systems in order to model them mathematically and look for improvements.

6. Part way through 1986 I moved to a new role as Head of Planning for Mental Health Services but based at Tooting Bec Hospital – another hospital managed by West Lambeth DHA. I remained employed in this role until I was made redundant in 1990.

7. Between 1991 and 1992 I worked as a Financial Adviser, before returning to work in the NHS. From 1992 to 1993 I was employed in the role of Contracts & Business Manager at Queen Victoria Hospital, East Grinstead, until I was made redundant.

8. After a period looking for a new job, I joined Grampian Healthcare NHS Trust in Aberdeen, Scotland where I worked as Trust Contracts Manager until they made me redundant in 1996.

9. After taking stock and reviewing my career history I decided to make a change and began training as a Mathematics Teacher. Once I had qualified, I taught in state Comprehensive Schools until 2004 when I re-joined the NHS.

10. My first job after returning to the NHS was as Contracts Manager at North West London Hospitals NHS Trust, based at Northwick Park Hospital. This lasted until 2008 when I joined the London Specialised Commissioning Group (LSCG) as a Senior Contracts Manager. The LSCG made me redundant in 2012, but I was redeployed within London. This resulted in my joining the North West London Consortium of Primary Care Trusts, working as a Contracts Manager. Internal reorganisations in the structure of the NHS

caused the Consortium to become a Commissioning Support Unit, and I worked there until I retired in April 2016.

Section 3. Knowledge of the Risk of Infection from Blood Products

11. In the 1980s I didn't really know anything about the risk of infection from blood products. I knew diseases could be carried in the blood, but I assumed that any donated blood would be screened or treated in some way to safeguard against infection. I was a blood donor at the time, so I was aware of the sort of questions people are asked before giving blood. I understood that in America blood donors are paid, and this could lead to problems of various sorts. I also knew that HIV/AIDS was an infection transmitted via body fluids, including blood, but I never thought anyone would ever be infected by it as the result of hospital treatment. I learned that this is exactly what had happened, when I attended a DHA meeting during which Factor 8 blood products were discussed, as detailed below.

12. That was in the 1980s, but even in April 1991 an American actor GRO-A GRO-A died of AIDS that he contracted from a blood transfusion during an operation. It does seem to indicate that the American system of blood donation leaves a lot to be desired.

13. The infection of Haemophiliac patients by Factor 8 products has been covered in news reports from time to time since the DHA meeting, but the publicity has been short-lived.

14. According to news items, it seems that although Patient Action Groups had been formed, they were finding it to be an uphill struggle to get any satisfactory outcome. The government health hierarchy, in its various guises over the years, were unwilling to accept responsibility, by all accounts, and I found this disgraceful.

15. My connection with the issues surrounding Blood Products is solely as an observer in my career as a professional NHS Manager. I don't know anyone

personally and I'm not acquainted with any person who was affected by this issue.

Section 4. District Health Authority Meetings

16. In my role as Head of Operational Research based at St. Thomas's Hospital, I regularly attended the meetings of the DHA. These monthly meetings were predominantly held at St. Thomas's Hospital in the evening. The meetings were in three parts: Part 1 had members of the public (including local press reporters), members of staff, and members of the DHA present, Part 2 excluded the public and press, and Part 3 was DHA Members alone. In Part 1, members of the public would be invited to ask questions by the chairman, depending on the topic covered in the Agenda. Given that the health authority was a public body funded by taxes, this was an essential requirement for local accountability. On average there were around 20 attendees at these meetings, in addition to the DHA Members.

17. Part 2 had members of staff attending voluntarily, but in some cases, attendance was by invitation in order to explain a particular topic or elaborate on it. I attended out of interest in case there were matters that could be investigated using operational research.

18. Part 3 involved DHA Members alone, with support from the District Administrator. Other officers such as the Director of Finance, or the Personnel Director, might also be in attendance as requested for specific Agenda items.

19. At some time between 1983 and 1986, I don't remember the exact date, I attended a DHA meeting that I have never forgotten. As I recall, when the Factor 8 issue was discussed in Part 2, the meeting was chaired by the appointed chairman, whose name I think was Nick Black (an investment banker from The City). David Howells, the District Administrator at the time, was present because he acted as the committee secretary, so he would have been present at all three parts of the meeting. I also remember that Stephen Bubb, a local councillor, was a member of the DHA then, and he rarely

missed a meeting, so it is likely he would have been there too. At that time, I reported to Peter McGinity, whose title was something like "Director of Corporate Strategy". Peter didn't always attend the meetings, so he would not necessarily have been present at this meeting; I don't remember. In any case, if he had been there, he would not have attended Part 3 unless he had been specifically invited.

20. Minutes of the Meeting were always taken as a public record and submitted to the DHSS via the Regional Health Authority.

21. In Part 2 of the meeting on the date in question, a consultant doctor employed by the DHA, presented a report about Factor 8 blood products. This had not been a Part 1 Agenda item and it soon became clear why not. This consultant was not known to me and I don't remember his name, but he must have been the Clinical Director of the Haemophilia service, given the nature of the issue. It seemed clear to me, as I watched, that he had been summoned to explain exactly what had happened to patients using the haemophilia service.

22. He reluctantly told the meeting that the hospital had procured Factor 8 blood products from America and used them to treat haemophiliac patients. After taking delivery of the Factor 8 blood products it had been decided not to heat treat these products on the grounds of the costs involved, he said, because hospital departments were being required to make savings in their budgets. I never saw any written report as part of the meeting's papers, even though getting supplies from America wasn't normal, as far as I was aware.

23. The consultant went on to explain that since using them, they had discovered that these products were infected with Hepatitis and/or HIV/AIDS. The consultant confirmed that patients had been infected with Hepatitis and HIV/AIDS as a result of receiving transfusions. He appeared to be limiting the degree of detail he was giving and was very ill at ease. The DHA members were clearly taken aback and looked at each other in disbelief; the consultant looked embarrassed. At the end of his report there were one or two questions from DHA Members, but there seemed to be a general

reluctance to delve too deeply there and then. In answer to one of the questions, the consultant admitted that Heat Treatment would have been enough processing to eliminate these infections. He was then instructed to heat treat all blood products in future without fail, as an official DHA directive.

24. The Members obviously wanted more information but there seemed to be tacit agreement among them that such a serious matter shouldn't be discussed in Part 2. There was then limited discussion to clarify how to deal with it in Part 3 and the availability of further details, before quickly moving on to the next agenda item. I don't know what was said in Part 3 because I was excluded as usual.

25. I was truly astonished that a leading teaching hospital could fail to safeguard patients by omitting such basic procedures. It seemed at odds with the super sterile procedures introduced elsewhere in the hospital to combat the lack of treatments for HIV/AIDS at the time, and the limited understanding, then, of the risks. I don't remember this matter ever being mentioned thereafter in any meeting of any sort I attended, although I feel sure it was discussed extensively in other quarters. I wasn't involved in any clinical circles routinely, so I don't know what was said privately among clinical colleagues. I never discussed this issue with anyone after that meeting.

26. I imagine that the DHA would have issued briefings to staff about breaching confidentiality requirements and emphasised the liability issues for the Authority. The implications for the reputation of the hospital and the possible repercussions would also have been stressed. This would have made members of staff very wary of saying anything to anybody in case it was reported as gross misconduct.

27. Prior to this meeting I was not aware of any issues regarding infected blood products, and the haemophilia service wasn't one I had any contact with, so this report was like a bolt from the blue. I suppose those staff involved in the service became aware of the situation some time before the meeting, but the news didn't leak out.

28. Judging by the way the consultant talked about Heat Treatment I concluded that it was normal procedure to use it with blood products. In an effort to understand what had gone wrong, I supposed that someone in the Haemophilia department decided that the supplier of the Factor 8 blood products could be trusted to make them infection-free. That allowed this person to take the opportunity to save on costs by not heat treating them (again?). It might have been a decision made by the manager of the Clinical Directorate, who would have been responsible for remaining within budget, so it was understandable if financial considerations were all-important. At the time, health authorities were under constant pressure from the DHSS to make savings, and such savings were assumed in the annual allocation of funds. In addition, London hospitals were deemed to be over-funded compared to the national standards for their resident populations, following a change in the allocation methodology. This meant that the DHSS withheld funds every year for many London hospitals, in order to gradually bring their funding levels down to match the result from the methodology. According to this analysis St. Thomas's Hospital was one of the most over-funded ones.

29. Whether or not clinical staff were party to the decision not to use Heat Treatment is an open question, but obviously, ultimate responsibility rested with the Clinical Director. Under the circumstances, it seemed he did his best to provide a plausible reason for the calamitous decision, but he wasn't comfortable doing it. I did wonder why the blood wasn't tested prior to being used for transfusions because, for one thing, that would reveal infections and impurities that were not affected by any Heat Treatment. Equally, I didn't understand how the consultant could be so categorical about the effectiveness of Heat Treatment, if blood products had not been previously tested before and afterwards. If so, it seemed unwise to omit Heat Treatment without performing some form of checks to confirm the implicit assumptions – unless there had been a breakdown in communication between clinical staff and others. This was a conundrum for me, but I never had any further involvement that could solve it.

30. I was surprised to find out at the meeting that the Factor 8 blood products had been supplied from America. I couldn't guess the reasons for that decision, unless there was a shortage in the UK. It seemed unlikely that it would have been more cost-effective, given that American blood donors are paid, and transportation costs would be relatively high, so perhaps these higher costs placed additional pressure on the budget. I felt that the DHSS must have approved the decision to obtain supplies from America because it was so unusual, and that wouldn't have been inconsistent with the trend by the DHSS at the time to seek suppliers outside the NHS structure.

31. There was no mention of any other hospitals experiencing the same problem, and only Factor 8 blood products were cited. I assumed that other blood supplies were coming from the National Blood Supply Service. It did seem incredible that a leading London Teaching Hospital, reputedly at the forefront of clinical practice, could have allowed patients' lives to be ruined in this way. At the time HIV/AIDS infection was considered to be one of the biggest threats in hospitals, and exceptional procedures had been introduced to safeguard patients and staff. It was truly astounding that fluids being used for transfusions, no less, had been handled in such a cavalier fashion, no matter what the supplier may have guaranteed.

32. I automatically assumed that there would be no questions over paying compensation – though how anyone could be compensated for contracting AIDS was beyond me, given the certain death it would lead to in those days.

Section 5. Other Issues

33. I was not aware of the Penrose Inquiry or the Archer Report, and I can't remember how I heard about the Infected Blood Inquiry. There have been news items over the years to remind me of the meeting, but I never thought I might have to speak out.

34. I have been asked what my expectations are from the Inquiry, and I have none personally. I am appalled that the government has still not settled this matter and that patients have not been compensated. It is obnoxious that the

ruling bodies are benefitting from the attrition rate of the hapless victims of, what amounts to, criminal negligence.

35. This many decades later it is unlikely that any individual will be held liable, and the changes in the structure of the NHS probably obfuscate the liability issues now, but the government department overseeing it all still stands. In my experience it is usual for the serving government to question the causative links that support the attribution of liability in such cases as this, so if I can do anything to counter this approach, I will.

Statement of Truth

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

Signed GRO-C

Dated 15.8.2019