Witness Name: Brenda Gibson
Statement No.: WITN3528001
Exhibits: None
Dated: 13th December 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR BRENDA GIBSON

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

I, Dr Brenda Gibson will say as follows: -

Section 1: Introduction

1. Professor Brenda Elizabeth Simpson Gibson
   DOB: GRO-C 49
   Address: C/O Royal Hospital for Children, 1345 Govan Road, Govan, G51 4TF
   Qualifications: MB ChB (Aberdeen University), FRCP (London), FRCPCH (London) FRCPath (London), DFM (Glasgow University).

2. Appointed Consultant Paediatric Haematologist in 1984.
   Royal Hospital for Children, Glasgow (RHC)
   - Lead Clinician.
   - Director of Haemophilia Unit 1988-1996.
   - Programme Director for the Haematopoietic Stem Cell Transplant Programme- 1988-present.
   - From 1984 – 1988 I had responsibilities for general clinical and laboratory haematology, leukaemia and stem cell transplantation.
   - From 1988-1996 – in addition to the responsibilities listed above, I assumed responsibility for haemophilia.

- Since 1996 my main responsibilities have been for providing care for children with leukaemia and those undergoing stem cell transplantation having demitted responsibility for haemophilia in 1996.

3. Member of Scotland and Northern Ireland Haemophilia Centres Directors 1988-1996

Section 2: Responses to criticism of Mr GRO-B

4. I have been asked to respond to a criticism made of me by Mr GRO-B, father of identical twins who both had severe haemophilia A and who both contracted HIV and Hepatitis C from blood products.

   My Rule 9 states that in paragraph 45 of his statement, Mr GRO-B states that myself, and Sister Chris Murphy, attended his family home in Glasgow at a time when his wife made a comment that she felt like "walking in front of a train". He states that I responded that she (his wife) did not look like a woman with depression.

   The exact wording in Para 45 is- "I recall Dr Gibson and Sister Chris Murphy visiting my wife at home in GRO-B in Glasgow when she was at her lowest while treating GRO-B at home (circa 1991). She told Dr Gibson that she felt like walking in front of the train GRO-B. My wife always kept care of her appearance and Dr Gibson remarked that she certainly did not look like a woman with depression"

   Para 46 of his transcript indicates that my comment was not perceived in a critical way.

   I don't recall what was said during that visit, but I do remember the visit itself. GRO-B. I can only speculate why I visited Mrs GRO-B at home. Usually we visit families at home to spare them a hospital visit when they are very unwell and when a hospital visit would pose difficulties. Sometimes it is to take bloods and sometimes to review children and suggest any change in medication. I would not have visited this family to take bloods because Mrs GRO-B did this herself. I don't actually remember GRO-B being there and Chris Murphy and I may just have gone to talk with GRO-B and bring out supplies of Factor VIII concentrate and needle disposal bins etc. We went during school time and that was probably deliberate.

Firstly, if I said anything that caused offence to GRO-B or her husband, I unconditionally apologise. I would have made this visit to support the family and to be seen as being critical is the last thing that I would want.

Secondly, if I said the words "you do not look like a woman with depression", I would have meant this as a compliment in that despite how she felt and despite everything that she was dealing with, she was managing to maintain a front of normality for her family. This could not have been easy. She always looked smart and was very fashionable.

As I have mentioned, I don't remember what was said at the visit, but I do remember sitting in the car outside the house afterwards and feeling overwhelmed by the tragedy of it all. These were identical twins who were becoming less identical every day and we didn't know if this family would lose one or both twins to AIDS. I also remember being minded, as I always am when visiting families at home, that in addition to one child's illness, they have to cope with all of the other stresses and strains of their other children and day to day life.

Section 3: Other Issues

5. I would like to respond to some points in Mr GRO-B 's statement, but to restrict my comments to events that occurred between 1988 and 1992 when I was the Haemophilia Director. I have had no access to GRO-B or his twin's medical records and make these responses from memory, accepting the accuracy of dates in Mr GRO-B 's statement. I note that he only had access to a medical record for GRO-B from 1991-1992.

6. Mr GRO-B 's twin sons acquired HIV and HCV from Factor VIII concentrates and criticism has been made of the use of commercial Factor VIII at RHC, Glasgow which was associated with a higher incidence of HIV transmission. Seroconversion for HIV happened sometime after 1981. I was appointed a Consultant Paediatric Haematologist in 1984 and became the Haemophilia Director at RHC in 1988. Between 1984 and 1988 my responsibility for haemophilia was restricted to out of hours cover. I was not involved in the selection/commissioning of Factor VIII products before 1988 and certainly not in the early 1980's when seroconversion occurred.I was not involved in, and cannot comment on the following prior to 1988: the counselling/support given to parents of boys with haemophilia, the treatment

of their haemophilia, the consent taken for treatment or viral screening or the risks associated with the available Factor VIII concentrates. By 1984, when I was appointed a Consultant Paediatric Haematologist, Scotland approached self sufficiency with the SNBTS producing Factor VIII and IX concentrates. Heat treated concentrate was introduced in January 1985. In 1986, following evidence that the degree of heat treatment of the SNBTS Factor VIII concentrates (68 degrees for 24hrs) was insufficient to eliminate transmission of viral hepatitis, SNBTS heat treatment was intensified (80degrees for 72hrs) and concentrate available for clinical use by April 1987. By 1988 heat treated Factor VIII concentrates (80 degrees for 72hrs) were in use and had been since April 1987. These products did not transmit HIV or viral hepatitis and Scotland became the first country to have a product that did not transmit hepatitis C. High purity Factor VIII concentrates were to follow in 1993 and recombinant Factor VIII in 1996. After becoming responsible for haemophilia care I was involved in 'Previously Untreated Patients' (PUP) studies for heat treated Factor VIII concentrate, followed by high purity Factor VIII and recombinant Factor VIII concentrates. There were Patient/Parent Information Sheets which provided details of the product/ concentrate which would have included any potential associated risks. This would have complemented verbal discussion which would have outlined potential benefits and risks and consent was obtained as I recall. My recollection is that this was written consent.

7. Mr GRO-B states that the risks associated with Factor concentrate were never discussed with him or his wife. The HIV virus was isolated in 1984 and routine NHS HIV testing by the Regional Virus Laboratory was established by October 1985. GRO-B and his twin were known to be HIV antibody positive in 1985 when they were 10 years old and Mr GRO-B states that his wife was informed of this by Professor GRO-D HIV seroconversion is thought to have happened around / after 1981 for the majority of HIV positive haemophiliacs in the UK. He also states that his wife was told in 1980 that the twins had non A, non B hepatitis and that this was confirmed in 1985 by Professor GRO-D who told GRO-B that both twins had Hepatitis C and had acquired this from infected Factor VIII concentrate. I was not involved in telling any families that their children were HIV positive and can make no comment on the selection of Factor concentrate, information given on the risks of Factor VIII concentrate, consent for viral testing, the manner in which the family were given the results, or the counselling and advice/information given for the twins and other family members after they were known to be HIV/HCV positive.

There was a UK Haemophilia Society Haemofact Newsletter on AIDS, which families had access to.

8. We did monitor CD 4 counts in all boys who were HIV antibody positive as a marker of their immunodeficiency. The mothers took the blood samples along with other routine blood samples. We would not have taken written consent for monitoring, because this would have been a routine investigation and appropriate clinical management in a patient developing immunodeficiency. GRO-B 's CD 4 count was low and caused concern. I note from Mr GRO-B 's statement that he was notified of this.

9. All patients who were HIV positive were managed jointly with consultants from the Infectious Diseases Department at Ruchill Hospital, Dermot Kennedy and Campbell Love. This allowed access to the best local expertise in HIV. From 1985 onwards GRO-B became symptomatic with weight loss and mouth ulcers. He was started on Azacytidine (AZT) in or around 1989 - the only treatment available at that time for HIV. In para 38 of his statement, Mr GRO-B states that he was told by a hospital pharmacist that GRO-B was receiving the wrong dose of AZT , which caused side effects , and that the dose was subsequently halved. I am not in a position to comment on this without access to the medical records, which I understand are no longer available. He also states that doctors at RHC didn't have experience in the management of AIDS and doctors at Ruchill didn't have experience in the management of children or haemophilia. HIV is an infectious disease and it is true that doctors at RHC, who were paediatric haematologists, had no prior experience of HIV/AIDS until their patients with haemophilia were affected. As paediatric haematologists we had no previous experience of HIV /AIDS and would have taken the advice of the consultants in Infectious Disease at Ruchill who had this experience. This would have included advice on the appropriateness of treatment, on the drug to be prescribed and on the dose of AZT; this was probably decided by joint communication. AZT was an unusual drug to give to a child and experience would have been limited. However, Ruchill doctors did have paediatric experience. There was no consultant in Infectious Disease at RHC until 1995 when Dr Rosie Hague was appointed and all infectious diseases of significance were treated at Ruchill at that time. It was not only boys with haemophilia who were jointly managed with the Infectious Disease team at Ruchill during this period, but also patients with leukaemia who contracted chickenpox or measles. Neither did we at RHC have experience of Hepatitis C.

There was no paediatric hepatologist at RHC, although one of the gastroenterologists had an interest in liver disease and I did refer boys with hepatitis C to him. My recollection is that both Drs Love and Kennedy would come to RHC to do joint consultations on boys infected with HIV or /and hepatitis C. They came to RHC to prevent the boys having to attend Ruchill Hospital for treatment. We in turn tried to support them around issues related to haemophilia.

10. In December 1990 GRO-B developed pneumocystis carinii pneuemonia (now called pneumocystis jirovecii) classifying him as having AIDS. In Para 40, Mr GRO-B talks about the stigma of HIV infection. It is true that precautions were taken which are now known to be unnecessary. However these would have been compliant with guidance issued by the Control of Infection Department and staff would have had to comply. I don't think that it is true that the nursing and medical staff, who were responsible for haemophilia, avoided the boys and remember very clearly the frustration and anger felt by all haemophilia staff about the precautions that were imposed. These were boys whom we had known for a long time and we sympathised with how they and their families felt about the control of infection precautions.

11. The Hepatitis C virus was identified in 1989. Routine screening of blood donations was introduced throughout the UK in September 1991 using second generation ELISA and RIBA tests. Under 0.1% of blood donors were positive for antigen to hepatitis C and these donors excluded. The UKHCDO issued guidelines on Hepatitis C testing in 1991. HCV testing was added to routine surveillance for hepatitis (HBV, HAV, LFTs) in 1991 in accordance with UKHCDO discussions and guidance. My recollection is that advice given to families was complemented by a pamphlet from the British Liver Trust / UK Haemophilia Society which the families had access to. Vaccination against hepatitis A was recommended in 1992 by UKHCDO. RHC complied fully with all of these guidelines.

Statement of Truth

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

Signed GRO-C

Dated 13/12/19

Table of exhibits:

Date	Notes/ Description	Exhibit number