Witness Name: Christopher Ludlam
Statement No.: WITN3428022
Exhibits: None
Dated: 14 November 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR CHRISTOPHER LUDLAM

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 7 October 2019.

I, Christopher Ludlam, will say as follows: -

Section 1: Introduction

1) My full name is Christopher A Ludlam. My date of birth is GRO-C 1946. My address is known to the Inquiry. My professional qualifications are B.Sc, M.B.,Ch.B, MRCP, MRCPath, Ph.D, FRCP, FRCPath.

2) I have set out the positions I have held as a haematologist in the curriculum vitae held by the Inquiry (WITN3428002).

3) All past and present memberships of committees and groups relevant to the Inquiry's Terms of Reference are set out in my curriculum vitae (WITN3428002).

Section 2: Responses to criticism of W2202

4) I am distressed to read of Mrs GRO-B 's criticisms in her statement. My recollection is that Mr GRO-B 's principal medical records are not in existence, despite my strenuous efforts to try and ensure that all medical records for individuals with haemophilia so be preserved.

Mrs GRO-B states in paragraph 13 of her statement that Mr GRO-B found me 'unapproachable' and 'didn't want contact with people.'

5) When patients attended with acute bleeds they would generally be seen by the duty haematology doctor who would organise appropriate treatment. If management was not straight forward I would be contacted for advice and generally went to see the patient. Patients would also be seen for periodic review at a clinic by myself or one of my colleagues. If any patient asked to see me personally I would do so if I was available. If I was occupied I would have tried to arrange a mutually convenient time to meet, or we could have had a subsequent telephone conversation if that seemed appropriate. Looking after patients with haemophilia was only a relatively small portion of my responsibilities – I was also helping to provide the main leukaemia and lymphoma service for South-East Scotland as well as a haematology laboratory service for the Royal Infirmary and all general practitioners in south Edinburgh.

6) When I first took up my appointment in 1980, because most patients attended the hospital with every acute bleed or they spent periods in hospital receiving treatment, I got to know many very well. This was at a time when the haemophilia team consisted only of me and a haematology registrar.

7) I very much appreciated that looking after people with long term chronic disorders places a particular responsibility of the health service to be readily responsive and especially for doctors to try and be as available as possible. Furthermore because there was only one 'Haemophilia Service' in South East Scotland, based at the Royal Infirmary, this placed a particular responsibility on it to be as flexible as reasonably possible in response to the patients. This was a particular responsibility on me as a provider of a 'monopoly' service – there was no other place where the patient could seek treatment.

Mrs GRO-B in paragraph 17 of her statement inquires why Mr GRO-B 'wasn't told before and he was told by Dr Henry Watson that Dr Ludlam didn't like telling people unless they asked'

8) Mr GRO-B attended the December 1984 meeting in the Royal Infirmary. The letter of invitation to the meeting indicated that patients could bring a spouse or friend. Mrs GRO-B would have been welcome at the meeting. We tried to make it very clear at the meeting that we had recently learned some people with haemophilia had tested

positive for the antibody to HTLVIII, the AIDS virus. We also emphasised that we were keen for all patients to make an appointment to see their haemophilia doctor to discuss their individual situation. I have referred elsewhere to the informal minute of that meeting which is to be found in (PRSE0002471). This was followed up by a letter and information sheet to all patients in January 1985 which again asked patients to make an appointment to see their haemophilia doctor. The information sheet also explained safety precautions that all people with haemophilia should observe.

9) We wanted to allow patients to seek information about their anti-HTLVIII status when they felt ready to discuss their own personal situation. Some individuals sought appointments almost immediately after the meeting whereas others required much more time. This was a difficult and sensitive issue because of the adverse publicity in the media about AIDS which created a hostile environment for those with haemophilia. At this time the significance of an anti-HTLVIII positive result was uncertain and there was no specific treatment for those who were positive. We wished to ensure that the Haemophilia Centre continued to be seen as a welcoming place for patients and family members and therefore we tried to be discreet about patients' AIDS situations. We did not want to apply pressure on patients to confront knowledge of their status. There were opportunities for patients to discuss AIDS when they collected home treatment, were reviewed at a routine clinic or they could drop in at any time to talk with a member of the medical or nursing staff. We developed a broad based supportive counselling service for all patients (anti-HTLVIII positive and negative individuals) which tried to respond to individual patient and family situations. Mrs Geraldine Brown, Social Worker, took a lead in the formal counselling process but the nurses became very busy responding to patients' needs during 1985 and 1986. Dr Alison Richardson, clinical psychologist, was also part of the team and Mrs GRO-B reports that she and her husband were visited at home and found her contribution helpful.

10) It is relevant to note that Dr Watson was not working in the Royal Infirmary in 1986, he was appointed in 1989 for three years.

11) The doctor Mr GRO-B saw at the end of 1986 (not Dr Watson) was therefore correct in responding to Mr GRO-B by saying that the agreed haemophilia team's view was that patients should receive the information when they inquired.

Mrs GRO-B in paragraph 18 states that 'They knew in 1984 that my husband had HIV but they did not tell him for two and a half years.' In paragraph 16 Mrs GRO-B

states that Mr GRO-B went to the Haemophilia Centre at the end of 1986 to ask for an HIV test'

12) For the reasons set out above we waited until Mr GRO-B asked for his result. Although Mr GRO-B 's first stored blood test positive for anti-HTLVIII was in May 1984 I did not know that he had tested positive until towards the end of 1984 when the preliminary results from Dr Tedder became available.

13) In the statement by Mr GRO-B 's brother, Mr GRO-B he describes how in late 1985 Mr GRO-B appears to have been told whilst an in-patient that he was positive for the AIDS virus. According to Mr GRO-B his brother was very upset learning about this late one night from a junior ward doctor and that he immediately left the hospital. It is not clear whether this was at the Royal Infirmary in Edinburgh or possibly at another hospital perhaps closer to his home. Thus it appears that Mr GRO-B at least knew there was a strong possibility that he had the AIDS virus but he made no attempt to inquire further about this possibility until nearly a year later.

Mrs GRO-B states in paragraph 20 that it was 'the doctors who put me and my son at risk by not telling him about his infection.' In paragraph 31 Mrs GRO-B indicates that there was no information about preventing other members of the family being infected.

14) Mr GRO-B had received information about how to reduce the risk of infection to others from the Haemophilia Society in the summer of 1984 (Paragraph 14 of Mrs GRO-B 's statement). Important safety information was given at the meeting in December 1984 and reiterated in the information sheet sent to all patients in January 1985. Furthermore condoms were discreetly given to patients at the Haemophilia Centre, particularly when they collected home treatment. Patients could also take condoms (placed in plain paper bags) from the Centre waiting room. Mr GRO-B therefore had the necessary safety advice brought to his attention to prevent infection of Mrs GRO-B . Non-sexual household contacts of individuals with HIV are not at significant risk of infection – again this was stated in the circular sent to all patients. Furthermore as Haemophilia Society members, Mr and Mrs GRO-B will have received advice in the Society's publications about safe sex. They could also have inquired of the Society about this and other issues in relation to AIDS.

Mrs GRO-B in paragraph 26 states that I enquired of her GP as to whether she had 'contracted hepatitis C' and Mrs GRO-B states 'there was not good medical reason' for accessing her medical records.

15) I do not have the case records of Mr GRO-B so I do not recall the context in which I spoke to Mrs GRO-B s GP. I considered that I had some responsibility to try and ensure that her possible risk of infection was considered and for this reason may have contacted her GP. I also considered that it was important for me to know if sexual partners of people with haemophilia had been infected although the spouse was not a patient of the haemophilia service. It was however important epidemiological information that would have been potentially informative for other local patients and families with haemophilia. If the GP had considered my inquiry inappropriate he could have said so and not given me the information.

Mrs GRO-B asks about 'missing notes 1985-87' and a letter I wrote explaining their absence.

16) I do not have access to this letter nor Mr GRO-B s case notes including his treatment records. My recollection is that his treatment record sheets do not record any home treatment being issued during this period. Although Mr GRO-B had haemophilia my recollection is that he experienced fewer bleeds that many individuals. Mrs GRO-B indicates that his records note that 'expired factor VIII was returned' (Para 11). This suggests that he had relatively few bleeds and that his unused factor VIII concentrate at home had not been used. I note that Mrs GRO-B states that on occasions he used factor VIII that had been issued to his brother and this may have led to an under-estimate of number episodes of bleeding if the information was not recorded on his 'home treatment forms' which were returned to the Haemophilia Centre.

Mrs GRO-B in paragraph 35 states that she believed that Mr GRO-B was tested without his consent for HIV and hepatitis C.

17) Mr GRO-B was tested in Dr Tedder's then recently developed and set up test for anti-HTLVIII without his consent. This was done as part of the arrangements at that time for monitoring infections that might arise in people with people with haemophilia. This was part of the monitoring process which included other investigations which were pertinent and commensurate with then current knowledge of haemophilia and its complications.

18) I am sorry that Mrs GRO-B felt that just because of my 'interest in research my husband was like a guinea pig for him'. My principal responsibility was to try and provide a high level of clinical haemophilia care for all patients. Part of this responsibility was to keep up to date with developments in the field and to respond to these. The rapidly changing haemophilia scene in the early and mid -1980s required new investigations to be introduced to provide optimal management of patients. In these circumstances, in relation to 'AIDS', as it was completely new, almost any monitoring of immune and virologic status was new and might be viewed as research although it was undertaken to try and comprehend what was being experienced by people with haemophilia and to be able to respond appropriately. Good clinical care and medical research are often found together and one does not exclude the other.

19) An example of the benefit of my active investigative approach was that I sent samples to Dr Tedder as soon as I knew he had an anti-HTLVIII test available. The positive results in those treated exclusively with NHS factor VIII concentrates was one of the first indications in late 1984 that the UK blood supply had become contaminated with HTLVIII. This led rapidly to the decision to heat treat UK clotting factor concentrates at the meeting in London on 10th December 1984.

20) As a result Scotland was the second country in the world to introduce heat treatment and render the concentrate non-infectious. The consequence of that is that there were no further HTLVIII infections by factor VIII in Scotland. Had I not had an active interest in the safety of blood products the meeting on the 10th December might not have been convened and there might have been a delay in introducing heat-treated concentrates in the UK. Additionally I might have waited for national guidance about testing and the results might not have been available until the several months later in the Spring of 1985. Such a delay would have allowed time for seeking consent from patients. Meanwhile further non-heat treated SNBTS factor VIII concentrate now known to be potentially infectious for HIV would likely have been issued to people with haemophilia in Scotland (Cuthbert et al, Vox Sang, 1988 54, 199-200). Furthermore, non-heat treated commercial concentrate use might have continued longer in the rest of the UK.

In paragraph 35 Mrs GRO-B thinks 'that he (Mr GRO-B) was tested for hepatitis C without his knowledge.'

21) Mr GRO-B will have understood that those with haemophilia were at risk of hepatitis and that is why it was routine to monitor liver function tests routinely. As well as learning about this from staff at the Haemophilia Centre he will have had the opportunity to learn more about it from the Haemophilia society Bulletins which he will have received as a member. For one form 'non-A non-B' hepatitis there was no diagnostic test in the 1980s, it was a diagnosis of exclusion, but around 1990 a reliable investigation, the hepatitis C test, became available and this was able to further characterise the nature of this hepatitis. The hepatitis C test did not identify a new form of hepatitis but did give it a more specific name.

22) The hepatitis C antibody test first became available in 1990 and in conjunction with Dr Peter Hayes and Dr Peter Simmonds it was used to characterise hepatitis in those with haemophilia. The usual arrangement was for Dr Hayes to see patients and explain about the hepatitis C antibody test. He would also discuss the significance of a positive result and what further tests and investigations might be appropriate. Unfortunately Mr GRO-B 's main medical case notes are not available and I am therefore unable to say whether he was explicitly asked for his consent before being tested.

23) I hope that my response has helped the understanding of Mr GRO-B s unfortunate and tragic situation.

Statement of Truth

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

Signed GRO-C

Dated 14/11/20