Witness Name: Professor Turner
Statement No.: WITN3530102
Exhibits: WITN3530103-104
Dated: 26th October 2022

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF PROFESSOR TURNER**

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I provide this statement on behalf of SNBTS in response to the request under Rule 9 of the Inquiry Rules 2006 dated 2 September 2022.

I, Marc Turner, will say as follows: -

## Section 1: Introduction

1. **Name:** Marc Leighton Turner

2. **Date of birth:** GRO-C 1959

3. **Address:** Scottish National Blood Transfusion Service, The Jack Copland Centre, 52 Research Avenue North, Heriot-Watt Research Park, Edinburgh.

4. **Qualifications:**

   Bachelor of Medicine, Bachelor of Surgery, University of Manchester
   Doctor of Philosophy, University of Edinburgh
   Master in Business Administration (Life Sciences), Open University
   Fellow of the Royal College of Physicians of Edinburgh
   Fellow of the Royal College of Physicians of London
   Fellow of the Royal College of Pathologists
   Fellow of the Royal Society of Edinburgh

5. **Occupation:** Clinical Academic Haematologist

6. **Employment History:**

   April 1997 – July 2007 Senior Lecturer in Immunohaematology, University of Edinburgh

   Aug 2007 – March 2011: Professor of Cellular Therapy, University of Edinburgh

   April 2011 – March 2022: SNBTS Medical Director

   April 2022 – date: SNBTS Director

**Section 2: Response to Criticism by witness W4204**

7. SNBTS would like to apologise to witness W4204 that it did not follow up on the lack of response to its letter of 3rd April 2000 (WITN4204003).

8. The witness was identified as being HCV positive following a blood donation made on 13th March 2000. SNBTS wrote to the witness on 3rd April 2000 (WITN4204003) using the address she provided at the time of this donation informing her that one of her tests had given rise to an unusual result and inviting her to attend the Blood Donor Centre at St Vincent Street in Glasgow on 13th April 2000. Unfortunately the witness did not receive the letter for reasons uncertain. SNBTS failed to detect that she had not responded and so far as we can tell did not therefore follow up with further attempts to contact her.

9. This came to light in 2016 when another (former) donor approached SNBTS expressing an interest in donating again. He similarly had tested positive and had been written to at the time of his original donation but had not responded and it became clear during discussion that he was not aware of his diagnosis.

10. When reviewing this incident, SNBTS was concerned that other donors that had evidence of viral infection may not be aware of their diagnosis. A Problem Assessment Group (PAG), chaired by Professor David Goldberg (Health Protection Scotland), was set up to manage the investigation of donor and patient records and coordinate subsequent actions. This included representation from SNBTS, Health Protection Scotland (HPS), relevant clinicians and patient groups. The main objective was to identify any other positive donors for whom we did not have evidence that we had successfully informed them of their results. This review, which included cases from 1991 onwards, was complete by December 2016 (WITN3530103).

11. As well as reviewing SNBTS data, a successful application was made to the Community Health Index Action Group (CHIAG) via the Public Benefit and Privacy Panel for access to healthcare and GP details for the purposes of notification to check individual records against various registers of patients known to have relevant viral infections. SNBTS does not normally have access to this information.

12. The Problem Assessment Group decided to notify any donor for whom SNBTS had no record of them responding to SNBTS letters (or other means of communication) and who were not recorded as having accessed an appropriate clinical service for assessment and/or treatment of their infection.

13. The review identified witness W4204 as one of the donors who required follow up as she had not responded to the letter sent in 2000. SNBTS wrote to her GP on 11th January 2017 (WITN4204002) to inform them of the diagnosis and ask whether they wished us to contact the witness. In view of her ongoing health problems, her GP informed her directly and arranged for referral to a liver specialist.

14. The witness contacted us by telephone on 19th January 2017 and again on 26th January 2017 for information and advice. She called our Donor Enquiry Line again on 1st June 2017 asking for advice about compensation from SNBTS. We wrote to her on 15th June 2017 (WITN3530104), apologising for the fact that we hadn't notified her earlier of her infection, and also explaining that there was no compensation scheme for donors who are diagnosed with a pre-existing blood infection following donation.

15. The witness was one of a number of donors who were not notified of their infection at the time of their donation. In almost all cases, this was because the donor did not respond to one or more letters sent to the address given at the time they attended to donate. Whilst some donors choose to ignore letters advising of testing, other donors have not received letters because of problems with the postal systems used at the time or because they have changed address, given incomplete address information or their details have been recorded wrongly in our computer system.

16. When donors fail to respond to letters, the options for further action are limited because SNBTS does not ask donors for details of their GP when they register or attend to donate, and our records do not hold a national identifier such as an individual's CHI number. This is because we do not treat blood donors as patients and we do not access their healthcare records without their permission. When necessary, e.g. when

assessing a donor's eligibility to donate, we will obtain explicit consent from the donor to share information with their GP.

17. At the time of the Witness' donation, there was no national procedure for managing donors who tested positive for infection. Each of our five blood centres followed their own process and appeared to have different approaches to managing donors who did not respond to initial letters.

18. Having completed the exercise to notify donors who were unaware of infections, we accepted that donors expected SNBTS to make more extensive attempts to contact them. Formal procedures for management of donors who test positive were standardised across Scotland in 2007 and have been reviewed and updated regularly since. Several attempts are now made to contact positive donors, including letter, telephone or email. Donors who fail to respond are discussed with a senior clinician and further advice sought from local Health Protection teams or Sexual Health Services as appropriate. We have also included advice in our Donor Information Leaflet (read by all donors attending session) to let donors know if we are unable contact them about any significant test results then we may share information with other health care providers. This is with the aim of ensuring these individuals receive appropriate care.

19. We would like to reiterate our apology to witness W4204 and the other donors affected that SNBTS did not follow up the lack of response to our initial letter with more extensive attempts to contact them.

**Section 3: Other Issues**

20. SNBTS holds no further evidence which we would consider to be relevant to the Inquiry's investigation of the matters set out in its Terms of Reference.

**Statement of Truth**

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

Signed: GRO-C

Dated: 26th October 2022

**Table of exhibits**

| Date | Notes/Description | Exhibit Number |
|---|---|---|
| 31/05/2018 | SNBTS Donor Notification Exercise Final Report | WITN3530103 |
| 15/06/2017 | Letter to witness W4204 | WITN3530104 |