Witness Name: Audrey Dawson
Statement No.: WITN3503001
Exhibits: WITN3503002-3
Dated: 13 August 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF AUDREY DAWSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20th June 2019.

I, Dr Audrey Dawson, will say as follows: -

Section 1: Introduction

1) **Name:** Dr Audrey Anne Dawson.
Address: GRO-C
Date of birth: GRO-C 1933.
Professional Qualifications:
a) MB. Ch.B. (Honours), University of Aberdeen,1956;
b) MRCP, Royal College of Physicians of Edinburgh,1959;
c) MD. (Honours), University of Aberdeen, 1966;
d) FRCP, Royal College of Physicians of Edinburgh, 1972;
e) MRCPath, London, 1972;
f) FRCPath, London, 1978;
g) OBE, June 1991;
h) BD (Honours), University of Aberdeen, 2000;
i) PHD, University of Aberdeen, 2005;
j) LL.D (honorary), University of Aberdeen, 2013.

2) I was Senior Lecturer in Haematology, University of Aberdeen/Honorary Consultant Clinical Haematologist with Grampian Health Board, from 1967—1990, when I transferred to being NHS Consultant Clinical Haematologist, Grampian, Honorary Senior Lecturer in Haematology, University of Aberdeen, until I retired in1996.

3) Initially, I worked single-handed, doing clinical work in paediatric haematology at Royal Aberdeen Children's Hospital, as well as adult haematology at Aberdeen Royal Infirmary, until the appointment of a paediatric haematologist, in 1986. Thus, I was involved in the care of children with haemophilia, including GRO-B as well as adults.

I was a member of the British Society for Haematology throughout my senior career, and assisted with arrangements when the Society met in Aberdeen (President, Professor A.S. Douglas.)

4) I was President of the Scottish Society of Physicians, 1995-6; Member of Association of Physicians of GB and Ireland.

5) My special interests were in the treatment of leukaemia and lymphomas, e.g. I was founder member of the Scottish and Newcastle Lymphoma Group, and chairman of the group one year.

6) As consultant haematologist, from 1967 I was Haemophilia Centre Director, but shared responsibilities as a team with my colleagues, Dr D.J. King (paediatric haematologist), and the late Dr N.B. Bennett (Reader in Medicine, honorary consultant haematologist).

7) I was, and am, a member of the Medical and Dental Defence Union of Scotland

8) I am not a member of any groups or committees relevant to the Inquiry's Termsof Reference other than as mentioned above.

Section 2: Responses to criticism of GRO-B

9) The criticisms I have been asked to address are that:

Mr GRO-B states that although he was tested for Hepatitis C in 1992, he was not told about the Hepatitis C infection until around 1997.

Mr GRO-B claims that while he remembers being told that there were drugs to help treat the Hepatitis C infection, any further information was limited and inadequate. Mr GRO-B was not told about the long term effects of the Hepatitis C and the side effects of the treatments available at the time.

10) I have a great deal of sympathy for GRO-B and indeed all our patients with bleeding disorders who, in receiving treatment that was life-saving and was meant to significantly improve their quality of life, sustained the complication of transfusion- transmitted infection. I am sorry if there is anything that we did not provide that could have been done better or earlier to help these patients. However, it is sad that many patients feel that we conspired against them, or that we did not do our best for them at all times. I came into medicine to help people and throughout my consultant career I can never imagine a time when I would have done anything other than my best, for every patient I was involved with. Let me say at this point that I believe that everything that is written in GRO-B statement is a true reflection of what he remembers, and I hope that, as such, my response will be treated similarly.

11) In response to the delay in speaking with patients about HCV infection, the honest answer is that we did not know what to tell them, or what to do until the late 1990s. This is borne out by the observation that the same issue arises time and again from all the haemophilia centres around the UK and indeed elsewhere. Doctors caring for

haemophilia patients were aware of the issue of non-A, non-B hepatitis (NANBH) and were aware also of the lack of good information on the likely outcomes of NANBH. The published information around haemophilic liver disease was not conclusive and, furthermore, when HCV was discovered in 1989 it was not clear whether all NANBH or only a percentage of these cases were indeed due to HCV. The concern over there being more than one NANB virus is reflected in the leading UK textbook of the time on liver diseases (Sherlock, Diseases of the Liver and Biliary system, 8th Ed 1989).

12) Studies from early 80s did not completely clarify the issues around the nature and progression of non-A non-B hepatitis in patients with haemophilia. Although some studies suggested that the infection might be associated with progressive liver disease, this was not confirmed in other notable studies from highly reputable centres (Mannucci et al, 1982, White et al, 1982). In 1983 Stevens et al actually published a paper in British Journal of Haematology titled "Liver Disease in Haemophiliacs – an overstated problem' (Stevens et al, 1983). In March 1983 the UKHCDO published an article in the BMJ reporting, in total, two deaths in the whole of the UK related to hepatitis in patients with haemophilia and bleeding disorders over a 5-year period (Rizza et al 1983). In 1985 Hay et al published data that suggested a more rapid course of deterioration in haemophilia patients studied by longitudinal biopsy (Hay et al 1985) but this report was offset by other studies that continued to confirm low rates of progression of liver disease in haemophilic patients (Aledort et al, 1985). This lack of a good understanding of the natural history of NANBH persisted into the 1990s and the discovery of HCV in 1989 did not quickly clarify this situation.

13) In the early 1990s, when results of HCV testing were starting to become available, we were cautioned about the interpretation of these results. It was clear that the early, first generation tests were producing a lot of false positive tests to the extent where the national blood transfusion service made a decision to delay introduction of HCV testing until such times as it was deemed both sensitive and specific enough to be clinically useful. In the early to mid 90s it also became clear that around 20% of all patients who had a positive anti-HCV test had in fact cleared the virus through their own immune response. As such, in retrospect, it would have been inappropriate and indeed misleading in around 1 in 5 patients to indicate to the patient that they had chronic hepatitis C infection. In addition to our lack of understanding of the natural history of the disease and our difficulties in interpreting the early antibody tests, there was no available treatment for HCV at that time (Interferon Alpha became licensed for the treatment of hepatitis C infection in November 1994) and from the very small sized clinical studies that had been published it was clear that it had very limited success and a difficult side-effect profile for patients – as has been mentioned in several testimonies in this Inquiry to date.

14) The overall lack of a clear and clinically proven way to proceed is summarised in a report from 1996, which was generated in response to a request for an HCV look- back exercise by the ACMSBT. The draft interim report which was generated by ministers in early 1996 stated that part of the reason for no action before December 1994 was that even when infected individuals could be identified the lack of an effective treatment would result in a situation where informing those patients who were unaware of their

situation could not be justified, since it would cause further distress and anxiety without benefit (SGH.002.8359) (SGH.002.8302).

15) Based on all of these issues, and the lack of consensus on what to tell these patients and how to proceed with their clinical management, I think that it is very clear that, as I indicated above, the prime reason for our apparent inertia was that we did not know what to tell our patients, and we did not know how to treat them until the mid to late 1990s. As further evidence I note, in the context of GRO-B' submission, a letter of August 1995 indicating that, even at that fairly early stage, we had performed PCR and viral genotyping with a view to considering alpha interferon therapy in our patients (less than 8 months after it had become licensed for use in this indication) (WITN2223015).

16) I recall that we did arrange for combined specialty HCV clinics along with colleagues Professor Peter Brunt, hepatologist, and Dr Pamela Molyneaux, virologist in Aberdeen Royal Infirmary, and from memory, the first of these was held at the end of 1995 or the beginning of 1996.

17) Finally, I would like to draw attention to another letter that GRO-B has included as part of his statement (WITN2223008). In this letter my colleague Dr Bruce Bennett records a difficult consultation with GRO-B around the issue of his HIV infection. In my opinion this letter demonstrates the difficulties of dealing with transfusion transmitted disease and how opinion and practice change with time. In the letter Dr Bennett gives factual information where he can, provides the current best advice where needed and is guarded around prognosis – giving a balanced opinion based on the information that was available to him at that time. Much of what is said in this letter is no longer deemed to be relevant to HIV infection but at the time it was best opinion and it was delivered in a balanced and compassionate way trying to take into account the life of the young man to whom it was delivered. As a final comment on this letter, which reflects the way that we dealt with our patients, it is notable that Dr Bennett acknowledges the difficulty of assimilating all the content of the meeting and indeed, based on the difficulty involved in attending mid-week, offers the couple the chance to return for further discussion over the weekend.

18) I hope that this does help to try to answer some of GRO-B' questions. I have been totally honest in my reply but my recall of information and dates and times is, for obvious reasons, not as good as it once was. I will always be very sorry for the awful "double-edged" outcome of what we thought was going to be excellent treatment for our patients. With the benefit of hindsight, and with other alternatives to treat haemophilia, we would have done things differently.

Section 3: Other Issues

19) There are no further issues that I wish to discuss.

Statement of Truth

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

Signed GRO-C

Dated 13 August 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
	Interim Report on the Hepatitis C Lookback Exercise	WITN3503002
	Interim Report on the Hepatitis C Lookback Exercise	WITN3503003