Witness Name: Marc Turner
Statement No.: WITN3530001
Exhibits: NIL
Dated: 27th June 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MARC TURNER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 June 2019 addressed to Hazel Thomson (Acting Director).

I, Marc Turner, will say as follows: -

Section 1: Introduction

1. On behalf of SNBTS I would like to express its sincere apologies to Mr GRO- and his family for the fact that he became infected with HCV from a blood transfusion and for the suffering that they have endured as a result.

2. Name: Marc Leighton Turner
Address: Scottish National Blood Transfusion Service, The Jack Copland Centre, 52 Research Avenue North, Heriot-Watt Research Park, Edinburgh EH14 4BE.
Date of Birth GRO-C 1959.
Qualifications: MB ChB, PhD, MBA, FCRP(Edinburgh), FRCP(London), FRCPath.

3. I am the current Medical Director of SNBTS, a position which I have held since April 2011. My principal responsibilities relate to oversight of the clinical governance of the organisation including compliance with the legal and regulatory responsibilities under SNBTS's Blood Establishment Authorisation, Human Tissue Authority licence and Advanced Therapy Medicinal Product manufacturing licences. I provide management to the SNBTS Medical and Clinical Scientist staff, the Tissues, Cells and Advanced Therapies Directorate and the Quality and Regulatory Compliance Directorate.

Section 2: Response to Criticism of GRO-B

4. Please note that I was not a member of SNBTS in 1988 and although I have been a member of the organisation since 1994, I have not been previously involved in the investigation or responses to Mr GRO-B Due to the passage of time we no longer have anyone left in the organisation who was involved at the time at a senior medical, scientific or managerial level. My testimony on behalf of SNBTS is therefore based on and constrained by, the internal documentary evidence available to me, my general knowledge of the field and, with respect to sections 21 to 16, advice from the Scottish Health Service Central Legal Office.

5. At paragraph 27 of his statement, Mr GRO- states that his treating consultant was suspicious that a blood transfusion he received from the Glasgow Victoria Infirmary may have been infected with hepatitis C (HCV). He then states, "*This indicates to me that, retrospectively, staff at the Victoria Infirmary or the Blood Transfusion Service would have known that people receiving blood transfusion* [s] *there during the relevant time period may well have become infected with contaminated blood*".

6. In 1988 the blood components for Glasgow Victoria Infirmary (GVI) were supplied by the Glasgow and West of Scotland Blood Transfusion Service based at Law Hospital. There is evidence that at the time of implementation of HCV screening (September 1991) that blood donors in the west of Scotland had a higher prevalence of HCV infection (0.075%) than those in other parts of Scotland (0.053%) which I would assume is likely to be a reflection of differences in the epidemiology of HCV infection in the general population in different regions of Scotland. However, to the best of my knowledge there would have been no systematic difference in the blood components supplied to GVI and those supplied to the other hospitals in the west of Scotland.

7. From paragraphs 43-46 of his statement, Mr GRO-B describes receiving confirmation from his consultant that a blood transfusion was the source of his hepatitis C infection. This was confirmed by way of a letter from his consultant, which is appended to Mr GRO-B statement. The letter said the SNBTS had informed his consultant that a unit of donated blood Mr GRO- had received was infected with HCV and that this may have been the source of Mr GRO-B infection. Mr GRO-B believes the wording of the confirmation his consultant received from the SNBTS was a deliberate attempt by the SNBTS to deflect blame from themselves, although he notes he has never seen the actual reply from the SNBTS to his consultant.

8. SNBTS fully accepts that Mr GRO-B became infected with HCV from a blood transfusion in 1988.

9. At paragraph 182, Mr GRO-B states he has never been otherwise contacted by SNBTS about having received contaminated blood or his subsequent infection with HCV.

10. SNBTS supplies blood components to hospital blood banks labelled with a unique number which retains traceability to the donation without disclosing the identity of the donor. The hospital blood banks carry out pre-transfusion testing and issue blood to patients. Patient data is held by the 32 Scottish hospital blood banks. At the time of Mr GRO-B transfusions, SNBTS managed 4 of the hospital blood banks (in the Royal Infirmary of Edinburgh, Ninewells Hospital Dundee, Aberdeen Royal Infirmary and Raigmore Hospital Inverness), the other 28 including all of those in the west of Scotland were managed by the hospitals themselves. SNBTS would not, therefore, have had direct access to Mr GRO-B hospital blood bank and medical records including his personal contact details. In addition, when conveying very serious information it is important not to bypass the attending clinicians who will know the person and understand his/her current medical condition.

11. SNBTS clinicians are open to meeting with patients if or when requested to do so by the attending clinicians or the patients themselves.

12. At paragraph 183, Mr GRO-B states that he does not believe that the SNBTS has contacted everyone who received infected blood, despite having claimed this.

13. I am not personally aware of SNBTS having claimed to have contacted everyone who received infected blood. In fact, SNBTS is aware that there remain HCV infected patients who have not been traced.

14. There are 3 ways in which SNBTS would become aware of a donation made by an HCV positive person prior to the introduction of HCV screening:

(i) A donor himself / herself returned to donate after the introduction of HCV testing in September 1991 and was found to be HCV positive. SNBTS initiated a pilot targeted lookback exercise in Edinburgh from the outset of HCV testing in 1991. This was implemented across the rest of Scotland and the UK in 1995 in an attempt to trace previous recipients of blood components from these donors. Recipients who were identified as part of lookback were (and are) contacted, informed and offered HCV testing through their attending clinicians. In Scotland this exercise identified 360 Hepatitis C positive donors who had donated 1,658 donations (2026 components) before 1991, of which 1356 could be traced but 670 could not, mainly due to unavailability of medical records. In addition recipients of blood components from donors who did not return to donate again after September 1991 (as happened with the infected donor to Mr GRO- would never have been part of a lookback exercise.

(ii) A patient is diagnosed as HCV positive and it is identified that he or she has received blood components. Provided the identification numbers of the blood components received by the patient are available from the hospital blood bank or medical records, SNBTS can trace the original donation and, where available, test archive samples in order to clarify whether or not the donor was infected at the time of donation (a reverse lookback). This was the situation with regard to Mr GRO-B

(iii) Where a donor is identified as HCV positive as a result of a reverse lookback he/she is informed by SNBTS clinicians and referred for specialist advice and a targeted lookback is carried out for other recipients who may have been exposed to infected blood components from the same donor either before or after the index donation. Again this was done for the donor and other recipients of blood components from the donor of the infected donation received by Mr GRO-

15. At paragraphs 184-186, Mr GRO- states he believes there has been a disregard for his and his family's safety by the SNBTS's failure to contact him about receiving infected blood, he has never received an apology from the SNBTS and he believes individuals at the SNBTS were negligent in respect of their knowledge that people had been and were being infected. He further states that the SNBTS did nothing to prevent infections and protect the families of those who had been infected.

16. I am very sorry that Mr GRO- feels that there has been a disregard for his and his family's safety. Mr GRO-B was infected from a blood transfusion in April 1988 prior to the introduction of HCV testing in September 1991. As described in section 6, the donor of the infected blood component never attended to donate again and so SNBTS was unaware that Mr GRO- was HCV positive until Dr Peters' letter of 21st January 2002 informing us of this. During the subsequent reverse lookback investigation SNBTS was able to trace the donations received by Mr GRO-B through the unique blood component numbers supplied by Dr Peters from Mr GRO-B medical and /or hospital blood bank records. SNBTS was then able to retrieve archive samples relating to the original donors and test these using both serological and nucleic acid tests for HCV (neither of which was available in 1988).

17. At paragraphs 187-188, Mr GRO-B states that he instructed lawyers to undertake legal proceedings against the SNBTS in 2002. His lawyers asked the SNBTS why Mr GRO- had not been informed that he had been infected with HCV. The SNBTS stated that they were not aware that the donor's blood was infected with HCV. Mr GRO-B considers this to be contradictory given the letter sent by the SNBTS to Mr GRO-B consultant.

18. As described above, SNBTS was unaware that Mr GRO- was HCV positive until contacted by Dr Peters, Specialist Registrar to Dr Fox on 21st January 2002. Testing for HCV was not available in 1988 and because the donor of the infected blood donation did not donate again after HCV testing was introduced. SNBTS only became aware that the donor was infected when it carried out the investigation in 2002 of all of the donations received by Mr GRO- in 1988, the results of which were included in the letter sent by SNBTS to Mr GRO-B Consultant, Dr Fox in June 2002.

19. At paragraph 189, Mr GRO- states he suspects the blood he received may have been from the American penal system, and if this were the case, it should have been rechecked for HCV.

20. To the best of my knowledge SNBTS did not import blood components from America. The only exception to this might be very occasional donations from targeted donors for specific patients with rare blood groups and multiple alloantibodies. However, this wasn't the case with Mr GRO- who received standard donations from Scottish blood donors. The Glasgow and West of Scotland Regional Transfusion Centre discontinued collections from Scottish penal institutions in 1984.

21. At paragraph 190, Mr GRO- states that the lawyer acting for the SNBTS said any claim under the Consumer Protection Act was time barred as it was over 10 years since Mr GRO- had been infected.

22. I understand that on 4 July 2003, the Scottish Health Service Central Legal Office (CLO) wrote to Mr GRO-B Solicitors in response to Mr GRO-B claim. This response was based on instructions that CLO had previously received from the Scottish Executive in relation to claims such as that intimated on behalf of Mr GRO-B These instructions were to investigate claims involving transmission of HCV through medical treatment on or after the date on which the Consumer Protection Act 1987 came into force (1 March 1988) and prior to the date of introduction of donor testing for HCV in the UK (1 September 1991), in which legal actions citing the Consumer Protection Act 1987 had been timeously raised in Scotland.

23. In advising Mr GRO-B Solicitors that any claim that Mr GRO- may have had under the Consumer Protection Act 1987 was time barred as it was over 10 years since Mr GRO- had been infected, CLO was referring to the provisions in that Act relating to prescription of obligations.

24. At paragraph 193, Mr GRO-B questions what the SNBTS's lawyer was doing with patient claims at that time and what was being done to deter patients from claiming compensation.

25. I understand that in July 2003 CLO was continuing to receive instructions to respond on behalf of NHS Scotland to Solicitors' enquiries, legal claims and legal actions involving transmission of the Hepatitis C virus to Scottish patients. It received those instructions both from SNBTS and from the Scottish Executive, the latter only in respect of those claims which met the criteria outlined in the answer to section 21 above. Also, in relation to such claims, instructions were received to carry out investigations on behalf of NHS Scotland with a view to making offers in settlement, provided the criteria were met in full.

26. My understanding is that no actions were taken by CLO to deter patients from making compensation claims.

27. At paragraph 194, Mr GRO- states he still feels that the SNBTS "... *were more interested in saving themselves than the people they were knowingly killing* ".

28. I am very sorry that Mr GRO-B feels this way. Over the 30 years or so since Mr GRO-B became infected with HCV through a blood transfusion SNBTS will have supplied in the order of 7.5 million blood components to patients in Scotland. These can only be provided through the generosity of altruistic blood donors and most will have been life saving, life enhancing or permitted other medical or surgical interventions. The period during which Mr GRO-B received his infected donation was one of great uncertainty and evolving understanding. The discovery of HCV was announced by the Chiron Corporation in May 1988. Tests became available for antibodies to HCV in 1989 and screening of donated blood for HCV was implemented in the UK in September 1991. There has not been a transfusion transmitted HCV infection in Scotland since 1991. SNBTS is committed to assisting the Infected Blood Inquiry in its investigation of the circumstances and events of those times.

Section 3: Other Issues

29. Under sections 4-6 of his statement Mr GRO-B indicates that he is uncertain of the dates of his surgery and the volume of blood he received. The clinical information provided to SNBTS in 2002 indicated that Mr GRO-B had received 6 units of red cells and 7 units of fresh frozen plasma / cryoprecipitate at the time of his road traffic accident on the 6th April 1988, a further 2 units of red cells on the 11th April 1988 and a further 4 units of red cells on the 19th April 1988 at GVI. SNBTS does not have any information relating to Mr GRO-B subsequent surgery at Phillipshill Hospital.

30. Under section 43 Mr GRO- states: 'It was finally confirmed in writing in a letter signed on 27th September 2002 that I had become infected by receiving contaminated blood via a blood transfusion. This was nearly 2 years since I had first been diagnosed with hepatitis C."

31. SNBTS's understanding is that Mr GRO-B was diagnosed with Hepatitis C on 31st October 2000. SNBTS was informed of his infection and that he had received blood transfusions in 1988 in a letter from Dr Peters, Specialist Registrar to Dr Fox dated 21st January 2002. Dr Peters' letter included the unique numbers for the 19 blood components that Mr GRO-B recived over this period which must have been recorded in his hospital blood bank or medical records. It does take some time for SNBTS to link the component numbers to the original donations/donors and then to identify and retreive the archive samples, particularly where the records are either paper-based or contained within legacy IT systems. The donor samples were tested by the SNBTS National Microbiology Reference Unit and one was found to be HCV positive on both serology and nucleic acid testing. Neither of these HCV assays were available at the time of the original donations. The other 18 samples were negative. SNBTS wrote to Dr Fox on 28th June 2002 with the results of the investigation. I believe Dr Fox subsequently wrote to Mr GRO-B on 27th September 2002. Whilst reverse lookback investigations of this kind are complex and challenging, this one took longer than usual (5 months) for reasons that are unclear to us now and SNBTS apologises to Mr GRO-B for its part in the delay.

Statement of Truth

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

Signed GRO-C

Dated 27th June 2019.