Witness Name: Professor Turner
Statement No.: WITN3530106
Exhibits: PRSE0007002
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR TURNER

I provide this statement on behalf of SNBTS in response to the request under Rule 9 of the Inquiry Rules 2006 dated 1 December 2022.

I, Professor 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**

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. **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.

Section 2: Response to Criticism by witness W2177

8. Please note that I was not a member of the Scottish National Blood Transfusion Service at the time that Mrs O'Hara received her blood transfusions in 1972, 1979 and 1985. I have no personal knowledge of this Lady, however I note that Lord Penrose provided an extensive medical history and analysis in respect of Mrs O'Hara's care in Volume 1 Chapter 7 of his Final Report **(PRSE0007002)**.

1. **Response to criticism WITN2177001 Paragraph 16, page 7: The doctor my sister Annette had initially spoken to suggested that she phone the Scottish National Blood Transfusion Service, which she did. A female doctor from the SNBTS told her that there was nothing they could do as my mother had been given the blood in good faith. "Given in good faith" was a phrase that came up a lot. It was like they were saying it saved your life at the time, it has repercussions now, but we didn't know that, end of discussion. The SNBTS were pretty rubbish, they were only interested in covering it up. She also said that because my mother had cirrhosis of the liver there was no treatment that would be effective. This call probably took place in 1995.**

9. SNBTS would like to apologise for the unsatisfactory response to the enquiry from Mrs O'Hara's family.

2. **Response to criticism WITN2177001 Paragraph 16, page 7: I think the attitude of a lot of doctors was very dismissive. It was like they were saying you're lucky to be alive, what are you moaning about? I don't think that SNBTS were very forthcoming, they were very protective of their information. Even just the issue of tracing the source of the infection, they had no idea where the blood had come from. Even hearing that the blood had come from prisoners, things like that made my mum really upset. And it was a doctor that told her that in the early 90s before all those stories really came out in the media. I know that some of those stories are nonsense but I didn't know that at the time. It was a dangerous thing for my mum to be told. I think even when my mum had the blood platelets they knew it could be a risk. It was so concentrated and from so many different sources. I am extremely angry that SNBTS did not heat treat the blood they used until a year after England had started doing it, which put people at risk.**

10. In 31st March 1972, Mrs O'Hara received a single unit of whole blood at Stobhill Hospital during childbirth. Subsequent investigation by the SNBTS showed that the blood was donated at Lockerbie on 5 March 1972. There was no test for non-A, non-B Hepatitis/Hepatitis C at that time and there is no record of the donor having been subsequently tested for Hepatitis C.

11. On 28th November 1979, Mrs O'Hara received one unit of whole blood and one unit of packed red cells at Stobhill Hospital in the course of a surgical procedure. Subsequent SNBTS investigation traced the donations, to Coatbridge and East Kilbride, in November 1979. Again there was no record of either donor having been subsequently tested for Hepatitis C.

12. In June 1985, Mrs O'Hara underwent cardiac surgery at Glasgow Royal Infirmary during which she received five units of concentrated red cells. SNBTS was not able to trace the donors because the pack numbers of the units provided were allocated by the hospital blood bank and were not able to be cross-referenced to the SNBTS donation numbers. Mrs O'Hara also received an infusion of Human Plasma Protein Fraction at this time.

13. Hepatitis C testing of donated blood was not introduced in the UK until 1991.

14. Mrs O'Hara was diagnosed as HCV positive in 1995.

15. We are not aware that Mrs O'Hara ever received a platelet transfusion. She did receive a total of 8 units of whole blood or red cells between 1972 and 1985. These would not have been pooled.

16. Blood components such as whole blood, red cells and platelets cannot be heat treated because this would destroy the cells.

17. Human Plasma Protein Fraction was an albumin product prepared from large batches of pooled plasma. All human plasma protein fractions prepared by the Protein Fractionation

Centre for use in Scotland were heated to, and maintained for ten hours at, 59.5°C to 60.5° so as to prevent the transmission of hepatitis since 1964

Section 3: Other Issues

18. SNBTS does not hold any evidence which I consider may 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 DocuSigned by: GRO-C EE82BA7D41354DF...

Dated: 9th January 2023

Table of exhibits:

Date	Notes/ Description	Exhibit number
01/03/2015	Penrose Inquiry Final Report	PRSE0007002