Witness Name: Dr Audrey Dawson

Statement No.: WITN3503004

Exhibits: Nil

Dated: 27 October 2020

INFECTED BLOOD INQUIRY

SECOND WRITTEN STATEMENT OF AUDREY DAWSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 June 2020

I, Audrey Dawson, will say as follows: -

Section 1: Introduction

1. Name: Audrey Anne Dawson

   Address: GRO-C

   Date of Birth: GRO-C 1933.

   Professional Qualifications:

   - MBCh.B. (Honours), University of Aberdeen, 1956;
   - MRCP, Royal College of Physicians of Edinburg, 1959;
   - MD (Honours), University of Aberdeen, 1966;
   - FRCP, Royal College of Physicians Edinburgh, 1972.
   - eMRCPath, London, 1972;
   - FRCPath, London, 1978;
   - OBE for Services to Medicine, 1992;
   - BD (First class honours), University of Aberdeen, 2000;
   - PhD, University of Aberdeen, 2005;

- LL.D (honorary degree), University of Aberdeen, 2013.

2. After preregistration posts in Aberdeen Royal Infirmary , 1956-57, I was senior house officer in Hammersmith Hospital, London, till February 1958, when I became, first, Terminable Lecturer, then Lecturer in the Department of Medicine, University of Aberdeen, and honorary registrar in Aberdeen Royal Infirmary (haematology and medicine), until 1967, when I became Senior Lecturer in Haematology/honorary consultant clinical haematologist, until 1990, before moving to NHS consultant haematologist until I retired in September 1996. Until 1986, I was haematologist also to the Royal Aberdeen Children's Hospital.

3. On retiring, I set up a Fellowship in Haematology for graduates in Medicine, to enable early research in the specialty.

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.)

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

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.

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).

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

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

4. I also worked on the Parole Board, Local Review Committee of the Scottish Prison Service, for at least 10 years. I was, from its inception, on the board of Instant Neighbour, a prominent charity in Aberdeen.

Section 2: Decisions and actions of the Aberdeen Haemophilia Centre ("the Centre") and my decisions and actions at the Centre

5. This is a very difficult section for me to answer accurately. You are effectively asking me to recall structures and processes that were in place 60 years ago and then to comment on how and when they changed over the period of 35 years during my career. Due to the passage of time I cannot recall anything about the structures and processes that were in place at the Centre and how they changed overtime except to say that in Aberdeen I worked alongside Bruce Bennett who was effectively the expert in Haemostasis and Thrombosis. Bruce was a University of Aberdeen employee, a Reader in Medicine, with great expertise in bleeding conditions. I was more involved with the provision of the malignant haematology service and spent most of my time developing the service for leukaemia, lymphoma and myeloma. However, because, in the final 6 years of my working career (1990-96), I was the NHS employee I was more visible to the patients and so became identified by them as a treater of their haemophilia and I was officially the haemophilia director from 1967-1996 when I retired.

6. I have little or no recall of the processes that were in place for the ordering of factor concentrates. However, I should add that in the same way I also have no recollection of the process for ordering or deciding upon the purchase of any of the drugs that we used in our daily clinical practice and I have to say I doubt if any clinician practicing then would have recall of the structures in place and the process for purchasing countless other drugs which all had serious side effects – like chemotherapy drugs that we used in our patients. From memory, we used the products that came from the protein fractionation centre in Edinburgh and when we did not have enough of a product we would have used commercial factor, although I think in Aberdeen that was

rarely the case. The rule 9 questions ask if there was any financial consideration around the purchase of factor concentrates – I would answer there was none from what I can remember. I have no idea who was responsible for ordering any specific commercial concentrate, we just used what was provided by the Blood Transfusion Centre which had a department on site in Aberdeen. I supposed that the transfusion service were responsible for that process. Once the patients with haemophilia knew about factor concentrates and learned that there was home treatment in America they were very keen to have the same treatment option, which I can fully understand. As time went on I can remember that there was discussion in the Haemophilia Centre Directors meetings about trying to be self sufficient in factor VIII production for Scotland, because there was concern about viral infection in commercial concentrates. Most of the boys and men that we treated had severe haemophilia and so had no alternative to factor concentrate. We certainly would not have been able to continue home therapy if we had gone back to using cryoprecipitate. In cases of mild haemophilia we would have used concentrate when we felt that was required for difficult operations or for bleeding that didn't respond to DDAVP. This would have been based on clinical knowledge based on what was known at the time. In some situations we did use DDAVP for haemophilia A and use of this increased with time in the appropriate cases. The answer to most of the other questions is really the same, and on all occasions I would have made decisions based on my clinical knowledge at the time. I would always have done what I thought was best for the patient.

7. I am not sure how many patients we had with haemophilia or von Willebrand disease. The numbers changed with time and most of the patients never required treatment especially if you include the VWD patients many of whom had mild disorders. I would think that the total number of severe patients would have been less than 20. The annual returns from Aberdeen to the UKHCDO should clarify that.

Section 3: Knowledge of, and response to, risk

8. I can recount from memory what I knew about transfusion transmitted disorders but my recollection of the timing of events is vague at best. I was appointed in 1967, and we were aware that hepatitis B could be transmitted by blood in the early 1970s but were unaware of any other pathogens that were. There were not tests for other pathogens like non-A, non-B hepatitis. HIV of course was not active then. I really don't remember when in the 1970s I became aware of non-A, non-B hepatitis, but when we did, it did not change treatment much as it did not appear to be a progressive condition

and none of the patients were dying of liver disease, but would have suffered seriously if we had stopped their factor VIII treatment. In the early 1980s we started to hear more about virus inactivation treatments for factor concentrate but the main reason for that was to prevent HIV transmission although it was suggested that it might have a benefit for non-A, non-B hepatitis also. Being in Scotland I do remember the Blood Transfusion Service and the haemophilia directors discussing the aim of being self sufficient in coagulation factors as it was deemed the best option to reduce use of American concentrates, which appeared by that stage to be more likely to be associated with HIV transmission. I think that we used mostly Scottish coagulation factor and only bought commercial factor if we did not have enough to cover our needs. I have no idea who decided what treatment to buy or how it was decided.

9. Around 1990 hepatitis C was discovered. Testing of blood for it began a couple of years later because the tests were so poor initially, with lots of false positive and negative cases. We tested some of our patients but we did not know what to tell the patients because we were not sure how the virus behaved and whether having it meant that the patients would go on to have liver disease or be able to transmit it or not. It turned out that 1 in 5 patients who were positive for the antibody test had actually cleared the virus and so would have been wrongly told that they had chronic hepatitis C before the PCR test became available. In 1995 Dr Peter Brunt, who was a consultant in gastroenterology contacted me and we decided at that point to set up a clinic shared with Dr Molyneaux, a virologist, to see the patients with possible hepatitis C and try to interpret their results. I think it was then that we started doing PCR tests. It was at that time that we started treating some of the patients with interferon. I retired in late 1996.

10. My memory of HIV /AIDS was of the panic that set in once it was known that it could be transmitted by transfusion and was then shown to have infected men with haemophilia. It was highlighted in the Scottish Haemophilia Centre Directors meetings and there was discussion on how to test patients, and what to tell them based on the current knowledge. There was initially very little that was known but this, and what we told the patients, changed with time. We referred patients with HIV to colleagues in the infection unit locally.

11. In regard to some of the more specific questions that are included – I really don't feel that I could answer them with any degree of accuracy.

Section 4: Treatment of patients at the Centre

12. What I would say here is that in the 1970s and 1980s there was very little information given to patients about their treatments, and that this relates to all treatments across the board in all areas of medicine, not just the use of blood and blood products. In retrospect that is probably not a good thing, and dealing with informed patients is probably easier. However, that was not the case at the time and in fitting with this the patients did not expect that information and did not tend to enquire in any detail about treatments and side effects. From my own basic nature I can say that I would have tried to answer any request of this nature if I had been asked, but it is very difficult to compare practice then with the current situation, where information on conditions and treatments are widely available from many different sources.

13. You make reference to a statement provided to the Penrose Inquiry, a haemophilia patient who was infected with HIV and hepatitis C and who was treated by myself and Dr Bennett, said that the risk of infection which might occur as a result of receiving blood or blood products was never discussed with him, nor was their discussion of alternative treatments or the opportunity to refuse transfusions. You ask if the statement reflects the Centre's policy and/or practice while I was Director or Co-Director. I cannot imagine any situation where Dr Bennett or myself would, as is suggested, have forced a patient to have a transfusion against their will – I just cannot imagine that scenario or how it could physically happen.

14. When patients were told about transfusion transmitted infection this would have happened at a standard clinic appointment. The patients were not told any such detail as a group and we tried to maintain confidentiality. Patients could then attend again and bring partners and family with them if they wished to. Testing of family members was not routine but I am sure that it would have been offered if the request was made.

15. You ask specifically about a meeting between Dr Bennett and a patient and his current partner at the time. You refer me to a letter of 4 June 1987, in which Dr Bennett records his discussion on implications on HIV and haemophilia with that patient. You ask if the advice given by Dr Bennett reflected the Centre's policy at the time. I have reviewed that letter and I would agree that what was said would have reflected what we knew and what we were telling patients at that time. Of course a lot of what is said

in this letter is no longer practiced but that was the current best knowledge and advice at the time.

16. You ask what was discussed by myself and Dr Watson in relation to the Penrose data notes of January and March 2011 for the Penrose Inquiry on HIV infection [PRSE0001248] and [PRSE0002684]. I don't remember speaking with him but I would have thought he was just trying to clarify that what he submitted was correct and that there was nothing else I could remember that had been omitted, but I have no recall of this whatever.

17. I think that we had 3 patients infected with HIV all had severe haemophilia A. I don't know the number of HCV infections but it was estimated at the time of the Penrose Inquiry, and should be available from that. With regard to the confidentiality of patients, that is something we always tried to maintain but we did have a policy of flagging up blood samples from patients with haemophilia for the labs to allow then to take precautions with them. I don't remember when we started doing all of this however.

18. From the research point of view all of the studies that you mention, none of which I recall in detail, were all performed as part of the Scottish Haemophilia Directors group. We believed that in each study the patients were receiving a better and maybe safer form of treatment. There was no "standard of treatment" as such and we used the treatments in day to day management of the patients at the centre – there were no other treatments most of the time, apart from commercial treatments. I don't remember any details of what we told the patients when we were treating them – it was all just part of the standard management of the patients with what we thought was the best treatment. I never received any financial reward for any of these studies or from any commercial company. I do understand the principles of ethics and I think that at all times I followed these, in that I would never have considered giving a patient treatment if I thought they would suffer any harm from being in the study.

19. Patients with HIV/AIDS were still followed up in the haematology clinic. We took advice about their management from specialist colleagues in the Infection unit in Aberdeen and at least one of them was treated with AZT. I retired before other anti-HIV drugs became widely used.

20. There was no treatment for HCV except interferon which we started to use in 1995 or 1996. We did develop a combined clinic between virology, hepatology and haematology to plan the care of patients who were shown to be HCV positive and to have on-going infection. I do remember telling the patients about the side effects of interferon and saying that the most common side effect was feeling as if you had flu as a result of treatment. We did not have any patients with active hepatitis B as far as I can remember.

21. We did adopt a policy of offering testing for HCV to all patients who came to attention and who had had treatment with concentrate in the 1970s and 80s.

22. We did not keep separate records for any of these patients – everything was kept in the standard NHS G/ARI notes.

Section 5: Self sufficiency

23. As I indicated earlier I was aware of attempts to make Scotland self sufficient in the 1980s based on the suggestion that Scottish factor concentrates might be safer than commercial concentrates. This was an aim that arose from BTS and the Scottish Directors. I do not know any of the detail of how commercial concentrates were chosen for use – only that they were only used where we had no option – because we didn't have enough NHS concentrate to provide for the patients. The only other thing I recall is that the Scottish Directors and SNBTS felt that Scotland was nearer to achieving self sufficiency than England and Wales and that this was deemed to be a good thing because of concern over commercial concentrates from America.

Section 6: Blood Services

24. We received concentrates from the Blood Bank in our local BTS. The concentrates were mostly SNBTS concentrates. We used the batches as they arrived in BTS and the Blood Bank staff kept details of the amount of products that were issued to each patient through the year. At the end of each year Rosemary Spooner from Oxford used to come up to Aberdeen and take the full record of all the uses for each patient from the Blood Bank for the UKHCDO annual return. This continued until I retired. I would have said that our relationship with SNBTS was good, as they provided the best

treatment they could and played a key role in maintaining records of its use whenever it was released from the transfusion centre.

25. There were many discussions with SNBTS and local BTS about the risk of infection but none of these were formal meetings and in them we tried to make the best decisions that we could based on what was known at the time. The minutes of the SHCDO might contain details of what was said in these meetings. This obviously changed with time as research was published and we always felt that the SNBTS protein fractionation centre did their best to keep up with developments in treatment and treatment safety.

Section 7: UKHCDO

26. I had little involvement with UKHCDO. We supplied data to the UKHCDO on a yearly basis to help to collect information that would ultimately improve the treatment of patients with bleeding disorders. Most of the UKHCDO involvement for Scotland was carried out by Edinburgh and Glasgow who were the bigger centres. Things that were discussed in UKHCDO would be passed on to us at the SHCDO meetings.

Section 8: Pharmaceutical companies/medical research/clinical trials

27. I was never involved in any consultancy or advisory capacity with any company who were making concentrates. I do not remember ever receiving gifts or money from the aforementioned. I cannot remember having any financial support for any project from a pharmaceutical company making blood products.

Section 9: Involvement with the financial support schemes

28. You ask me about my involvement with the different Trusts or Funds. I certainly wrote to support at least 1 patient in an application to the Macfarlane trust as you have indicated (PRSE0003592 pg. 37, 38 and 51). I would have done the same for any other patient who approached me. Discussion about this type of support would have taken place at outpatient appointments or if the patient contacted us by mail to request our support in an application. I don't remember if we had a departmental policy about referral but we would never have declined such an approach. The information given to any of the trusts would have been similar to that given in the letter that you refer to above.

Section 10: Other issues

29. You ask me about any complaints made about me. One patient, I recall, through a lawyer based in Manchester, accused me of removing information from her records. I don't recall the outcome of the case as I never heard anything official of the outcome.

30. I am aware of the case of GRO-A that you mention. I am not aware of any other complaints against me that are relevant to this Inquiry, and I heard no more about that case.

Statement of Truth

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

Signed GRO-C

Dated 27th October, 2020.