Witness Name: Dr Saad Al-Ismail
Statement No.: WITN3761039
Exhibits: WITN3761040 to
WITN3761053
Dated: 27 January 2021

INFECTED BLOOD INQUIRY

THIRD WRITTEN STATEMENT OF DR SAAD AL-ISMAIL

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 01 December 2020.

I, Dr Saad Al-Ismail, of GRO-C will say as follows: -

Section 1: Introduction

1. I have reviewed the information I provided in my first witness statement to the Infected Blood Inquiry dated 24 September 2019 [WITN3761001] and to the second witness statement dated 09 September 2020 ("Second Statement") [WITN3761005]. To the best of my knowledge the information I provided in both previous statements was and is correct.

2. My date of birth and professional qualifications are as set out in paragraph 1 and my membership of various organisations and different committees (past or present) are known to the Inquiry from paragraphs 12 and 13 of my Second Statement [WITN3761005].

3. In addition, the position I held as a Consultant Haematologist, the organisations in which I held this position and my role and responsibilities are set out at paragraphs 6 to 11 of the Second Statement [WITN3761005].

Section 2: Responses to criticism of Witness W2384

4. I feel it is important to provide information as to the background that prompted the Infected Blood Inquiry to ask me to give a third statement under Rule 9 of the Inquiry Rules 2006 dated 01 December 2020.

5. Prior to my oral evidence to the Inquiry on 17 November 2020, I had a virtual meeting with the Counsel to the Inquiry, Ms Jenny Richards ("Counsel"), on 16 November 2020. The meeting was arranged by the Inquiry Team to discuss certain issues, mainly the logistics of giving oral evidence. Towards the end of the meeting on 16 November, I raised with the Counsel my concern about some of the comments made by Witness W2384 about the care he received in the Swansea Haemophilia Centre. He raised these issues in his written statements and in his oral evidence to the Inquiry on 30 October 2019. I explained to Counsel that I consider several of the statements made by Witness W2384 are not true. I asked if I could be given the opportunity to respond to these allegations and provide the supported facts to the Inquiry. Counsel explained that she would not raise these issues during my oral evidence but that she would arrange for a request for me to provide a third statement under Rule 9 of the Inquiry Rules 2006 to respond to some of the statements made by Witness W2384.

Issues raised by Witness W2384 relating to Hepatitis C testing, information about Hepatitis C and management with Interferon

6. When Witness W2384 moved from London to live in Swansea in 1987, his haemophilia care was transferred from the Royal Free Hospital ("Royal Free") in London to the Haemophilia Centre in Swansea in July 1987. Prior to the transfer of his care, Witness W2384 had been informed by the Haemophilia Centre in the Royal Free he was exposed to Non-A and Non-B ("NANB") hepatitis as a result of some of the previous treatment he had received. Professor Peter Kernoff, Co-director of the Haemophilia Centre at the Royal Free, informed Witness W2384 in a letter dated 6 March 1987 (WITN2384023) that *"As I am sure you know, a problem of concern for some years has been the transmission of non-A, non-B hepatitis (NANBH) viruses by clotting factor concentrates. Many people with haemophilia have abnormal liver function tests (LFTs) and, although the significance of these abnormalities is not known with certainty, there is a possibility of progressive liver damage due to chronic NANBH infection."*. Professor

Kernoff went on in this same letter (WITN2384023) to inform Witness W2384 about the trial with interferon.

7. Witness W2384 was a very well informed and articulate individual. In addition, it is both my belief and contention that Witness W2384 had already been told by Professor Kernoff about his diagnosis of NANB hepatitis and the possible consequences to some of the patients infected (in terms of progressive liver damage) before his care was transferred to Swansea.

8. The first generation of blood tests for the hepatitis C virus ("HCV") antibody became available to patients in Swansea in 1990. Patients were told that the hepatitis antibody test became available in order to confirm that their NANB hepatitis was due to HCV.

9. The Haemophilia Nurse in the Swansea Haemophilia Centre contacted individual patients and offered them the test. The Haemophilia Nurse gave the request form for the test to individual patients or carers who agreed to be tested. Patients were asked to go to the phlebotomy area for the blood sample to be collected. Many patients receiving home treatment preferred to collect the sample themselves when they next treated themselves with Factor VIII concentrate using one venepuncture. All patients therefore were informed that they were being tested for HCV as the test for it became available in Swansea.

10. The Haemophilia Nurse in the Swansea Haemophilia Centre informed individual patients of the result of the test upon receipt of that result. She provided that information to each patient tested, or their carer, either in person or by telephone. Patients who wanted to see the consultant haematologist to discuss the result would have been booked in for the next available general haematology out-patient clinic. There were no dedicated out-patient clinics for haemophiliacs prior to the commissioning of the Haemophilia Centre in Singleton hospital in Swansea in 1991/1992.

11. Witness W2384 was given the form for the tests for HCV, hepatitis B virus ("HBV") and hepatitis A virus ("HAV"). The form was completed by the Haemophilia Nurse with his details and the tests requested and was given to him. I have no doubt that the Haemophilia Nurse informed him of the positive result for HCV (WITN3761040) on or around October 1990 when his first positive test result was received. In my view, it is inaccurate for Witness W2384 to suggest that he did not know he was being tested for

HCV. This would have been made clear to him by the Haemophilia Nurse by the information on the request form he was given.

12. Witness W2384 was tested for HCV with the different generations of HCV antibody tests as they became available. He had another request for the HCV antibody test given to him in September 1991 (WITN2384018). The form was again filled by the Haemophilia Nurse and was given to Witness W2384. On receipt of the result by the Department, the result was directed to the Haemophilia Nurse, as written on the form to inform Witness W2384. He was also tested in March 1992 as can be seen by the copy of the test result (WITN3761041). He was informed about these results in the same manner as set out above. His GP, Dr Lewis had been kept informed about the changes in his liver function tests which were probably related to his HCV as can be demonstrated by my letter of 10 December 1992 (WITN2384016). By updating his GP, Witness W2384 could have sought to discuss any concerns he had over HCV with Dr Lewis, myself or colleagues in the Swansea Haemophilia Centre.

13. Witness W2384 had not requested to see me or my colleague, Dr Beddall, to discuss the results of his HCV tests. It is my view that he had suspected, on the balance of probabilities, that he would test positive for the HCV antibody as early 1990 as he knew he had NANB hepatitis. He had already been told by Professor Kernoff in the letter of 6 March 1987 (WITN2384023) of the possibility of progressive liver damage due to the infection in some patients. Therefore Witness W2384 is inaccurate when he suggested at pages 133 to 134 of the oral evidence transcript that he gave to the Infected Blood Inquiry on 30 October 2019 ("the Transcript"), that he did not learn or I did not inform him of his positive HCV test result until January 1993 or that he was not aware of being tested for HCV. It is clear he had been notified of the possible long-term implications of his HCV diagnosis also.

14. Witness W2384 was informed about his liver function results as part of his outpatient consultations with the Swansea Haemophilia Centre. These results showed persistently raised liver enzymes as the result of the NANB hepatitis/HCV infection. He was told about the risk from alcohol consumption in patients with HCV infection. He would have been given the opportunity in outpatient clinics, or whenever he asked to see me or my colleague, to discuss the significance of the results of these liver function tests. The information given to him, and all other patients with HCV, would have been the information known to me and my consultant colleagues at the relevant time.

15. I saw Witness W2384 in the out-patient clinic on 21 January 1993 to discuss further the implications of him being exposed to HCV and discuss again the need to avoid excess alcohol as that would exacerbate the effect of HCV on his liver. There were times when he consumed excess alcohol. My notes of that discussion are contained in (WITN3761042). The purpose of the out-patient appointment on 21 January 1993 was not to inform him about the fact that he was HCV positive as I believed he already knew that. He received test forms for HCV in 1990, 1991 and 1992. I also explained that treatment with interferon may be considered as an option as explained in my letter, dated 21 January 1993 to his GP, Dr Lewis after that consultation (WITN2384015).

16. Witness W2384 was informed on several occasions, by me and my colleagues, of the need to avoid excess alcohol due to the combined risks from HCV infection and alcohol. The notes and letters of my colleagues relating to discussions with him reflect this (WITN3761043).

Information about treatment with Alpha Interferon

17. I have had regard to pages 139 to 143 of the Transcript. Witness W2384 stated that he was not given information about the possible side effects of treatment with interferon.

18. The Swansea Haematology Department and Swansea Haemophilia Centre used only alpha interferon for the management of patients with HCV. The possible side effects from alpha interferon are well known to myself and my consultant colleagues in the Haematology Department in Swansea and we did explain these side effects to patients before prescribing alpha interferon. Alpha interferon was used in Swansea for patients with haematological cancers including Chronic Myeloid Leukaemia (CML) and Myeloproliferative disease from the mid-1980s. In CML, we escalated the doses from an initial dose of three mega units daily to higher doses for patients who tolerated the higher doses. There was evidence that higher doses of alpha interferon were more effective in some patients with CML. Many patients could not tolerate the alpha interferon due to the side effects even when prescribed at three mega units three times a week.

19. Swansea Haemophilia Centre offered treatment with alpha interferon to patients with HCV when such treatment became available. The interferon dose for HCV was three mega units three times a week (for example on Monday, Wednesday and Friday).

Similar to patients with myeloproliferative diseases, many patients with HCV declined treatment with alpha interferon when the side effects were explained to these patients. The side effects could range from flu like symptoms to extreme lethargy, mood changes, depression of bone marrow function etc.

20. Witness W2384 accepted treatment with alpha interferon after I explained the possible side effects to him. The source of information relating to interferon would have been the Chronic Hepatitis in Haemophilia article published in the Blood Review 1993 [WITN3761012] which recommended alpha interferon. Each vial of interferon alpha had a leaflet insert in the package that explained the possible side effects as well.

21. I reviewed Witness W2384 on 21 April 1994 and explained the abnormal liver function tests he had as demonstrated by my handwritten notes (WITN2384026). I explained that interferon was an option and stated in the notes "*Explained the rationale behind interferon and possible benefits and side effects*". Then the outpatients note stated "…*wanted to start on interferon*". I would have told him that the side effects from alpha interferon could range from flu-like symptoms such as headache and tiredness, to the more severe ones such as mood changes, difficulty in sleeping, nausea, vomiting, diarrhoea and bone marrow suppression. Bone marrow suppression would be detected on undertaking a full blood count on him. I would also have told him that he would need to stop taking the drug if the side effects became too difficult.

22. The letter I sent to his GP, Dr Lewis, at the West Cross Medical Centre, dated 21 April 1994 (WITN2384026) indicated that I discussed the "ins and outs" of interferon treatment with him and he expressed a wish to start on this.

23. Witness W2384 was started on alpha interferon at a dose of three mega units three times a week. He was reviewed in the outpatient clinics on a regular basis. In my letter of 19 May 1994 to his GP, Dr Lewis, at the West Cross Medical Centre I confirmed that Witness W2384 had been tolerating his interferon doses quite well, which means that he was not complaining of side effects (WITN3761044). My further letters of 16 June 1994 and 10 November 1994 to Dr Lewis at the West Cross Medical Centre, show clearly that Witness W2384 was asked about any side effects from interferon on a regular basis as I confirmed that he was still tolerating his doses and he remained generally well. The outpatient notes completed by my colleague Dr Beddall on 18 August 1994 (WITN3761044) states "no S/E from interferon". All of these records

indicate that Witness W2384 maintained that he did not experience any side effects from alpha interferon.

24. Although his liver function tests improved while receiving alpha interferon, he did not clear the virus with that treatment.

Treatment with Pegylated Interferon and Ribavirin

25. Treatment of HCV with pegylated interferon and ribavirin became available later. Such treatment carried many more side effects than alpha interferon.

26. The Swansea Haemophilia Centre did not offer such treatment to haemophilia patients. However, patients did receive such treatment from the Cardiff Haemophilia Centre or Hepatology colleagues in Swansea if they wished to be referred for this.

27. Witness W2384 was referred to the Cardiff Haemophilia Centre where he was offered treatment with pegylated interferon plus ribavirin. Colleagues in Cardiff informed me at that time that he completed a fourteen-week course. The letters I received from colleagues in Cardiff regarding that treatment are included in the following exhibit (WITN3761045}The letters show that he was given full information about the possible side effects of the treatment with pegylated interferon and ribavirin. He tolerated the full course of treatment but failed to clear the HCV.

Prophylactic treatment with Septrin (Co-trimoxazole)

28. For many years, Septrin (Co-trimaxazole is the non-generic name of the drug with Septrin being one generic name of the drug) was given to immunocompromised patients with different haematological malignancies for prophylaxis against Pneumocystis jirovecili (carinii) pneumonia ("PCP") prior to this being prescribed for HIV infected patients in the 1980s. I was aware of this at the time, as I was a trainee doctor in Haematology in Cardiff where we treated patients with blood cancer and used Septrin to prevent PCP particularly in Acute Lymphoblastic Leukaemia. Septrin was used as a treatment in this manner both nationally and internationally.

29. The side effects of Septrin are well known to haematologists. Explaining the possible side effects from Septrin to patients is ingrained within haematology practice. Some of the side effects are potentially life threatening such as the Steven Johnson reaction.

Prior to prescribing Septrin, patients are asked about any history of reactions to Septrin or sulphonamide.

30. All patients offered Septrin, including Witness W2384, are warned about the possible side effects. Patients are asked to stop taking the drug once the patient noticed a skin rash, fever, nausea or any other unexplained new symptom or side effect.

31. I was acutely aware of the side effects of Septrin not just as a result of medical knowledge but also as I had first-hand experience of them since 1972 as I personally suffered a side effect called Fixed Drug Reaction to Septrin. This led to the development of painful ulcers in different part of the body on exposure to the drug.

32. Septrin was discussed with Witness W2384 as a prophylactic treatment against PCP several times and the possible side effects were explained as stated above. He was made aware that this was an effective prophylaxis if his CD4 count ever dropped below 200. Due to the passage of time, I cannot specifically recall what I told Witness W2384 about the side effects but I am certain that I did so as this was an ingrained part of my practice. The information would have been as outlined in paragraph 30 above. He agreed to start Septrin on 19 November 1992 as his CD4 count was below 200.

Emergency admission on 2 December 1992 – Reaction to Septrin

33. Witness W2384 was told, as all other haemophilia patients, that if he needed urgent treatment in Swansea he needed to contact the Haemophilia Centre during working hours or to contact the haematology ward (Ward 11) after hours. He was advised, as all other haemophilia patients, not to go to the Emergency Admission Unit. This advice and practice, adopted in nearly all haemophilia centres in the UK, was given in order to avoid any delays for the patient being assessed by the haematology team ie the team with the appropriate expertise.

34. When he needed urgent treatment on 2 December 1992, Witness W2384 did not contact the haematology ward but went to the Emergency Admission Unit instead.

35. He was seen on 2 December 1992 by the Haematology senior house officer when she was contacted by the Emergency Admission Department. She admitted him to the haematology ward. He complained of vomiting, conjunctivitis and night sweats, and

had a high temperature. He was subject to a full assessment and investigations on admission and was started on intravenous antibiotics).

36. I saw Witness W2384 the next day on 3 December 1992 and made sure that his treatment with Septrin was permanently stopped. I wrote in his medical notes that a reaction to Septrin was the possible underlying cause for his symptoms. However, he needed to continue on intravenous antibiotics as a bacterial infection remained a possibility. The handwritten Clinical Summary Sheet, which is the discharge summary, completed by the senior house officer on 7 December 1992, reflects my comments that Witness W2384 had a Septrin allergy and that the Septrin was stopped (WITN3761046).

37. In his oral evidence, Witness W2384 stated that *"Anyway, they started me on various antibiotics, thinking it was something HIV related, but after I think it was a week, someone -- I suspect it was the GU clinic, the GU clinician, I think they consulted him and he said -- asked the question, "Is he on Septrin? Stop the Septrin"*. Witness W2384's recollection is inaccurate and in contradiction to the facts as documented in his medical notes referred to above. It was not the GU clinician but myself that made the decision and within less than twenty-four hours from the time of his admission, that the most likely cause of his symptoms was a reaction to Septrin. It was clear to me that he should no longer receive Septrin as a treatment. After his reaction to Septrin, we discussed the next option, pentamidine, if his CD4 count dropped. This is referenced in my letter to his GP, Dr Lewis dated 8 February 1996 (WITN3761047). This was discussed with him several times (as demonstrated by the further correspondence from myself and colleagues in the Swansea Haemophilia Centre dated 1996) before he accepted pentamidine in 1997. Dr Sian Lewis, my colleague in the Swansea Haemophilia Centre, wrote to the Ysgol Street Surgery dated 18 December 1997 to confirm that Witness W2384's current medication included "*nebulised Pentamidine prophylaxis*" (WITN3761047).

Witness W2384's care upon admission to the Haematology Ward

38. I have had regard to paragraph 6.1 of the first statement of Witness W2384 (WITN2384001). Witness W2384 claims that, when he was hospitalised in Swansea, he was put in a separate room and confronted with gloved and masked doctors, nurses and ancillary staff. He states that he felt isolated and stigmatised enough, without "*having these feelings reinforced by the attitude of hospital staff*".

39. All haematology patients including those with haemophilia were admitted and treated in the haematology inpatients beds on wards 11 and 12. The vast majority of haematology patients on these two wards were those with haematological cancers and were immuno-compromised. The haematology health care staff on Wards 11 and 12 also managed or cared for patients with HIV and other risk populations before this also became a problem for haemophiliacs. All such HIV patients were admitted to the haematology ward in Singleton Hospital. The health care staff are very experienced in the management of such patients in terms of shielding the patient from any possible infective agents and were very familiar with the mode of transmission of HIV. The health care staff including doctors and nurses would all use masks and gloves if there were risks to the patients from cross infection from other patients with airborne or skin contaminants which are infective agents. The precautions that could have been taken by the health care staff in managing Witness W2384 would have been for the safety of Witness W2384 and would not have been different from the precautions taken for any other severely immuno-compromised patient at the time. In my view, that would have been explained to him by the health care staff looking after him at the time and it is unfortunate that Witness W2384 had not realised that he was being treated no differently in that admission to other immuno-compromised patients.

40. Any precautions taken by the health care staff on the haematology ward were more for the safety of the patients than the staff themselves.

Dental Care

41. I have had further regard to paragraph 6.1 of the first statement of Witness W2384 (WITN2384001) in which he states that he had "*difficulties getting dental treatment*" when he was first taken off the roll at Morriston Orthodontic Department, but was eventually able to sign up with a family member's community dentist.

42. Patients with haemophilia in Swansea received their specialist dental care in the Restorative Dental and Maxillo-Facial Department in Morriston Hospital. The clinical support from dental colleagues in Morriston Hospital for patients with inherited bleeding and haematological disorders has been excellent throughout the years.

43. Haemophilia patients are also encouraged to register with their local dentists for regular check-ups. However, community dentists did not perform any active dental

interventions for patients with inherited bleeding disorders. Such interventions are rightly considered specialist care as they require support with coagulation factors concentrate and pharmacological agents such as DDAVP, and the coagulation results require monitoring.

44. As stated previously, the care of Witness W2384 was transferred from the Royal Free to the Haemophilia Centre in Swansea in July 1987. I saw him for the first time on 24 July 1987. On the same day, I referred Witness W2384 to Mr Charles Rowse, Consultant Oral Surgeon in Morriston Hospital. I asked Mr Rowse to see him and add him to the dental patients list of haemophiliacs. This initial referral is included in (WITN3761048).

45. Mr Rowse acknowledged my letter on 29 July 1987 (WITN3761048). Witness W2384 was seen on 9 September 1987 for assessment. The comments in the notes that "*Examination- Teeth and periodontal condition in order but review state of MOD in L6 L5 in 6months time*" shows that he received support from the appropriate specialist within the Morriston hospital in a timely manner (WITN3761048).

46. As can be seen from Mr Rowse's letter to me dated 6 January 1988 (WITN3761049), Witness W2384 received regular treatment from Mr Rowse's team. The letter confirms there was a need to remove a right carious molar tooth which was discussed with Witness W2384. Mr Rowse asked me to arrange for Witness W2384's haemophilia care management plan to enable the procedure to go ahead. I made and implemented a management plan for support with Factor VIII concentrate and the carious tooth was extracted as confirmed by the medical notes (WITN3761049).

47. In a different episode that required specialist dental care, Witness W2384 was admitted on 2 May 1995 with submandibular abscess requiring intravenous antibiotics. He was managed jointly with Mr A Ali, Consultant in Restorative Dentistry and myself which is confirmed by the letter I sent to Witness W2384's GP, Dr Lewis on 18 May 1995 (WITN3761050).

48. Witness W2384 was reviewed on a regular basis by the Restorative Dentistry Department for monitoring and assessments. He was also referred, in addition to his routine appointments, whenever a further need was identified, such as an occasion when he was referred by me in a letter to Mr Rowse dated 21 March 1996, after he presented with a white discolouration to his tongue (WITN3761051). This is also confirmed by Mr Rowse's letter to Dr Beddall dated 16 April 1996 (WITN3761051).

49. It was not the case that Witness W2384 faced difficulties in obtaining dental treatment at Morriston hospital and far from it, in my view, he was always seen promptly by the Dental team after such referrals. However, at times he did not keep his appointments and failed to inform the dental department as demonstrated by Mr Rowse's letter to Dr Beddall dated 17 September 1996 (WITN3761052). The Haemophilia Centre always took steps to ensure that he was re-admitted to the roll of patients so that Witness W2384 could have a regular follow up with Restorative Dentistry if he had not attended follow up appointments with the dental team.

Information about the Birchgrove Cardiff Support Group

50. I have had regard to paragraph 4.4 of the second statement of Witness W2384 (WITN2384002) and page 173 of the Transcript. Witness W2384 has suggested that up to 1993, the Swansea Haemophilia Centre neglected to inform him and his wife of a Cardiff based support group specifically for people with haemophilia and HIV.

51. The Haemophilia Centre in Swansea informed patients with haemophilia and other inherited bleeding disorders about all support groups known to the Centre at the relevant time.

52. I accessed the web page of the group last on 4 November 2020 (WITN3761053). The Chair of the Birchgrove Group who lived in Swansea has written in the section of History of the group, 1988 "*Mary Dykes contacted the haemophilia nurse at Singleton Hospital, Swansea, where I lived and I was invited for a free weekend."* This indicates that the Haemophilia Nurse was aware of the Birchgrove group (WITN3761053).

53. It would be inconceivable that the Haemophilia Nurse in Singleton Hospital would only inform selected groups of haemophilia patients in Swansea infected with HIV about the Birchgrove group. After all, there were only six adult haemophiliacs in Swansea infected with HIV.

54. In my view, on the balance of probabilities, it is more likely than not that the Haemophilia Nurse would have informed Witness W2834 about the Birchgrove group not long after it had been established and as soon as the Haemophilia Centre in Swansea knew about the group which would have certainly been before 1993. Therefore, I regard the suggestion by Witness W2384, in paragraph 4.4 of his second statement (WITN2384002) and at page 173 of the Transcript, that the Haemophilia

Centre in Swansea "neglected" to inform him about the Birchgrove group as inaccurate.

55. The Haemophilia Centre in Swansea arranged annual Christmas gatherings for adults and children with haemophilia. These gatherings were organised by the Haemophilia Nurse. In these gatherings, patients and their families and the haemophilia team met, shared experiences, information and had a very pleasant time. Discussions relating to the Birchgrove group would have undoubtedly arisen during these occasions. Therefore, I do not accept that the Swansea Haemophilia Centre neglected to pass on information to Witness W2384 about the Birchgrove group until 1993. I do not believe I learned about the group from Professor Bloom as Witness W2834 suggests at page 173 of the Transcript but believe I might have heard about it from Swansea patients that were involved, but I cannot specifically recall.

56. It is interesting that in paragraph 6 of his first statement (WITN2384001), Witness W2384 states "*I believe that both the Swansea Haemophilia Centre and the GUM Clinic did their best for me…".* I wholeheartedly agree with this statement.

Information about variant Creutzfeldt-Jacob disease ("vCJD") and precautions to be taken by patients

57. I have had regard to pages 157 to 159 of the Transcript in which Witness W2384 explains that he did not know why his Laryngoscopy appointment was cancelled.

58. Although I have addressed some questions related to this issue in paragraph 225 of my Second Statement [WITN3761005], I feel that I need to address this matter further in this, my third statement.

59. Witness W2384 was informed in 2004 about his risk of vCJD as were all other patients who had been treated with UK pooled coagulation factor concentrates between 1980 and 2001. He was informed of this in my letter to him dated 20 September 2004 ("at risk letter") [WITN3761017]. He was also informed of the same when seen by me in the outpatient clinic. In the at-risk letter, [WITN3761017], under the section entitled *What special precautions should I take?* (on page 3), Witness W2384 was told "…*you should tell whoever is treating you before you undergo medical, surgical or dental treatment, so that they arrange special procedures for the instruments used in your care*". Therefore, Witness W2834 was advised to communicate his at-risk status to health care workers before he underwent any medical, surgical or dental treatment so

that appropriate precautions could be taken. This would have been applicable to all procedures such as an endoscopy, biopsy or any surgery.

60. Witness W2384 failed to inform the Otolaryngologist, Mr Aird when he attended the ENT department to be assessed for hoarseness of voice that he was at risk of vCJD. That consultation was not arranged by the Haemophilia Centre.

61. I was only alerted to the fact this procedure had been arranged when I received Mr Aird's letter to me dated 29 December 2005 [WITN3761030]. Mr Aird indicated that Witness W2384 would be admitted for a microlaryngoscopy and excision of a legion from his vocal cord. Mr Aird asked me whether it was advisable that Witness W2384 should receive blood product support (prior to any intervention/biopsy). That was when I first learnt about the intended procedure.

62. Had Witness W2384 informed Mr Aird of his at-risk status in relation to vCJD, as explained to him in the letter he received in 2004 [WITN3761017], the Otolaryngologist would have contacted the virologist who would have, in turn, contacted the vCJD panel in Edinburgh. The vCJD panel would have given advice about the measures to implement to ensure that Witness W2384's endoscopy could be conducted in the safest manner possible.

Section 3: Other Issues

63. I firmly believe that my colleagues and I in the Haemophilia Centre in Swansea provided the best possible care for patients with Haemophilia and inherited bleeding disorders given the information we knew at any particular time.

64. I also firmly believe that that the most devastating experience for any doctor is to witness harm inflicted on his/her patients that resulted from their treatment. This feeling of devastation is felt even if the harm to the patient occurred unintentionally and even if the harm could not have been foreseen. I believe that this feeling of devastation is shared by my current and previous colleagues that looked after patients with haemophilia and other inherited bleeding disorders.

65. I have sought, in this statement, to correct the factual inaccuracies, as I see it, in Witness W2834's witness statements and oral evidence to ensure that the Inquiry has the full and accurate picture of how the Swansea Haemophilia Centre sought to care and treat Witness W2384 in line with all others under our care. There is a paramount

obligation on all witnesses to provide factual and accurate statements to help the Infected Blood Inquiry to reach the right conclusions. I take the signed Statement of Truth in each of my written statements seriously and appreciate the Inquiry providing me with this opportunity to correct any misinformation or misunderstanding relating to the Swansea Haemophilia Centre.

Statement of Truth

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

Signed GRO-C

Dated **27 January 2021**

Table of exhibits:

Date	Notes/ Description	Exhibit number
October 1990	Request form and result of HCV Antibody test 1990	WITN3761040
March 1992	Request form and result of HCV Antibody test 1992	WITN3761041
21 January 1993	Outpatient clinic notes - the need to reduce alcohol intake due to the risk associated with HCV infection.	WITN3761042
23 September 1993	Notes and letters relating to the advice on the need to avoid excess alcohol due to the combined risks from HCV infection and alcohol	WITN3761043
May 1994-November 1994	Letter to Dr Lewis, West Cross Medical Centre - Monitoring while on interferon alpha	WITN3761044
December 2002-April 2003	Correspondence from Cardiff Haemophilia Centre to Dr Al-Ismail - Treatment with Pegylated Interferon and Ribavirin in Cardiff	WITN3761045

2 to 7 December 1992	Notes and discharge summary relating to hospital admission following reaction to Septrin	WITN3761046
1995-1997	Letters from the Swansea Haemophilia Centre showing pentamidine offered and declined on several occasions	WITN3761047
24 July 1987	Initial referral to Consultant Oral surgeon, Mr Rowse in Morriston Hospital	WITN3761048
6 January 1988	Letter from Mr Rowse, Consultant Oral surgeon to Dr Al-Ismail – Need for dental extraction of a tooth planned and discharge summary after tooth extraction.	WITN3761049
18 May 1995	Letter to Dr Lewis, West Cross Medical Centre example of joined care with Restorative Dentistry for submandibular abscess	WITN3761050
21 March 1996 -16 April 1996	Further referral to Mr Rowse, Consultant Oral surgeon by Dr A.C. Beddall.	WITN3761051
17 September 1996	Letter from Mr Rowse, Consultant Oral surgeon to Dr Beddall - Failure to keep appointments with dental department	WITN3761052
4 Nov 2020	Extract from Web Site of Birchgrove Group	WITN3761053