Witness Name: Marc Turner
Statement No.: WITN3530105
Exhibits: WITN3530007;
WITN3530074; WITN3530075
Dated: 25 NOV 2022

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 12 October 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. **Please set out your employment history with dates if possible, including the various roles and responsibilities that you have held throughout your career.**

   February 1983 – July 1987 General Medical Training, Derby Royal Infirmary.

   August 1987 – March 1997 Higher Specialist Training in Haematology and Transfusion Medicine, Royal Infirmary of Edinburgh and Edinburgh and SE Scotland Blood Transfusion Service

   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

7. **Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership.**

   Member of the UK Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) January 2008 to December 2014, reappointed November 2021

   Member of the European Medicines Agency (EMA) Committee on Advanced Therapies (CAT) January 2017 to June 2019

   Member of the Scottish Medicines Consortium October 2019 – present.

   Commissioner on the Commission for Human Medicines (CHM) July 2020 – present. Chair of the CHM Clinical Trials, Biologics and Vaccines Expert Advisory Group (CTBVEAG) and Member of the CHM COVID-19 Vaccines Expert Working Group.

8. **Please explain how you kept abreast of medical and scientific developments and research in your field in the course of your career.**

   Through keeping abreast of the scientific and clinical literature, engagement and leadership of research and development and attendance at international conferences and other professional fora

9. **Please confirm whether you have provided evidence or have been involved in any other inquiries, investigations, criminal or civil litigation in relation to the human immunodeficiency virus ("HIV") and/or hepatitis B virus ("HBV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. Please provide details of your involvement.**

House of Commons Science and Technology Committee – UK Blood Safety and the Risk of variant Creutzfeldt-Jakob Disease 2014
The Penrose Inquiry (Scotland) 2015 – current SNBTS practice

Section 2:

Please note that I was not a member of the Royal Infirmary of Edinburgh Haematology Unit or the Scottish National Blood Transfusion Service at the time that Mr GRO-A received an HIV infected platelet transfusion, I have no personal knowledge of this Gentleman and no access to his medical notes. Therefore the testimony I give is wholly dependent on the documents provided by the Inquiry and some correspondence from the SNBTS archive.

10. **Please provide an explanation of when and how the SNBTS discovered that GRO-A had been exposed to a positive HIV donation (allegedly in 1986). Please also explain how much infected product Mr GRO-A received and when he received it.**

Mr GRO-A received a platelet transfusion on 31st December 1983. The donor was identified as being HIV positive when he/she donated following the introduction of HIV donor testing in October 1985. Mr GRO-A was found to have received an infected platelet transfusion during the subsequent lookback process.

11. **Additionally, please explain whether the exposure was through a donation of platelets. If not, through which means was Mr GRO-A exposed to infected product? Was the product provided to Mr GRO-A pooled with other donations? If the donation was pooled, what was the size of the pool?**

The donation was of whole blood which was separated into red cell and platelet components. Mr GRO-A received a platelet transfusion on 31st December 1983 which would have comprised of a pool of platelets from 4 or 5 donations in order to achieve a therapeutic dose.

12. **Please provide an explanation of any contact or interaction which SNBTS, or their staff, had with Professor Ludlam about the positive HIV donation which Mr GRO-A was exposed to. Further please explain when and why this contact with Mr GRO-A was made.**

It appears that as part of the HIV lookback process, Dr Jack Gillon contacted Professor Ludlam to inform him that Mr GRO-A had received a platelet transfusion which included a donation from a donor subsequently found to be HIV positive. To the best of my knowledge SNBTS did not have any direct contact with Mr GRO-A 's family.

13. **Please explain your response to Professor Ludlam's position in his response statement in which Professor Ludlam stated that it was for the SNBTS, and not him, to contact Mrs GRO-A and her family about Mr GRO-A 's care. What, if anything, did SNBTS do about this response.**

To the best of my knowledge SNBTS did not have any direct contact with Mr GRO-A 's family or access to their contact details or the Gentleman's GP or medical notes.

As stated in my first Witness Statement (WITN3530007), SNBTS rarely has direct contact with the patients who receive its blood components or plasma products because these are administered by clinicians within the NHS Scotland Territorial Health Boards. Where a donor is found to be positive for a potentially transfusion

transmissible infection, SNBTS looks for evidence of infection in previous donations and where possible identifies any other recipients of positive donations. These patients are contacted principally through their attending hospitals and clinicians because SNBTS would not have had their personal details or access to their medical records. It would therefore be the attending clinician with the knowledge of the patient and his / her clinical condition who informs the patient and/or his family and conveys information on the availability of the various Trusts and Funds (reference SHHD letter 21st April 1992 and HDL 2004 /31 (WITN3530074 and WITN3530075).

SNBTS does not have, and to the best of our corporate knowledge has never had, any direct involvement with the Trusts or Funds established to provide financial support to people who had been infected through blood products. For example we are contacted from time to time by the Scottish Infected Blood Support Scheme (SIBSS) to assist in trying to establish whether a patient has received a transfusion in the past or not. We provide any information to SIBSS but are not involved in any discussion between SIBSS and the patient or his/her family.

14. **Please explain whether SNBTS ever started to irradiate blood. If so, please explain what the purpose of this irradiation or blood was; and whether SNBTS have knowledge of whether the blood received by Mr** GRO-A **was or was likely to have been irradiated.**

I'm sorry, I don't know when SNBTS introduced irradiation of blood components, though it has done so for as long as I have been associated with the organisation. The purpose of irradiation is to reduce the risk of donor T cells causing Transfusion Related Graft versus Host Disease in the patient. We don't know whether the platelet transfusion Mr GRO-A received was irradiated or not but it would not have made any difference to the risk of transmission of HIV.

Section 3: Other issues

SNBTS would like to apologise to Mr GRO-A 's family that he was infected with HIV through a platelet transfusion on 31st December 1983.

Statement of Truth

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

Signed GRO-C

Dated 25th November 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number
2021	Written statement of Marc Turner	WITN3530007
1992	SHHD letter 21st April 1992	WITN3530074
2004	HDL 2004/31	WITN3530075