Witness Name: Charles Hamilton Massey
Statement No.: WITN3365011
Exhibits: WITN3365012-WITN3365031
Dated: 30 August 2019

INFECTED BLOOD INQUIRY

EXHIBIT WITN3365026 OF MR CHARLES HAMILTON MASSEY

WITN3365026 – Exhibit: Complaint by GRO-A against Dr Audrey Dawson (0196466). GMC Case Reference: 2003/1070

Case Examiner Decision Form

GENERAL MEDICAL COUNCIL
Protecting patients, guiding doctors

Investigation Officer: Richard Grumberg

File Reference No 2003/1070 Date 01/04/2005

Dr's Name Audrey DAWSON Reg No 0196466

Part 1.

Nature of Allegations

Date complaint first received by the GMC: 1/05/2003

Year alleged events took place: 1982

The following are the allegations raised by the complainant and/or employer: (TO BE NUMBERED)

The allegations from the CERF have been amalgamated to avoid repetition

1. Factor V111 was administered inappropriately, resulting in infection with hepatitis C

2. Failure to counsel the patient about Hepatitis C and its testing

GRO-C

Sorry I didn't get a chance to discuss this case with you, but could you have another look at the 2nd element of the complaint? I can't see any evidence on file showing that Dr Dawson did any form of counselling/advice etc (see note below). Have I missed it?

GRO-C

Element 2 is about alleged failure to counsel the patient, but the narrative is all about testing without consent. Is it that a separate issue? What advice/counselling/explanation did Dr Dawson give after the consultation following the +ve HepC test referred to in GP's letter of 21/10/85? What arrangements for follow up were made after Dr Dawson's consent?

OK - Try version 2 ?! GRO-C /xGx

Nature of Allegations: presumption of impaired FTP

1.1 Do the allegations fall within one of the categories where there is a presumption, if proven, of impaired fitness to practise to a degree justifying action on registration?

Sexual Assault or indecency	**Yes**	**No**
a. Indecent behaviour	☐	☒
b. Indecent assault	☐	☒
c. Rape/attempted rape	☐	☒
d. Female circumcision	☐	☒
e. Child pornography	☐	☒
Violence		
f. Assault	☐	☒
g. Attempted murder	☐	☒
h. Firearms offence	☐	☒
i. Murder/manslaughter	☐	☒
j. Robbery	☐	☒
Improper sexual/emotional relationship	☐	☒
Dishonesty		
k. False claims to qualifications/experience	☐	☒
l. Financial fraud/deception	☐	☒
m. Forgery/improper alteration of documents	☐	☒
n. Research misconduct	☐	☒
o. False certification, false reporting	☐	☒

p. False claims about effectiveness of treatment	☐	☒
q. None of the above dishonesty allegations	☐	☒

Part 2.

Nature of allegations: Good Medical Practice

2.1 Do the allegations relate to one or more of the principles of Good Medical Practice set out below? If yes, please tick and cite the relevant paragraph in the right hand column then go to Part 3.
If no, please tick ' None of the above' then go to Part 3.

(For more detail on the principles of GMP, refer to the GMP booklet and the guidance provided.)

		Para(s) in GMP
a. Good Clinical Care	☒	2,3, 5
b. Maintaining Good Medical Practice	☒	12
c. Teaching and Training	☐	
d. Relationships with patients	☒	17
e. Working with colleagues	☐	
f. Probity	☐	
g. Health	☐	
i. None of the above GMP allegations	☐	

Part 3

Criteria for assessing the seriousness of allegations

Questions 3a to 3g will help to identify whether the allegations are sufficiently serious to meet the Investigation stage test: 'Is there a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration?'

Please tick yes or no in each section

Do the allegations indicate that:

	Yes	No
a. the doctor's performance has harmed patients or put patients at risk of harm?	☒	☐
b. the doctor has shown a deliberate or reckless disregard of clinical responsibilities towards patients?	☐	☒
c. the doctor has abused a patient's right or violated a patient's autonomy or other fundamental rights?	☐	☒
d. the doctor has behaved dishonestly, fraudulently or in a way designed to mislead or harm others?	☐	☒
e. the doctor's behaviour is such that public confidence in doctors generally might be undermined if the GMC did not take action?	☐	☒
g. the doctor's health is compromising patient safety?	☐	☒

Part 4

Realistic prospect test

4.1 Is there a realistic prospect of establishing that the doctor's fitness to practise is impaired to a degree justifying action on registration

Yes ☐

No ☒

4.2 Please give reasons for your decision

This case is part of a wider series of cases received by the GMC from patient infected with Hepatitis C by blood replacement products. The circumstances of GRO-A 's case differ materially in that she does not have haemophilia and her bleeding disorder was treated mainly by one physician, Dr Audrey Dawson, Consultant haematologist who has been retired from medical practice for 9 years.

1. Factor V111 was administered inappropriately, resulting in infection with Hepatitis C

If the Dr had knowingly administered a product to a patient in the clear knowledge that it was dangerous and likely to cause serious infection that would be serious

GRO-A has a bleeding disorder that has resulted in several sever bleeding episodes in her past. Because of the risks associated with childbirth in 1982 she was given Factor V111 before and after the birth in order to prevent haemorrhage. Factor V111 helps the blood to clot. Heat treatment to prevent transmission of blood borne infections was not introduced until 1985. Although it is suggested that scientific journals had highlighted the risk before this time this cannot be said to mean that it was commonly or widely accepted. Dr Dawson has admitted that GRO-A unfortunately probably contracted the Hepatitis C as a result of these transfusions in 1982. Whilst in retrospect this has caused an unhappy outcome for the patient there is no suggestion that the Dr acted in anything other than the patient's best interests. Dr Dawson prescribed the Factor V111 to attempt to prevent possible life threatening haemorrhage. Whether or not this would have happened will never be known. It is not alleged that Dr Dawson knowingly and maliciously infected GRO-A . GRO-A has a bleeding disorder which is variable i.e. the effect of her condition changes so that on occasion she has bled from a dental extraction for example, but then had normal childbirth in 1987 without the need for clotting factors. Dr GRO-A 's comment about the child being "affected" relates to the probability of genetic transmission of the bleeding disorder.
Accordingly although in retrospect Factor V111 concentrate administration to GRO-A in 1982 cannot be said to have been actually in her best interests as she contracted Hepatitis C as a result I do not believe that this represents a breach of Good Medical Practice given the understanding prevailing at that time 23 years ago.

2. Failure to counsel the patient about Hepatitis C and its testing
Had GRO-A been tested without consent and found to be positive without that information being passed to her that would be a serious matter

GRO-A was tested and found positive for Hepatitis C in 1995. Since then her liver function as measured by blood tests and clinical examination have been normal, which indicates that she is not suffering any adverse effects as a result of the infection up until now. The test for Hepatitis C was not developed and widely used until the early 1990's. The diagnosis of Non A-non B Hepatitis referred to in the CERF was mainly a diagnosis of exclusion and no specific test for it existed. GRO-A 's GP, Dr GRO-A , requested the initial Hepatitis C test at the patient's request. The notes show that the patient had initiated this herself on the advice of the haemophilia society, with whom the patient was obviously in contact. The details of the test taken in 1996 prior to Dr Dawson's retirement relate to a calculation of viral load and took several weeks to come back as Dr Dawson suggests in her letter of 8 June 2003. There is no evidence in the notes that GRO-A was tested without consent at any stage. Ideally the term "consent" includes a discussion of the test, its prognosis and its implications. Often such testing these days involves both "pre and post test counselling". The blood test results flagged by the Investigation Officer relate to routine antenatal screening bloods and include blood group, rhesus antibody screen and a Hepatitis B screen. GRO-A 's GP was in correspondence with Dr Dawson prior to and following the testing. Although no specific mention of counselling from Dr Dawson is made she advised the GP in response to initial letter and following the clinic appointment on 16 January 1996 Dr Dawson wrote on 6 march 1996 advising of the test results which suggested a type of Hepatitis C "somewhat resistant to Interferon", which was one of the only available treatments at the time. GRO-A was then followed up as part of her regular annual review by Dr Henry Watson, Consultant Haematologist. At the 1st appointment with him Hepatitis C infection and its prognosis was discussed. It is arguable that Dr Dawson should have had a similar discussion with the patient at some stage, but when that should have happened is unclear, particularly given her retirement that year. These events happened against a background of rapidly evolving knowledge about the infection, its investigation, prognosis and treatment. In addition no evidence is presented that demonstrates any patient harm has occurred as a result of either Dr Dawson's action or inaction. Accordingly I can find no evidence that no significant breach of Good Medical Practice has occurred.

Summary
GRO-A has a bleeding disorder, which has in the past required transfusion with blood clotting treatments. In 1982 it appears that she became infected with the Hepatitis C virus as a result of some Factor V111 concentrate administered to prevent pregnancy related complications. Although heat treatment of such products was introduced in 1985 there is no evidence that Dr Dawson acted in the knowledge that such treatment in 1982 would cause infection. In addition there is no evidence that any covert testing for Hepatitis C was undertaken before GRO-A requested a test from her GP in 1995. The discussion of the detailed results relating to GRO-A 's Hepatitis C status occurred after Dr Dawson's retirement, although Dr Dawson communicated results to the patient's GP. Accordingly the GMC will not be taking any action on Dr Dawson's registration, whom we note retired from medical practice in 1996.

Case Examiner Referral Form

Section 1: Case Details

See Notes on Completion at end of form

FPD reference **RG/FPD/2003/1070**

Doctor's name **DAWSON, Audrey**

Registration no. **0196466**

Date **30 March 2005**

Investigation Officer Richard Grumberg

File location: E:\.... E:\CONDUCT\Manchester Screening\Grumberg R\Dawson, Audrey\CERF.doc

Section 2: Previous History

See Note 1

Previous history? No

FPD Reference	Nature of complaint	Outcome/current status

Section 3: Index complaint – background and summary

The complaint is made by GRO-A against Dr. Dawson after GRO-A GRO-A was infected with Hepatitis C from contaminated blood products.

Flags 1-4 and 6-10 are GRO-A 's complaints wherein she states that she was contaminated with Hep C through the blood product Factor VIII. She also states that she was born with a blood disorder and although no one seems to know what it is, she carries a card marked Von Willibrand's disease. GRO-A GRO-A also has a platelet abnormality.

In 1994 GRO-A joined the Haemophilia Society to find out more about her blood disorder since she passed it on to one of her children. She received a leaflet about Hep C and was shocked to learn about viruses in blood products and that she had all the symptoms of Hep C. The infection was later confirmed in a blood test taken by her GP and GRO-A wonders if she was tested without her knowledge prior to finding out about her condition.

GRO-A recounts that in 1982 she was pregnant and although Dr. Dawson told her that her blood was normal she was given two bottles of Factor VIII before the birth of her daughter and two more bottles after her birth. At Flag 9 GRO-A states that her medical records indicate Dr. Dawson authorised administration of two bottles of Factor VIII before induction when she was not bleeding. The records also state that the paediatrician should be alerted to the fact that the baby might be "affected." GRO-A queries what is meant by "affected" and that it indicates knowledge of possible infection. At Flag 10 GRO-A also questions why she was given Factor VIII since her medical records indicate that her blood coagulation test resulted in 290% clotting activity.

Seven weeks after the birth GRO-A had a haemorrhage and was admitted to GRO-A Hospital in GRO-A where contact was made with Dr. Dawson who instructed to give another bottle of Factor VIII. The following day GRO-A GRO-A was given an additional bottle of Factor VIII for a D & C. Prior to her treatment with Factor VIII, GRO-A had been treated for blood disorders with Cryoprecipitate.

In 1987 GRO-A became pregnant again and feared another haemorrhage. She was referred to Dr. Dawson and requested an HIV test because she knew by then that HIV was found in blood products. Dr. Dawson told her that she need have no fear of getting viruses out of Scottish blood products. Her HIV test was negative.

In January 1996, subsequent to GRO-A finding out about her infection, she consulted with Dr. Dawson who was very dismissive of GRO-A 's concerns stating that the Hep C "has never affected you at all, throw away your crutches and get a job." Dr. Dawson then turned and left. Dr. Dawson did not provide any information on the likely effects of the infection, did not offer to discuss treatment options, did not offer counselling, and did not offer any follow-up care.

GRO-A also complains that after Dr. Dawson retired and Dr. Henry Watson took over, no records of GRO-A 's treatment could be found. They were eventually located, but Dr. Watson had no record of GRO-A 's existence until she phoned Aberdeen Hospital herself – an indication of Dr. Dawson's failure to provide follow-up care. GRO-A was also having trouble locating batch numbers for the Factor VIII in order to sustain a civil suit in America where the products were believed to have come from at that time.

GRO-A justifiably wonders why her treatment was changed from Cryoprecipitate to Factor VIII, especially, according to GRO-A , since the American Medical Authorities as early as 1970 and certainly by 1982 had warned of possible contamination in Factor VIII and that it was only to be used in life or death situations. She also queries why, if Factor VIII was necessary, was she then subsequently returned to treatment with Cryoprecipitate. GRO-A GRO-A believes that had she been treated with Cryoprecipitate rather than Factor VIII, she would not have been infected.

Flag 5 is Dr. Dawson's response wherein she states that she is unable to comment on all the issues raised by GRO-A as her clinical records for Aberdeen Royal Infirmary are in the hands of the Legal Department, but that two enclosed letters by Dr. Watson [attached at Flag 5] written in response to GRO-A 's MP were helpful. Dr. Dawson claims that GRO-A 's main allegation was Dr. Dawson's alleged destruction of records (which GRO-A has apparently withdrawn since she subsequently received her records). However, GRO-A 's main concern is the question of why she was treated with Factor VIII to begin with, a question Dr. Dawson does not appear to address.

Dr. Dawson instead addresses the records issue by stating that Dr. Watson showed her the 1982 notes from the Aberdeen Maternity Hospital which contains the only clinical episode – childbirth in June and subsequent post-partum haemorrhage two months later – when GRO-A received Factor VIII concentrate. Dr. Watson found that the Factor VIII was given on 28 June 1982 from batch 649 prepared by the Scottish National Blood Transfusion Service in February 1982. This, believes Dr. Dawson, would have been the batch responsible for GRO-A 's Hep C. Dr. Dawson also claims that she was unaware of the entity Hepatitis C until the late 1980's.

With respect to allegation that GRO-A was given imported commercial concentrates from the USA, Dr. Dawson states that Dr. Watson found no evidence to support this claim.

Lastly, Dr. Dawson addresses the January 1996 consultation with GRO-A during which Dr. Dawson claims she examined GRO-A for clinical evidence of liver disease, and checked her biochemistry and viral status. She recalls encouraging GRO-A to get rid of her crutches, and to lead as normal life as possible. Dr. Dawson dubiously claims that until the detailed results were available it was not possible to counsel her about the Hep C.

Dr. Dawson ends by stating that as GRO-A 's notes are unavailable to her, and because of the distance in time, she cannot give details of the results but that Dr. Watson assures her that GRO-A had, and still has, normal transaminases, i.e., no biochemical evidence of liver damage, and so no treatment for Hep C was considered or given.

It is interesting to note the table set forth in attachment A to Flag 5 reflecting the treatment of GRO-A throughout the years with Cryoprecipitate, until 1982 when treatment was with Factor VIII, then a return to treatment with Cryoprecipitate. This also begs the question as to why treatment with Factor VIII was needed at that time and no other.

Flag 11 is the 2001 Report by the Scottish Executive on Hepatitis C and the Heat Treatment of Blood Products for Haemophiliacs in the Mid-1980's. On page 4, paragraph 7, the report states that Hepatitis C was first fully identified in 1989, but that knowledge about the virus had been developing since the mid 1970's when the scientific community began to comment on asymptomatic liver disease in haemophiliacs treated with blood products.

On page 5, paragraph 10, the report states that throughout the mid to late 1970's, scientific papers noted the occurrence of hepatitis and liver function abnormalities in haemophiliacs, and postulated that they might be related to treatment with blood products, particularly concentrates of Factors VIII and IX because the large donor pools used to produce these products would increase the risk of any hepatitis virus present in individual donations.

Page 13 of the report begins a timeline reflecting what was known in the medical/scientific community about the issue and states as follows:

1975 – Paper by Italian scientists describes "Asymptomatic liver disease in haemophiliacs", asserts Factor VIII/IX possibly responsible because of large donor pools; also that available methods for universal donor screening unlikely to eliminate risk.

June 1978 – US paper comments that liver abnormalities in haemophiliacs probably related to treatment with blood products and incidence of HBV.

Sept 1978 – *Lancet* paper identifies factor-concentrate replacement therapy as probably related to high incidence of chronic liver disease among haemophiliacs

1980 – German scientists for Behringwerke publish report which suggests that pasteurising Factor VIII at 60-C for 10 hours frees it from hepatitis B risk – says further clinical proof need for NANBH.

Sept 1981 – SNBTS begins its own research on pasteurisation.

Oct 1981 – Behringwerke get US patent for process to stabilise Factor VIII in pasteurisation (heat-treatment of liquid to 60 degrees C). Although BHV removed through this process, unclear at time whether this was because of purification or heat-treatment. Yelds low – less than 25% of SNBTS's own production process of Factor VIII.

Flag 12 is a 1975 article in The Lancet entitled, *An Outbreak of Hepatitis Associated with Intravenous Injection of Factor-VIII Concentrate*, further evidencing the medical community's knowledge of the issue long before GRO-A GRO-A was given Factor VIII in 1982.

Section 4: Additional information

As previously stated, Flag 11 is the 2001 Report by the Scottish Executive on Hepatitis C and the Heat Treatment of Blood Products for Haemophiliacs in the Mid-1980's. On page 4, paragraph 7, the report states that Hepatitis C was first fully identified in 1989, but that knowledge about the virus had been developing since the mid 1970's when the scientific community began to comment on asymptomatic liver disease in haemophiliacs treated with blood products.

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Page 13 of the report begins a timeline reflecting what was known in the medical/scientific community about the issue.

Section 5: Performance Assessments/Health Examinations

None.

Section 6: Summary of Allegations

See Note 5

A	B	C	D
No	**Allegation**	**Presumption of Impaired FTP?**	**Breach of GMP?**
1	Administering Factor VIII without informing patient of known risks	No	Yes
2	Unnecessarily treating with Factor VIII when Cryoprecipitate had been previously successful	No	Yes
3	Being dismissive of a life threatening infection	No	Yes
4	Failing to provide information on the likely effects of Hepatitis C infection	No	Yes
5	Failing to offer or discuss treatment options	No	Yes
6	Failing to offer or discuss counselling	No	Yes
7	Failing to provide for any follow-up care	No	Yes
8	Testing for Hepatitis C without consent	No	Yes

Other relevant guidance? No

See Note 6

Section 7: Charges

None.

Section 8: Conclusion/Suggested Action

Given the information widely available to the medical community in the 1970's and early 1980's as reflected in the report by the Scottish Executive, the Lancet article, and that testing for a heat treatment to specifically inactivate the known risk of viral infection was begun as early as 1980, it is difficult to believe that Dr. Dawson, the Haemophilia Director in Aberdeen, was unaware of the risks of infection with what was then known as Non-A Non-B hepatitis in 1982 when she ordered treatment of GRO-A with Factor VIII. It therefore appears that Dr. Dawson should at the very least have informed GRO-A of the known risks of such treatment.

Additionally, the still unanswered question remains: why did Dr. Dawson treat GRO-A with high-risk Factor VIII in 1982 at a time when GRO-A was pregnant, was not bleeding, had a blood coagulation test that resulted in 290% clotting activity, and had previously been successfully treated with Cryoprecipitate?

Further, during the 1996 consultation when it was known that GRO-A was infected with Hepatitis C, it appears that Dr. Dawson failed to provide any information on the likely effects of the infection, did not offer to discuss treatment options, did not offer counselling, and did not offer any follow-up care to the point that Dr. Dawson's successor did not even know that GRO-A GRO-A existed.

While it appears that Dr. Dawson breached her professional duty to GRO-A GRO-A in several respects, I defer to the Medical Case Examiner's opinion.

Dr entitled to rely on safety of blood products supplied by National Blood Transfusion Service?
Para 11 of Report of Scottish Executive on Hep C & the Heat Treatment of Blood Products for Haemophiliacs (flag 11) says that some patients developed HCV were treated with cryoprecipitate and not Factor VIII.
Consequently, the decision to use Factor VIII after previous administration of cryoprecipitate may not have been a material factor in GRO-A contracting Hep C

Memorandum

Ref: **2003/1070**
To: 1. Medical Screener
2. Lay Screener

Out	Back

From: Tim Cox-Brown
GRO-C

Date: 12 May 2004

Complaint by: GRO-A

Against Dr(s): **Dr. Audrey Anne Dawson**
MB ChB 1956 Aberd SR (Haematology)

Registration No: 0196466

Identification & History

1. Dr. Dawson has been identified. There have not been any previous complaints about her. This complaint has already been considered by a Medical Screener, who was asked to decide whether the public interest required that we consider GRO-A 's complaint, despite the events leading to it having taken place over five years ago. The Medical Screener confirmed that we should consider the complaint (see memo below at Flag A), and we have therefore dealt with this complaint in the usual manner, including disclosure to Dr. Dawson. At Flag B below is a copy of our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s.

2. GRO-A 's complaint is at Flag 1. Dr. Dawson's response is at Flag 5. Further information from GRO-A is at Flags 2 - 4, and 6 - 10. We have obtained copies of GRO-A 's medical records from her GP (Volume 2), GRO-A GRO-A Hospital (volume 3), Aberdeen Maternity Hospital (volume 4), and Aberdeen Royal Infirmary (volume 5).

Background

3. GRO-A was born with a coagulation disorder (a platelet abnormality), which was identified as similar to Von Willebrand's Disease by Dr. Dawson. This diagnosis has been registered in her medical records, and she has been treated as though she were a haemophiliac, although recent investigations have cast doubt on the diagnosis. GRO-A says that she is not registered on the Haemophilia Centre Directors' Organisation's national haemophiliac database, even though she has been considered to be a haemophiliac for much of her life. Dr. Dawson was responsible for GRO-A 's care for many years, as far as her coagulation disorder was concerned.

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To: 1. Medical Screener
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Out	Back

From: Tim Cox-Brown
GRO-C

Date: 12 May 2004

Complaint by: GRO-A

Against Dr(s): **Dr. Audrey Anne Dawson**
MB ChB 1956 Aberd SR (Haematology)

Registration No: 0196466

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3. GRO-A was born with a coagulation disorder (a platelet abnormality), which was identified as similar to Von Willebrand's Disease by Dr. Dawson. This diagnosis has been registered in her medical records, and she has been treated as though she were a haemophiliac, although recent investigations have cast doubt on the diagnosis. GRO-A says that she is not registered on the Haemophilia Centre Directors' Organisation's national haemophiliac database, even though she has been considered to be a haemophiliac for much of her life. Dr. Dawson was responsible for GRO-A 's care for many years, as far as her coagulation disorder was concerned.

4. GRO-A has been infected with hepatitis C, probably through her treatment with human plasma-derived clotting factor concentrates. GRO-A found out that she was positive for hepatitis C antibodies in 1995. She joined the Haemophilia Society and discovered from information leaflets given to her that there was a strong possibility that she would have been infected with hepatitis C as a result of the treatment she had received for her coagulation disorder. GRO-A GRO-A's GP requested a blood test, and when the result showed that she was positive for hepatitis C antibodies, he referred her to Dr. Dawson at Aberdeen Royal Infirmary.

Allegations

5. GRO-A alleges that:

a) During the time Dr. Dawson was responsible for her care she (Dr. Dawson) changed GRO-A's treatment from cryoprecipitate to Factor VIII without her knowledge or consent, and without providing any information about the (known) potential risks inherent in this treatment, i.e. being exposed to blood-borne viruses such as HIV and hepatitis C (originally known as non-A non-B hepatitis).
b) She may have been tested for hepatitis C without her knowledge or consent.
c) Dr. Dawson told her (in 1987 when GRO-A requested a test for HIV) that she need have no fear of getting any viruses from Scottish blood products (GRO-A's HIV test was negative).
d) When she consulted Dr. Dawson in 1996 after testing positive for hepatitis C, Dr. Dawson was dismissive of the infection, saying merely that it hadn't affected GRO-A.
e) Dr. Dawson did not provide any information on the likely effects of the HCV infection.
f) Dr. Dawson did not offer to discuss treatment options.
g) Dr. Dawson did not offer counselling
h) Dr. Dawson did not provide for any follow-up care – indeed Dr. Dawson's successor at Aberdeen Royal Infirmary was not aware of GRO-A's existence until she contacted the hospital herself.
i) As her coagulation disorder was only a mild one, she should not have been given Factor VIII, especially as she says that medical authorities in the USA warned UK practitioners about the virus risks posed by US blood products and suggested that those products should only be used in life or death circumstances. GRO-A says that these warnings were ignored by UK practitioners, including Dr. Dawson.
j) The rheumatoid arthritis which she suffers from could have been caused by a breakdown in her immune system triggered by a viral infection, namely hepatitis C.

k) Dr. Dawson persuaded her to have a pregnancy terminated in 1973 at the age of 20, as she (Dr. Dawson) thought that there was a fair chance that the baby would have been affected, presumably by the coagulation disorder.
l) Dr. Dawson removed or destroyed medical records relating to GRO-A 's Factor VIII infusions (this allegation has now been withdrawn by GRO-A).

Conclusion

6. It would seem that GRO-A has been treated as a sufferer of von Willebrand's disease for many years when she shouldn't have been, and has therefore received potentially unnecessary infusions of infected blood products.

7. It would also seem that Dr. Dawson is claiming that she was unaware of the existence of hepatitis C, along with all other UK medical practitioners, until the late 1980s, and could not therefore advise GRO-A of the potential risks of treatment with blood products. There is information available (see other haemophilia files) which suggests that this is not the case, and that UK Haemophilia Centre Directors, and by extension anybody practising in this field of medicine, were fully aware of the risks of contracting blood-borne viruses, and non-A non-B hepatitis in particular, from both commercially-produced clotting factor concentrates and from UK-produced versions. Dr. Dawson also told GRO-A GRO-A in 1987 that she could not get blood-borne viruses from Scottish blood products, but now claims that that is how the virus was passed on.

8. It seems clear that Dr. Dawson treated GRO-A as a haemophiliac with the concomitant use of clotting factor concentrates when she did not necessarily need to do so, subsequently changed GRO-A 's treatment without her knowledge or consent, and did not warn her of the potential risks of treatment with blood products. More worryingly, Dr. Dawson seems to have ignored the warnings regarding the use of blood products, and continued to advocate their use, despite being aware of the risks. When GRO-A had tested positive for HCV Dr. Dawson did not offer counselling, or provide any advice regarding prognosis and treatment, or arrange for any follow-up care.

Recommendation

9. GRO-A has made serious allegations against Dr. Dawson, which meet the threshold of SPM and which are properly arguable. I have not, however, drafted charges as I should be grateful for your advice on this case.

10. I should also be grateful if you would confirm that the public interest requires that GRO-A 's complaint should be referred to PPC despite the events giving rise to it occurring over five years ago.

11. I look forward to receiving your advice.

Memorandum

A

To **Dr. Fiona Pearsall**

From **Tim Cox-Brown**
Caseworker
Screening – Manchester

Date **21 May 2003**

Re: Dr. Audrey Dawson
Case ref.: 2003/1070
Complainant: GRO-A

We have received a complaint (Flag 1) from GRO-A, which concerns events which are over five years old. Further information is at Flag 2 which identifies the doctor concerned as Dr. Audrey Dawson. At Flag A below is a copy of our Standards guidance issued in 1988 regarding the testing of patients for hepatitis C and HIV in the 1980s.

This complaint is one of the complaints we have received about testing patients for hepatitis C without consent. You have already seen four of the existing complaints, and you agreed that we should consider them despite their age.

It would seem that GRO-A was infected with hepatitis C sometime after 1978, yet she was not informed of this infection until 1995, following a blood test carried out by her GP. It is unclear whether she was tested without her consent at Aberdeen Royal Infirmary, but it is clear that GRO-A is also complaining that she was treated with Factor VIII without being provided with any information about the risk of infection by HIV and hepatitis C.

I believe that the issues raised are serious ones, and we should consider the complaint. I should be grateful if you would make a decision on whether this case should proceed through our Screening procedures despite the events giving rise to it occurring over five years ago.

I should be grateful if you would give this file your consideration as quickly as possible, as this issue is rapidly gaining momentum.

Please note that Neil Marshall has agreed that these files can be excluded from the current anonymisation pilot.

GRO-C

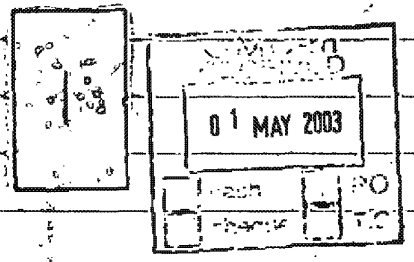
Tim Cox-Brown
Caseworker, Fitness to Practise Directorate
Direct Line: GRO-C ; Fax: GRO-C
E-mail: GRO-C

Not know anything about Hep C. It stared at me for a few days, so I picked it up and read it. I recieved such a shock. I was never told of viruses in blood products. I realised I had all the symptoms of Hepatitis C. I took the leaflet to my G.P. He took a blood test, which came back Hep C positive. I have an active virus.

I do not know if I was tested in hospital in aberdeen prior to me finding out myself. No one has ever told me. I went to Aberdeen Royal Infirmary for an operation on my back. I was ignored in the hospital by Doctors and Medical staff. They did not offer me any treatment. They don't want me there. Did they know? I think they did.

Yours Sincerely

GRO-A



GRO-A

RECEIVED
0-1-MAY-2003

30-4-03

Dear Mr Brown,

I am writing to you as a person who has been infected with Hepatitis C. I got my Hepatitis C through contaminated blood products namely FACTOR VIII. I was born with a blood disorder Von Willibrand disease I also have a platelet abnormality.

I do not know if I was tested secretly or not. I joined the Haemophilia Society in Dundee in 1994. To find out more about my blood disorder, as I have passed it on to one of my children. I recieved information from the Haemophilia Society. One leaflet about Hepatitis C I put aside, as I did

RECEIVED
12 MAY 2003

GRO-A

8-5-03

Dear Mr Cox Brown,

I have filled in these forms. I was born with a bleeding disorder, although no one seems to know exactly what it is. I carry a card with Von Willibrand plus a platelet abnormality. I have received Cryo percipotate in the late 1969 also I had 32 bags (8 pints) of CRYO in 1970 for a major car accident. I received CRYO AGAIN IN 1973. This is all in Aberdeen Royal Infirmary. In 1978 at the birth of my son I received FACTOR VIII Dr AUDREY DAWSON was then my haemotologist. She changed from Cryo to FACTOR VIII, putting myself and Baby at risk from Blood borne viruses. It is interesting to note when pregnant she told me my blood was Normal. She Dr Dawson gave my FACTOR VIII as a preventive of bleeding. I then had a baby girl in 1982. I got more FACTOR VIII

At the birth I took a post partum haemorrage 7 weeks after in August 1982. I was given an FACTOR VIII treatment at the Gilbert Bain Hospital in Lerwick prior to being flown to Aberdeen hospital, where I received more FACTOR VIII. And These FACTOR VIII product Name and Batch numbers are missing.

When I accidently found out I had been infected with Hep C I was sent down to Aberdeen to Dr DAWSON. She Kept me waiting from my Appointment time of 10-30 till 1-30 when she eventually saw me. She examined my Stomach and looked in my mouth and told me there was Nothing wrong with me, "I.T." had not affected me. She walked away from me I had so much to ask her about Hep C. She didnt want to know. I made a complaint against her, but it was her word against mine! When Dr Henry Watson took over when DAWSON retired NO records of me could be found in Aberdeen. He did eventually find them, but he did not know of my existence until I phoned Aberdeen.

NOW I find all these FACTOR 8

products the product name a batch are missing. I have come to the conclusion Dr Audrey Dawson when She retired took the evidence away, and hid my Notes. Dr Watson had a struggle to find them.) why Did Dr Dawson change my treatment from Cryo to FACTOR 8? Putting me at risk of HepC AND H.I.V. and more importantly my children. I had another baby IN 1987 Dr DAWSON was away on holiday. I got NO clotting FACTORS, I managed the baby without and factor 8. I have Hepc I also have Rheumatoid Arthritis I am aged 50 and my working life and indeed my health has been taken from me. Thanks to Dr DAWSON. I have NO case for litigation in the States as my FACTOR 8 TREATMENTS, product name a batch Number are missing. Dr DAWSON needs to be told what She has done. Between the years 1980 to 1985 Blood was in short supply in Britian. So American products were used. there is NO record of them at the B.T.S. in aberdeen.

This is a big cover up a Public Inquiry

must be held and these criminal Doctors made to pay for what they have done.

Yours hopefully
of your help and
understanding

GRO-A

I have enclosed some letters to you.
IF DR DAWSON HAD LEFT ME ON THE CLOTTING AGENT CRYO, I MAY NEVER HAVE BEEN INFECTED BY HEP C. Why did She change TREATMENT, ESPECIALLY WHEN I WAS PREGNANT. Why has She distroyed ALL EVIDENCE of MY FACTOR 8 TREATMENTS I HAVE NO PROOF BUT I KNOW She did THIS.

THE HAEMOPHILIA SOCIETY

The Haemophilia Society
123 Westminster Bridge Road
London SE1 7HR

Telephone: 0171 928 2020
Facsimile: 0171 620 1416

17 January, 1996

Dr Audrey Dawson
Grampian Area Haemophilia Centre
Department of Medicine
Aberdeen Royal Infirmary
Foresterhill
Aberdeen AB9 2ZB

Dear Dr Dawson,

Re: GRO-A

I am writing to you concerning the above who contacted me today with regard to her last appointment with you, dated 16 January of this year.

This appointment left GRO-A feeling extremely distressed for several reasons which I will outline in the course of this letter.

GRO-A made an appointment with you for herself and her son GRO-A at 10.30 a.m. on the above date and had their return flights to the GRO-A booked for the early afternoon.

It appears that she was not seen by you until 12.50 p.m. which meant that she had had to wait for an extremely long time, and little time remained when she was finally seen by you.

GRO-A comacted the Society several months ago after she was informed that she had been diagnosed as HCV positive. As the only patient suffering from von Willebrands disease at her nearest hospital, she was not provided with any information on either condition. I spoke to her at length and told her that whenever she could she should visit the centre at Aberdeen for check-ups relating to her hepatitis C including liver function tests and a PCR test. It was for the purpose of having a PCR test that GRO-A made this particular appointment. She was eventually neither offered a PCR test nor provided with the opportunity to ask you some questions that she wished to raise on Interferon treatment.

She states that when you finally arrived to see to her, you told her to lie down on the bed, checked her mouth, told her that 'it' had not taken effect in any way. Naturally she was not clear about what you were referring to, and assumed that it was her hepatitis C, although she claims that you offered no explanation for your comment.

GRO-A was most upset by the final incidence in which you remarked, on noticing her crutches beside the bed, that she no longer required them and that she should get up, leave them, and get on with her life.

As you would be aware, GRO-A suffers from osteoarthritis of the spine. Although she has experienced a distinct improvement in her mobility, she still suffers considerably and her mobility is still significantly distorted.

It is clear that GRO-A feels that her basic rights as a patient were severely infringed. She seems to have been treated with a total lack of concern. What was to be a routine visit for her resulted in a highly stressful and frustrating experience which left her with major questions remaining in relation to the state of her liver, and Interferon treatment, and accusations regarding the sincerity of her physical discomfort. GRO-A has conveyed to me that to all intents and purposes she was made to feel like she was wasting your time.

As a representative of the Society, with members in the Aberdeen area, I would be grateful for a response to this complaint or some clarification of the facts.

I look forward to hearing from you soon.

Yours sincerely,

GRO-C

Shanit Marshall
Information and Advice Worker

ABERDEEN ROYAL HOSPITALS *NHS TRUST*

Our Ref: MCL/lf

Direct Dial: GRO-C

27 February 1996

Foresterhill House
Ashgrove Road West
Aberdeen AB9 8AQ
Tel: (01224) 681818
Fax: (01224) 840597

GRO-A

Dear GRO-A

I refer to my letter of 15 February 1996 and having investigated the circumstances which have led to your dissatisfaction I can now respond.

Dr A Dawson, Consultant Haematologist, was very sorry to read the contents of your letter. She agrees that you do probably have a very mild von Willebrand's disease but she does want to encourage you to lead a normal life and not an invalid one.

We are very sorry that you have been unlucky and have developed Hepatitis C positivity as a result of blood products transfused many years ago. Dr Dawson has taken blood samples for specific tests including viral load and these have been sent to Edinburgh. These tests are done in batches and the results are normally returned to us 4-6 weeks later.

Dr Dawson recalls that the clinic was exceptionally busy and that there was a delay for which she personally apologised to you. She does want you to lead a normal life and for this reason, in the limited time available at the clinic, she did try to encourage you to throw away your crutches. She does not consider that you are a pest and did not intend that you should feel that she did.

We are grateful to you for bringing your concerns to our attention and we apologise for the distress you experienced. With regard to your son, I must correct a misunderstanding; the doctor who examined him, Dr Soutar was a Locum Consultant.

Yours sincerely

GRO-C

Moraig C Leys
Director of Nursing & Quality

TCB/FPD/2003/1070.

3

GRO-A

5/03

Dear Mr Cox-Brown,

Further to my previous letter, I realised there was a time barrier of five years. This seems rather unfair, it is only now I can piece things together.

All I really want to know is why Dr Dawson changed my treatment from Cryoprecipitate to FACTOR 8. Especially when I was pregnant, when my blood was as she said herself normal. Britain was warned by American Medical Authorities in 1970 that factor 8 was NOT safe to use, as it had blood borne viruses. American haemophiliacs in 1970 had abnormal liver function tests. America warned Britian that factor 8 was only to be given in life or death situations. British Doctors must have chosen to ignore this. I had my FACTOR 8 in 1982. So she can't say she

didn't know.

I joined the Haemophilia Society in 1994 after having physiotherapy for joint problems and a bad back. The physiotherapist asked if my blood disorder had anything to do with my joint pains. I got information about blood disorders from the Haemophilia Society, along with a leaflet on Hepatitis C. I read the leaflet and thought Dear God I have all the symptoms of this. So I went to my G.P. and the blood test was positive. He then sent me to Dr Dawson's Clinic in Aberdeen, where I got treated or should I say humiliated by her. I had seen Dr Dawson over the years, firstly as a teenager. I am 50 years old now. I thought the world of her, and couldn't understand why she treated me like this. I got no chance to ask her any questions on Hep C. No offer of counselling nothing. I tried to complain about her treatment of me at the time. I was told over the phone it was her word against mine. So I could do nothing. All I wanted was maybe the word "Sorry", but I was told she couldn't say she was sorry, it would be admitting

She had done wrong. Why did her attitude towards me change?

I have also just been diagnosed with Rheumatatoid Arthritis. Could be caused by a breakdown in the immune system triggered by a virus infection. So I think it has come with my Hepatitis C active virus. It is unfair to be time barred, as many haemophiliacs are only find out the truth now, after so many years.

Also the factor 8 products I have received can't be traced through the Scottish Blood Transfusion Service. So I can only assume they were not of British make. I can't get a Product name or batch number for any of my treatments. So I have no litigation case against anyone. You see my factor 8 must have been dropped on earth maybe perhaps from MARS. Strange NO one can trace anything not even the blood bank?

Yours

GRO-A

RECEIVED
0 3 JUN 2003

GRO-A

Dear Mr Cox-Brown,

Thanks for your latest letter. I am glad my complaint is to be considered.

I feel very strongly that Dr Dawson should not have changed my treatment to Factor 8. Especially when I was pregnant. Also the warnings by American Medical Authorities must have been ignored. Factor 8 was only to be used in life or death situations. So in 1982 she must have known the dangers of administering this product. I also think my blood was over clotted as when I had the haemorrhage in August it was huge clots of blood I lost. Also the bit of afterbirth should not have been left in my womb.

I am not a haemophiliac or so I have been told, so why was I treated as if I was.

I also in 1987 when pregnant with my 3rd child, asked for a test for H.I.V. She told me then I would get no blood borne Virus from Scottish Blood Products! I had my hep C then. I don't know if I was secretly tested for Hep C.

Also between the years 1980 to 1986 all blood products were supposed to have been American. I have no case as I can't get any Product Names or Batch numbers for my treatment in 1982. I carry the Genotype 1A of the Hep C. This Genotype is prevelant in America.

I feel a Public Inquiry must surely be held to discover how American Blood Products came to Britian, especially at the time America had stopped using FACTOR 8. As they knew the dangers why did Britian continue to use it?

I feel I should NEVER have been exposed to this product. I have lost my health and strength due to hep C. I can't work and can barely do my housework. Some days are better than others. I could have a job, but at the age of 50 hep C has robbed me of the chance to work.

This could all have been avoided. When I had the FACTOR 8 my blood was supposed to have been "NORMAL" being pregnant. I should never have been given it to prevent bleeding. I think this FACTOR 8 was also to strong for me.
This all could have been prevented.

Yours Sincerely

GRO-A

RECEIVED

11 JUN 2003

GRO-C

8 June 2003.

Ref. TCB/FPD/2003070

5

Mr. T. Cox-Brown,
Barnett House,
53 Fountain Street,
Manchester, M2 2AN.

Dear Mr. Cox-Brown,

Thank you for your letter and enclosures about GRO-A 's complaint about me. On their receipt, I arranged to meet Dr. Henry Watson, who succeeded me as Haemophilia Director in Aberdeen, and he has been most helpful. I enclose copies of relevant letters that he has written, initially in relation to her complaint to her MP, in 2001 (marked by me as 'A'), and two written last month (marked 'B' and 'C').

I am unable to comment on all the issues that GRO-A raises, as her clinical records for Aberdeen Royal Infirmary are in the hands of the Legal Department, and, so, not available to me.

The main allegation in GRO-A 's letters relates to a 'fitness to practise' issue, based on her belief that I deliberately concealed or destroyed sections of her notes, which contained details of episodes of infusion of Factor VIII concentrate. There is, however, clear evidence to the contrary. Dr. Watson has shown me the 1982 notes from the Aberdeen Maternity Hospital, which contains the detail of the only clinical episode (childbirth, in June and subsequent post-partum haemorrhage two months later, in August, 1982) when GRO-A GRO-A received Factor VIII concentrate. Dr. Watson has found that the Factor VIII given on 28 June 1982 was from a batch (649), prepared by the Scottish National Blood Transfusion Service in February 1982. This would have been the batch responsible for her hepatitis C. (We were unaware of the existence of the entity hepatitis C until the late 1980s.) Furthermore, it is evident that this information was available in 2001, when Dr. Watson, independently, and in response to a parliamentary question from GRO-A 's MP, studied these notes in order to transmit full details of the relevant clinical events to the Scottish Executive (see attached A). Clearly, therefore, the suggestion that I hid/destroyed evidence in her records is not confirmed. These notes are of course available for your perusal, on request to the Trust.

Another issue relates to the allegation that GRO-A was given imported commercial concentrates from the USA. On exhaustive review of her notes, Dr. Watson found no evidence to support this claim, and indeed, as stated by him in his letter of 2001 (A), it appears that GRO-A received Factor VIII concentrate only in 1982.

In response to your enclosure 7 (to which Ms. Moraig Leys replied at the time, enclosure 8), I do remember GRO-A 's visit, with her son, to a very busy clinic in January 1996. I did apologise to her then for the delay in seeing her; I examined her for clinical evidence of liver disease, checked her biochemistry and viral status (the latter was at that time performed by the supra-regional laboratory in Edinburgh). I do remember encouraging her to get rid of her crutches, and to lead as normal a life as possible. It will be obvious that, until these detailed results were available (see your enclosure 8), it was not possible to counsel her about the hepatitis C. In the event of her Aberdeen Royal Infirmary notes being unavailable to me, and at this distance in time, I cannot give you details of these results, but

Dr. Watson assures me that she had, and still has, normal transaminases (ie she had no biochemical evidence of liver damage), and so no treatment for Hepatitis C was considered or given.

I am sure that you will understand that detail of GRO-A 's clinical record are not at my fingertips. I retired in 1996, and have not practised since. In the interests of your receiving a rapid reply, I have contacted neither my Medical Defence Union nor other professional body, so far. Also, I have not made any representation to see GRO-A s Aberdeen Royal Infirmary notes. However, if you consider that I should do any or all of these, I will set these in motion.

Yours faithfully,

GRO-C

Audrey A. Dawson, OBE, DL, BD, MD, FRCPE, FRCPath.

GRO-A

Mr. Tim Cox-Brown,
Caseworker,
Fitness to Practice Directorate,
General Medical Council,
Barnett House,
53 Fountain Street,
MANCHESTER, M2 2AN.

Your Ref. TCB/FPD/2003/1070

19 June, 2003.

Dear Mr. Cox-Brown,

I have now decided to tell you the story of my life with a blood disorder as this seems the best way to illustrate why I feel that my blood disorder has been badly managed.

At the age of 6 or 7 I had teeth extracted by a local dentist. I bled all day and night and was taken back to the dentist next day when he plugged the holes with cotton wool and I was told to bite into this. I bled for a long time before it did eventually stop. When I was around the age of 10 – 12 I had two more teeth extracted. I was told by the school dentist that I would get my gums stitched. Unfortunately it was a different dentist who extracted my teeth and he poo-pooed the idea of stitches so I got none. I went home and started to bleed heavily. Back to the dentist next day when the other dentist stitched my gums. It was a few days before the bleeding stopped. My GP then decided to contact Dr. Dawson as the dentist was unwilling to take responsibility for me.

In 1969, at the age of 17, I went to Aberdeen Royal Infirmary where I had all of my top teeth extracted – one half were extracted and the gum stitched then, a few days later, the remainder were extracted. I bled for a long time and I was in hospital for nearly 3 weeks. I was eventually given Cryopercipitate which stopped the bleeding instantly.

In 1970 I was involved in a major car accident when I suffered a broken cheekbone, nose and had a fractured ankle. I was given 32 bags of Cryo – my brother remembers this well as he counted the bags which were left on a window ledge next to my bed!

Sadly, in 1973 I had a pregnancy terminated and again Cryo was given. For about a year afterwards I suffered heavy periods with large clots. I had to be sent home from work for 3 to 4 days. My mother would call the doctor who gave me injections to help the bleeding. I do not know what these injections were. I had never suffered these period problems before the termination.

In 1978 I had Cryo again at Aberdeen Royal Infirmary for the birth of my son. All went well. I have only one kidney and a bicornate womb so I was taken to Summerfield Maternity Hospital about two months before the baby was due in case of a miscarriage. Having a divided womb meant that the baby didn't have a lot of room to grow.

In 1982 I was given two bottles of Factor V111 before the birth of my daughter and two more bottles after the birth. Please note, when pregnant, my blood was "normal" – Dr. Dawson told me this. I went home with my baby but I always felt tired and exhausted after the birth of this baby and I didn't seem to recover. Seven weeks after the birth I had a haemorrhage when clots like liver fell out of me. This was horrific and absolutely terrifying. When I phoned my GP I was told to make my way to hospital. When I was admitted to the GRO-A in GRO-A they contacted Dr. Dawson. On her instructions I was given another bottle of Factor V111. This bottle looked very cloudy and contained a heavy sediment at the bottom. I asked the young Doctor if it was "alright". He replied that he had never seen this stuff in his life, he had been told to give it to me and that was what he was going to do. He couldn't get a vein so another doctor eventually administered it.

When being moved from a bed on to a stretcher, more clots, worse than ever, fell away from me. At this point the nurse pressed a bell, surely all staff of the hospital came to that room! I was then transferred by Air Ambulance to Aberdeen accompanied by a doctor from the hospital holding my wrist for a pulse (I now realise I was close to death). On arrival at the Maternity Hospital I was greeted at the door by Sister GRO-D who said " GRO-A are you here again? You are costing the NHS a fortune" – nice compassionate woman! On settling into the Labour Room I asked for a bedpan and more clots slid from me. I thought then that the Factor V111 had made it worse – these were my feelings at the time.

Next day I was given another bottle of Factor V111 for a D & C. On coming out of the anaesthetic I was given an injection for "labour to be induced" and spent the afternoon with labour pains. I see in Dr. Watson's letter to Sandra Falconer she refers to "retained products". I have also been led to understand that this is a term used for a foetus. I am now in the process of seeking access to my medical notes from Aberdeen Royal Infirmary as it is very important to me to know whether or not I was carrying a dead baby. If I was, then my pregnancy was totally mis-managed. I never was told the reason for the haemorrhage.

In 1985 I went to Aberdeen Royal Infirmary for bottom teeth extractions. I was given nothing – no Cryo or Factor V111 – before the teeth were extracted. My gum was stitched but, on arrival back on the ward, I was bleeding a lot. A doctor came to see me, he then left the room and returned with a bag of Cryo. The bleeding stopped immediately.

In 1987 I was pregnant again and very scared. I felt that I could not go through another haemorrhage like the previous one. I was again referred to Aberdeen and Dr. Dawson, as always, came to see me. Her very presence on the ward calmed me as I had come to respect this lady so much. I asked her for a blood test for HIV as I by then knew that it was found in blood and blood products. She told me I need have no fear of getting viruses out of Scottish blood products.

(I already had hepatitis C but didn't know). My HIV test was negative. I knew the pain and heart-break of a termination and I suddenly wanted this child within me. I went to Aberdeen for the birth only to be told that Dr. Dawson was on holiday. Dear God – what would I do without her? It was decided that I should have this baby without clotting factors but I was told these were in the fridge for me if I needed them. I had a natural birth and produced another beautiful baby girl. All without the need of clotting factors, childbirth is after all a natural procedure! I went proudly home with my baby.

In 1991 I suffered great disability through back problems and was referred to a Neurologist. This was another terrible incident. About a couple of days after my admission to Aberdeen Royal Infirmary, I was seen by a Neurologist – he wasn't a very pleasant fellow and seemed to want nothing to do with me. A scan showed two prolapsed discs and I was walking but only with the aid of a zimmer frame. I met Dr. Dawson in a lift, she said she hadn't known I was in the hospital but that, no doubt, she would be coming to see me. She never did come and I realised I was not going to get surgery for this problem. The Neurologist never came back to see me and I felt that I was ignored. I became extremely upset feeling that no-one would help me. After losing a stone in weight I decided to discharge myself and go home. I also had gastro-enteritis. After going home, I eventually got physiotherapy for my back problem. The physiotherapist asked if my joint problems were associated with my blood disorder.

I decided to join the Haemophilia Society and was given leaflets and information about bleeding disorders which included a leaflet about hepatitis C. As I read it I realised that I had a 99% chance of having this condition. I took the leaflet to my GP and asked for a blood test, the result of which was positive. My GP made arrangements for me to go to Aberdeen to see Dr. Dawson, I had already written to tell her that I had hepatitis C.

As my son was at Aberdeen University, he came with me and we both had appointments for 10.30 am. My son was seen sometime after 11 am but I was not seen until 12.50. Dr. Dawson had seen me sitting waiting and also walking up and down the corridor but never even said "Hello" which was most unusual. When she did see me she ORDERED me to lie down on the bed. She felt the top of my stomach, looked into my mouth and said "This (or it) has never affected you at all, throw away your crutches and get a job". She turned on her heel and walked away. I was 'gobsmacked', where was the lovely lady whom I respected, trusted and admired?

I returned home, very angry about the way in which I had been treated, and complained to the hospital. I had a life threatening virus but had been given no opportunity to ask a question about it. I wrote down my question to which Dr. Dawson replied – I have sent you a copy of this.

Please note Answer 2 : "From 1982 no coagulation abnormality has been detected". Why then was I given Factor V111? I wasn't bleeding nor was I in a life or death situation. I feel that my blood disorder has been completely mis-managed and that I should never have been given this as a preventative against bleeding. Getting this clotting factor at a time when I was pregnant was extremely dangerous to my unborn child.

Why was my treatment changed from Cryo to Factor V111, then changed back to Cryo again? I am led to believe that in the late seventies to mid eighties there was a shortage of blood in Britain and that this is why Factor V111 was imported from other countries. I also understand that Cryo is taken from a small pool of donors but Factor V111 comes from a pool of 60,000 donors. Why change my treatment? Other haemophiliacs also had their treatment changed and I wonder why and why all in the same years? May I also state that there appears to be no blood bank records for me and I was told that records are only kept for twelve years. In this day and age of blood borne viruses, surely this is wrong.

I apologise to Dr. Dawson for my comment regarding the possibility of the removal of sections of my medical notes. One Factor V111 batch number has now been found.

I cannot understand why, after Dr. Dawson's retirement, Dr. Watson was unaware of my existence and had difficulty in finding my medical records. A member of the British Liver Trust contacted Dr. Watson to inform him about me. Dr. Watson telephoned me to apologise for this and I go to his clinic in Aberdeen annually.

In 1969 I got a green medical card from Dr. Dawson with Christmas Disease diagnosed. Later she stroked this out and wrote Hereditary Haemorrhagic Disease. In 1974 or 1975 I got a green card from Dr. Forbes (Glasgow R.I.) with Von Willibrands on it. I now have a card with Von Willibrands / Platelet Disorder. I have passed this blood disorder on to my son and he has a card with Platelet Pool Abnormality. At this moment in time neither of my two daughters have been tested. I have recently been diagnosed with Fibromyalgia Syndrome and understand that this is caused by a car accident, a virus or trauma! This condition causes me chronic pain and writing this letter has left me with badly swollen hands!

Yours sincerely,

GRO-A

GRO-A

JW/DT

14 March 2001

HOUSE OF COMMONS
LONDON SW1A 0AA

GRO-A

Dear GRO-A

I refer to our previous correspondence regarding Haemophilia patients who have been infected with Hepatitis C. You will recall that I had taken this matter up with the Scottish Health Minister and now enclose, for your information, a copy of the reply which I have received. Unfortunately the Minister has taken a long time to respond to the points raised but states that enquiries took longer than anticipated.

You will note that the Minister states that although there were some non-UK Factor VIII concentrates authorised for use in the UK, enquiries suggest that the products used in your own treatment were not imported from the USA.

The Minister encloses a copy of the report "Hepatitis C and the Heat Treatment of Blood Products for Haemophiliacs in the mid 1980s".

Unfortunately the Minister does not believe that the financial assistance given to people infected with HIV constitutes a precedent for other conditions. However she does states that it would be possible to estimate what the approximate cost of compensation for those infected with HIV would be, but it would be necessary to take into consideration the pressure which would inevitably follow from other groups for a "no-fault" compensation scheme. The Minister believes that the authorities did their best for patients and states that when technology was available to eliminate HCV from blood products this was introduced. She does not believe, therefore, that the NHS should pay compensation for non-negligent harm.

The Minister is watching the progress of the case brought by 113 claimants infected with HCV through blood transfusion which is currently underway in England. A Court decision is expected by April.

Obviously you will find this a disappointing reply, but if you do have any comments on the Minister's letter, please do not hesitate to contact me again.

Yours sincerely

GRO-C

GRO-A

Tel: GRO-C Fax: GRO-C
Email: GRO-C

SCOTTISH EXECUTIVE

Minister for Health & Community Care
Susan Deacon MSP

St Andrew's House
Regent Road
Edinburgh EH1 3DG

Rt Hon GRO-A
House of Commons
LONDON
SW1A 0AA

Telephone: GRO-A
scottish.ministers@scotland.gsi.gov.uk
http://www.scotland.gov.uk

5 March 2001

Dear GRO-A

You will be aware from my Private Secretary's letters of 19 December and 1 February that enquiries were being made into the points raised by your constituent GRO-A GRO-A about the importation of blood products from America. I apologise for the delay in providing a response but enquiries took longer than anticipated.

It may be helpful if I first of all explain that although blood products are available to NHSScotland free of charge from the Scottish National Blood Transfusion Service (SNBTS) it is possible for clinicians in Scotland to purchase products independently. Whilst there were a few non-UK Factor VIII concentrates (all manufactured by reputable companies) authorised for use in the UK enquiries of the Haemophilia Centre Director at Aberdeen Royal Infirmary suggests that the products used in GRO-A 's treatment were not imported from the USA.

The report *Hepatitis C and the Heat Treatment of Blood Products for Haemophiliacs in the mid 1980s* which was copied to you with my letter of 24 October outlines the complex and technical processes which were involved in the development of the HCV-safe product. The background on HCV is given at paragraphs 7 and 8 and details on the development of heat treated products at paragraph 13 to 28. I enclose another copy for ease of reference.

You ask about compensation and draw comparison with the scheme of payments to those who were infected with HIV through blood and blood products. I sympathise with those who have been infected with HCV through their medical treatment but do not believe that the financial assistance given to people infected with HIV constituents a precedent for other conditions.

We do know from the information gathered for the report on heat treatment how many haemophiliacs have been infected with HCV. It would therefore be possible using this information to estimate what the approximate cost of compensation to this particular group of patients might be but in doing so we would also need to take account of the inevitable pressure from other groups of people for a so called 'no-fault' compensation scheme. Having examined and carefully considered the circumstances surrounding the development of the heat treatment in Scotland, I am satisfied that there is no evidence that the authorities did anything other than their best for patients. When the technology was available to eliminate HCV from blood products this was introduced. I do not believe that the NHS should pay compensation for non-negligent harm.

You may be aware that a class action, involving 113 claimants infected with HCV through blood transfusion, brought under the Consumer Protection Act 1987 is currently underway in England. I am watching progress of this case with interest. The Scottish claims are sisted at the moment. I understand the English court decision is expected by April.

Yours,

GRO-C

SUSAN DEACON

GRO-A NHS Board

Public Health Department

GRO-A

NHS

GRO-A

Telephone GRO-A
Fax

Date 30 May 2003
Your Ref
Our Ref ST/CC/404

GRO-A

Enquiries to Dr GRO-A
Extension GRO-C
Direct Line
E-mail GRO-C

Dear GRO-A

I am writing again to you following our previous correspondence to pass on some additional information that I have received from the Scottish National Blood Transfusion Service in Aberdeen. It is our understanding that blood products supplied in GRO-A in 1982 were all provided from the Blood Transfusion Service in Aberdeen, and that no separate sourcing from commercial routes was done by the GRO-A service. Contact with the Pharmacy at Aberdeen Royal Infirmary who would have handled commercial factor VIII products in 1982 have unfortunately reported that their records do not go back to 1982.

It is still not possible therefore to ascertain which product and which batch you may have received in that year.

We are however, along with colleagues in the Scottish National Blood Transfusion Service and the Central Legal Office, continuing to seek further information about the sourcing of blood products at that time, and I would expect to write to you again if further information does arrive. In any case I would write to you again when investigations have been concluded, to summarise the detail of our investigation for your information.

Yours sincerely

GRO-C

Dr GRO-A
DIRECTOR OF PUBLIC HEALTH

Cc: Tracy Turnbull, Central Legal Office
Sandra Falconer, Scottish Executive

SCOTTISH EXECUTIVE

Health Department
Directorate of Service Policy and Planning

Health Planning and Quality Division
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Telephone: 0131-244 2434
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GRO-C
http://www.scotland.gov.uk

GRO-A

Your ref:
Our ref: 2003/0011080OR

2 June 2003

Dear GRO-A

Thank you for your recent e-mails seeking assistance in trying to establish batch and product details of the blood products you received when you were a patient in GRO-A Hospital in 1982. I have also just received your letter of 20 May to Malcolm Chisholm.

As you know I spoke to Henry Watson, the Haemophilia Director at Aberdeen, last week and I am aware that he had contacted you on the evening of Wednesday 28 May. He has advised that following a further check of the details given on the notes he holds and additional enquiries of the Scottish National Blood Transfusion Service, Protein Fractionation Centre, that he is able to confirm that the product you received in 1982 was in fact an SNBTS product. I understand that Dr Watson will write to you directly confirming the details.

I am sorry for the distress and the delay you have experienced in trying to obtain these details and trust that this resolves the issue in relation to whether you were treated with an imported product.

As you know discussions are still continuing with the UK Government to resolve issues relating to the Executive's proposal for an ex-gratia payment scheme to those who have hepatitis C as a result of receiving NHS treatment with blood and blood products. An announcement on this will be made in due course.

Yours sincerely

SANDRA FALCONER (MRS)

SCOTTISH NATIONAL BLOOD TRANSFUSION SERVICE

PROTEIN FRACTIONATION CENTRE

Our Ref: RJP/LP

22nd January 2001

Henry G Watson
Consultant Haematologist
Grampian University Hospitals
Ward 16 – Haematology
Aberdeen Royal Infirmary
Aberdeen
AB25 2ZN

Dear Henry

I do apologise for not replying sooner to your letter of 11th December – it got buried.

My preliminary answer to your question, based on my recollections, is that there was US imported material used by Hemophilia Directors in Scotland in the early 1980's. This would not have been supplied by SNBTS. It is quite possible that the individual could have been treated with US product. However I cannot be specific on whether this has definitely been the case in 1982 – unless there are local records in BTS.

Please let me know if you want me to research further.

With kind regards

Yours sincerely

GRO-C

Dr R J Perry
Director

In reply please quote: RG/FPD/2003/1070

25 April 2005

GRO-A

GENERAL MEDICAL COUNCIL

Protecting patients, guiding doctors

Dear GRO-A,

I refer to our previous correspondence regarding your complaint about Dr. Audrey Dawson.

In accordance with Rule 8 of the General Medical Council (Fitness to Practise) Rules 2004, the Case Examiners have considered your complaint. They have concluded that we do not need to take any further action on Dr. Dawson's registration, in respect of this.

When making their decision, the Case Examiners must consider whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. In doing so, they must have in mind the GMC's duty to act in the public interest, which includes the protection of patients and maintaining public confidence in the profession.

They first consider the seriousness of the allegations and then whether the GMC is capable of establishing that the facts demonstrate the practitioner's fitness to practise is impaired to a degree justifying action on registration.

The Case Examiners concluded in this case that, whilst the allegations were serious, there was no realistic prospect of establishing that Dr. Dawson's fitness to practise is impaired to a degree justifying action on her registration.

They said that:

GRO-A has a bleeding disorder, which has in the past required transfusion with blood clotting treatments. In 1982 it appears that she became infected with the Hepatitis C virus as a result of some Factor V111 concentrate administered to prevent pregnancy related complications. Although heat treatment of such products was introduced in 1985 there is no evidence that Dr Dawson acted in the knowledge that such treatment in 1982 would cause infection. In addition there is no evidence that any covert testing for Hepatitis C was undertaken before GRO-A requested a test from her GP in 1995. The discussion of the detailed results relating to GRO-A GRO-A's Hepatitis C status occurred after Dr Dawson's retirement, although Dr Dawson communicated results to the patient's GP. Accordingly the GMC will not be

taking any action on Dr Dawson's registration, whom we note retired from medical practice in 1996."

I acknowledge that this may be disappointing news for you but hope that given our explanation you understand the reasons for our decision.

Yours sincerely,

GRO-C

Richard Grumberg
Investigation Officer
Fitness to Practise Directorate
Direct Dial: GRO-C
Fax No: GRO-C
Email: GRO-C