NOT RELEVANT

Witness Name Dr Bernard Anthony McVerry
Statement No: WITN 350 2001
Exhibits: NOT RELEVANT
Dated: 21/02/2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DOCTOR BERNARD ANTHONY MCVERRY

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

I, Dr Bernard Anthony McVerry, will say as follows :-

Section 1: Introduction

1. Bernard Anthony McVerry, GRO-C Leeds, GRO-C D.O.B GRO-C 1943 MB Bch BAO.
2. Senior Lecturer and Honorary Consultant. Haematologist to the Royal Liverpool Hospital. Mid 1980 to mid 1985. General Haematology care, Haemophilia care. Primarily responsible for establishing a bone marrow transplant centre for Merseyside. From mid 1985 until retirement (in 2012/13) Consultant Haematologist at St James' University Hospital, Leeds – General Haematology care and Haemophilia care.
3. Leeds member of UKHCDO in 1986.
4. I have no memory of Mr RW. Therefore the only evidence that I can offer in relation to this case is based on the records which have been supplied, which appear to be incomplete and my recollections of my general practise at the time (that is 35 years ago). As can be seen from my brief CV I did not arrive at St James's Hospital until the middle of 1985 and therefore I cannot comment on any matters which relate to before this date. When I arrived at St James's in mid 1985, I shared the clinics with Dr Swinburne. In mid 1986, we decided to split the clinics between adults and paediatrics, I took adults and she paediatrics.

Section 2: Responses to criticism of RW (Mr GRO-C 65)

1. Part of Mr RW's complaint was that he was not told as a result of a Hepatitis C test result until much later.

2. In February 1991 blood test indicated that there was an abnormality in liver function, but the cause of this was unknown at the time. However, it was known that the cause of these abnormal results was not Hep A or Hep B and that is why it was classified as non-A and non-B. There was nothing diagnostic that we could inform such a patient of, only that there was an abnormal reading on LFTs of unknown cause. I cannot say if the patient was informed of the abnormality, but the routine for these clinics was to check bloods at each review, so the patient's condition would be kept under review so when a definite diagnosis could be ascertained the patient could be informed of this.

3. Reliable Hepatitis C testing became available from late 1991/1992. Treatment programs became available much later. I understand that RW responded to treatment but now suffers from Cirrhosis. I have reviewed the case notes that have been disclosed in this investigation and the last recorded consultation is 11 July 1991 and this is with me. I could not find a definitive test result in these records indicating that RW had Hep C. According to these records RW does not appear to have returned to the clinic after 11 July 1991 (which was before Hep C testing was available).

   There are references to a number of 'did not attend' appointments for the clinic during 1992 and 1993. There is then a reference to a returned appointment letter in March 2000 and finally a notes from April 2000 that RW was being treated in Scarborough. In the early 1990s clinics tended to work on the basis of a patient attending, blood samples being taken for testing and results would be explained to the patient at the next visit.

4. **HIV TESTING**

   RW comments that there was a delay in receiving test results. I note a positive result of 27 December 1984, shortly before reliable tests became available in 1985 (National Haemophilia Database). This is before I came to Leeds so cannot comment as to why he was not informed then. RW suggest that he was not informed until, I believe 1988, but there is some correspondence in his case notes to suggest that he was aware of this problem before that. There is a letter from me to Dr Balfour dated 28 February 1991 which suggests this. There is also a letter from Dr Swinburne, Consultant in Charge, dated 8 May 1990 in which she states very firmly that RW was aware of his diagnosis for some time prior to this. Without the complete medical record it is not possible to say when this information was given to the patient.

5. Vcjd

RW states that he was informed that he may have received a batch of Factor8 from a contaminated individual. This information would have come from the HND or National Blood Transfusion Service. I have little recollection of this, but HND suggests that no haemophiliac has developed Vcjd and after all this time is unlikely to do so. At the clinical level where I would be involved, I could find no information regarding my involvement in the case notes nor any copies of letters relating to this.

6. **HEPATITIS B INFECTION**

RW was most likely infected prior to 1980 and possibly during his stay at the Lord Mayor Treolar School. I am unable to comment further as to who or when he would have received the result of a positive Hep B test. A more recent result suggests a high level of protective anti-body giving immunity to this infection.

Section 3: Other Issues

There is no test for Vcjd infection but it is considered unlikely that any Haemophiliac is at risk. Inactivated Factor8 became available in 1984/85 to prevent further infection from occurring.

STATEMENT OF TRUTH

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

Signed.. GRO-C

Dated.....16/02/2020.....