Witness Name: Anna Pettigrew
Statement No.: WITN3527001
Exhibits:
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR ANNA PETTIGREW

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28th June 2019.

I, Dr Anna Pettigrew will say as follows: -

Section 1: Introduction

Answer to Question 1

My name is Dr Anna Frances Pettigrew
My DOB GRO-C 1949
Qualifications; MB ChB (Glasgow 1975); BSc.(Hons Biochemistry Glasgow 1971)

Answer to Question 2

I have never held the position of Consultant in Haematology nor in any other speciality.
After completing my Pre Registration House Officer Posts in Medicine and Surgery, I took an additional Pre Registration House Officer Post in Medical Paediatrics at the Royal Hospital for Sick Children in Glasgow (RHSC) until February1977.
Thereafter, I was appointed to the post of Haemophilia Senior House Officer in the Professorial Department of Medicine at the Royal Infirmary, Glasgow. I was an SHO in Medicine, but also had duties in the Haemophilia Unit under the then Director Dr Colin Prentice and subsequently Professor Charles Forbes.

My recollection of treating adults with Haemophilia was of many who had debilitating joint disease and lives very much restricted by their Haemophilia, requiring frequent hospital admissions. Some of these patients had nephews whom I later treated in the RHSC.

I took Maternity Leave in February 1979, but was unable to return to my post as Haemophilia SHO as the then Professor of Medicine did not accept women returning from Maternity Leave in his department.

In May 1980, I was appointed by Dr Michael Willoughby, Consultant Haematologist, to the post of part time (6 sessions) Clinical Assistant in the Haematology/Oncology Department of the RHSC.I was based mainly in the Day Unit (which served all departments in the hospital) where haematology and oncology patients attended for procedures such as chemotherapy, venipuncture, blood transfusion and clinical assessment. Children with bleeding disorders such as Haemophilia A, Factor IX deficiency and VonWilliebrands disease also attended there during office hours for treatment of bleeding episodes or for review.

I worked closely initially with the Haemophilia staff nurse and then with Sister Murphy when she was appointed as Haemophilia Nurse Specialist. We were both involved in the training of parents for home therapy; supporting families of newly diagnosed children and also carried out both home and school visits.

In latter years these children attended ward 7A. I also assisted in the weekly Leukaemia outpatient clinic and in the Haemophilia clinic. I held this post until January 1989 when I commenced training for General Practice and became a Principal (and later Senior Partner) in Springburn Health Centre, Glasgow in February 1991.

Answer to Question 3

I am not a member of any such Committees or Groups.

Section 2: Responses to criticisms of Mr GRO-B

In answering these criticisms, I have not had access to the records of the RHSC. I understand that they have been destroyed, in accordance with policy, due to the passage of time.

Question 4

The criticism that I am asked to comment on (as set out in the Rule 9 Request) is that in paragraph 38 of his statement, Mr GRO-B states that I prescribed the AZT treatment to his son following my suggestion that there were no obstacles or difficulties in having this treatment. Mr GRO-B further states that a pharmacist informed him that his son was being prescribed too much AZT and that he subsequently saw in his son's medical notes that he had been prescribed an overdose of this drug. He states that the doctors at Yorkhill Hospital lacked experience when it came to treatment for HIV/AIDS as well as with children or haemophiliacs.

Answer to Question 4

I would not have been responsible for the decision to commence AZT to GRO-B GRO-B That decision, as well as the dose to be prescribed, would have been taken by the Consultant Haematologist following the advice of the consultants in Infectious Diseases based at that time in Ruchill Hospital. I may have given the medication, but I note that Mr GRO-B states in paragraph 38 of his statement that I had told him that there were no obstacles to "getting" (i.e *obtaining)* this medication rather than, as stated in the Rule 9 request, "*having*" *(i.e. taking)* this medication. It's possible that I may have said to Mr GRO-B that there should be no obstacles in getting this treatment.

This was a relatively new drug, and with my experience in administering chemotherapy, I would not have stated that there would be no side effects from this medication.

I left the department at the end of January 1989 and would not have been the clinician monitoring GRO-B's response to and side effects from treatment thereafter.

At that time doctors in the RHSC would not have had experience of treating children with AIDS and would have relied on advice from the consultants at Ruchill. As far as I recall, there would have been few, if any specialists in the treatment of AIDS in children in Scotland at that time. The clinicians at Ruchill Hospital were the only doctors in Glasgow with experience of treating patients who were infected with the HIV virus.

The Clinical Haematology staff at the RHSC worked closely with our colleagues in Ruchill and as well as the close clinical relationship we attended several educational meetings organised by our Ruchill colleagues as the knowledge of the HIV disease and its treatment evolved.

Question 5

The criticism I am asked to comment on is that in paragraphs 60 and 61 of his statement, Mr GRO-B states that evidence I provided to the Penrose Inquiry was in reference to his children. He exhibits the page of which he says refers to this incident. He further states that he felt as though I was trying to imply that parents were acting irresponsibly. He states that I was not taking responsibility for the treatment that was provided to the children.

Answer to Question 5

I am very sorry that Mr GRO-B felt that I was implying that he and his wife were acting irresponsibly. That certainly was not my intent and with the upmost respect to Mr GRO-B I would not interpret the passage of my evidence in the way suggested. This part of the oral statement, given by me to the Penrose Inquiry, was to inform the Inquiry of the impact of having a child with Haemophilia on the family and the impact of Haemophilia on the affected children and why this led to Dr Willoughby to introduce a programme of home and prophylactic therapy. The aim of this programme was to reduce the frequency of visits to hospital; to allow therapy to be administered promptly and to try to prevent life changing complications of bleeding episodes such as arthropathy.

I have great respect and admiration for the parents of children with Haemophilia and appreciate the difficulties they faced. I knew the families, and particularly this family, well and would never have considered them other than loving, committed and responsible parents. I sought to illustrate in my evidence, that the normal inquisitive and explorative behaviour of a toddler could, in a toddler affected by Haemophilia, result in the child having to be taken to hospital and the inevitable knocks and bumps in these toddlers could be potentially very serious.

Section 3: Other Issues

- I note that in Paragraph 38 of his statement Mr GRO-B states that he felt that the doctors at Ruchill Hospital lacked experience in dealing with children or Haemophiliacs. The physicians and staff at Ruchill did however, also treat other paediatric patients. Children with infectious diseases had, for many years (until, I think the early to mid-90s), been transferred from the RHSC to or admitted directly to Ruchill.

I also remember admitting children directly to Ruchill when I worked in General Practice.

- It is unfortunate that Mr GRO-B s son had to be admitted to the ward which dealt with HIV patients who, at the that time, would have been mostly those involved in intra venous drug misuse. These physicians, like the majority of doctors who are not involved in the treatment of Haemophilia, would not have expertise in haemophilia. It may be that they were of the impression that the parents, or the patient, who had administered home treatment and dealt with recurrent bleeding episodes for many years were more capable than them of managing their haemophilia. As already stated, however, there was close clinical liaison between the Infectious Disease consultants and the Haematology consultant and I am sure that if there had been any complicated bleeding episodes, that liaison would occur.
- Blood testing; I note that Mr GRO-B in his statement at paragraph 22 onwards refers to blood being taken without the permission or knowledge of the parents. By way of explanation, blood specimens were taken on a regular basis, perhaps 3-6 monthly). It was my practice to inform the parent and older patients that we were checking for Hepatitis B, blood count and liver function tests and that we were aware that some Haemophiliacs had abnormalities of liver tests, but at that time we did not know the cause or natural history of this abnormality. The specimens for testing for Hepatitis B were sent to the Regional Virology Laboratory where I understand the serum samples, post analysis, were stored. When what was then called the HTLVIII virus was discovered and a test for this became available, these samples were tested retrospectively. This was undertaken without having been requested by Dr GRO-D. Patients who tested positive were seen at the clinic, the result explained and a confirmatory sample taken.
- Attitudes to HIV; In Paragraph 40 of his witness statement, Mr GRO-B describes the infection control steps that were taken when his son was admitted to the RHSC. We haematology staff were upset at these measures imposed on us by Infection Control. At that time, there was hysteria and fear among the general public with regards to this new "plague". We even had portering services in the RHSC stating that they would not transport any child with AIDS. It was difficult to convince both professionals and the public that the risk of transmission out with the known routes was low. We did advise parents not to inform their extended families, school or friends about the infection as we feared that they would be excluded. This secrecy undoubtedly left families feeling unsupported and alone. Our social worker, Christina Leach, set up a support group for these parents and Sister Murphy, myself, Dr GRO-D and Dr Gibson tried to offer support at clinic and day unit attendance.

- Those involved in caring for patients with Haemophilia, and particularly those in Paediatric practice, build up a close relationship with the patients and their families over the years. All clinical staff involved, such as Dr Willoughby who instituted home therapy with Factor concentrate, acted in what was thought to be in the best interests of their patients. The evidence definitively implicating the transmission of HIV through use of Factor concentrate, particularly commercial concentrate, evolved slowly (this was pre introduction of the world wide web and internet access to journals and social media). When infection was confirmed in some of the children there was an awful realisation that, in retrospect, the treatment given in good faith had caused dreadful harm. When the transmission of HIV through concentrate was confirmed, steps were taken to reduce this risk of transmission of infection. Dr GRO-D drew up guidelines that patients be treated with SNBTS Factor VIII, which was thought to carry less, though not negligible risk, and those patients with no or little previous exposure to concentrate be treated with cryoprecipitate or DDAVP where appropriate. Factor VIII and IX were subsequently heat treated, a process which inactivated the virus.

Statement of Truth

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

Signed GRO-C

Dated 22nd December 2019.

Table of exhibits:

Date	Notes/ Description	Exhibit number