Witness Name: Dr Frank Ernest Boulton
Statement No.: WITN3456001
Exhibits: None
Dated: 12 June 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DOCTOR FRANK ERNEST BOULTON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 10 June 2019.

I, Dr Frank Ernest Boulton, will say as follows: -

Section 1: Introduction

1. Name. Frank Ernest Boulton:
   Address; GRO-C
   date of birth; GRO-C 1941
   professional qualifications; MD (Lond); FRCPath; FRCPEd
   Retired from clinical practice in June 2006

2. Senior Lecturer and honorary consultant, Liverpool University and Royal Liverpool Hospital; September 1975 to January 1980. Please note that my appointments to Liverpool University and the RLH terminated in January 1980 and not 1982 as stated by the Nevins in their witness statements. From January 1980 until September 1990 I was consultant in haematology and blood transfusion at the Edinburgh and SE Scotland Blood Transfusion Centre and the Royal Infirmary, Edinburgh; and from October 1990 to June 2006 I was consultant in haematology and transfusion at the National Blood Transfusion Centre at Southampton

3. Relevant professional organisations
   Royal College of Pathologists; UK Haemophilia Directors' Organisation

Section 2: Responses to criticism of the Nevin family

4. In answer to para 8 of Eleanor Lynne Nevin's witness statement, and para 8 of Sean Nevin's statement, I was indeed a witness to the Penrose Inquiry. In 1980 I was as aware as any of my colleagues responsible for the care of people with bleeding disorders such as haemophilia that transfusion of human-derived blood products carries a risk of transmitting viral hepatitis to any recipient although in early 1980 the degree of that risk was uncertain: nevertheless, all such products were tested for evidence of infection with syphilis, and the hepatitis B virus as indicated by the presence of Hepatitis B Surface antigen in the donated blood. It was also suspected that blood products obtained commercially, which I remember were available at Liverpool from at least 1976, carried a greater risk than products produced by the NHS laboratories at Elstree, Oxford and Edinburgh, which in turn carried a greater risk of transmission by cryoprecipitate from Regional Transfusion Centres such as Liverpool; but cryoprecipitate was less standardised, its clinical efficacy less predictable, and it was not risk-free even if reacting negatively in the most thorough screening tests then available; it was also much more cumbersome to administer to the patient, and therefore potentially more detrimental.
5. It was also recognised that the blood of some people with clinical viral hepatitis might have no evidence of the Hepatitis B Surface antigen or of other markers associated with infectious hepatitis which were being discovered around that time. As a form of hepatitis known as Hepatitis A which is transmitted by the faecal-oral route was also well established at the time, people with clinical hepatitis and evidence of neither hepatitis A nor hepatitis B were provisionally designated as being infected with a microorganism – thought most likely to be a virus – which was labelled 'non-A-non-B' hepatitis. The virus mostly responsible for this was isolated in 1990 and labelled hepatitis C.
6. Paragraph 9 of Eleanor Nevin's first written statement and para 9 of Sean Nevin's statement claim that I left Liverpool in 1982. This is incorrect as my employment there terminated on 13th January 1980. As I took annual leave over the preceding Christmas period my last day of work there was, to the best of my recollection, Friday December 21st, 1979. The leaflet referred to in para 17 of Mr Nevin's statement is dated April 1981 so I could not have been responsible for administering it to any patient based in Liverpool from that date. (However, earlier versions of that BPL leaflet would have referred to the risk of transmitting hepatitis.)

7. I may have met some of the Nevin family including the haemophilic boys in 1979 but I have no recollection of doing so and have not retained any notes from that time. I was the Haemophilia Centre Director at the RLH where many of the diagnostic tests were conducted under my direction, but this was mainly for adults and older boys. During my time at Liverpool, most younger boys were seen by Dr Martin, consultant paediatric haematologist at Alder Hey Children's Hospital. It seems that the Nevin boys were afflicted by a milder form of haemophilia requiring less treatment than the more severe form, although of course even mild haemophilia is disabling and causes significant morbidity; but it also seems likely that I was not involved in any treatment of any members of the family. I note that para 13 of Harvey Nevin's statement, which describes the 'training episodes', refers to the recruitment of Mr Sean Nevin as a previously untreated patient ('PUP') which would indicate that he had not received any treatment before those training episodes – from me or anyone else. Indeed, Sean writes (para 12) that he had never been given factor VIII for life saving purposes as he is only a mild haemophilic, and that the first treatment with factor VIII concentrate was on 19th February 1982.
8. I therefore submit that I was not responsible for organising any factor VIII treatment for Mr Sean Nevin at the RLH. I was aware of the great interest in testing for any side effects in PUPs receiving their first factor VIII treatment but feel that any such treatment must be justified solely on clinical grounds.

Section 3: Other Issues

9. There are no other issues I wish to comment on.

Statement of Truth

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

Signed : GRO-C

Dated: 12. JUNE 2019

Table of exhibits:

Date	Notes/ Description	Exhibit number