Witness Name: Dr Gillian Evans
Statement No.: WITN3775001
Exhibits: WITN3775002-005
Dated: 15TH October 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF GILLIAN EVANS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15th October 2019.

I, Gillian Evans will say as follows: -

Section 1: Introduction

1.

Dr Gillian Evans
Kent Haemophilia Centre
East Kent Hospitals NHS University Foundation Trust
Ethelbert Road
Canterbury

Date of birth GRO-C 1969

Qualifications :

• MBChB	1991	University of Aberdeen
• MRCP	1994	Royal College of Physicians (Glasgow)
• MRCPath	1999	Royal College of Pathologists (London)
• FRCP	2006	Royal College of Physicians (London)
• FRCPath	2007	Royal College of Pathologists (London)

2.

May 2017 – present	Head of service for laboratory	East Kent Hospitals Trust

	haematology and blood transfusion	Canterbury
July 2010 – present	Haemophilia Centre Director	Kent Haemophilia Centre East Kent Hospitals Trust Canterbury
April 2002 – present	Consultant Haematologist	Kent Haemophilia Centre Kent and Canterbury Hospital Canterbury

I have been a consultant haematologist at East Kent Hospitals Trust since 2002 and was appointed to the position of Haemophilia Centre Director in 2010.
My subspecialist interest is in the field of haemostasis, thrombosis and non-malignant haematology for both adult and paediatric services. I hold three outpatient clinics weekly for patients with bleeding disorders and thrombosis.

3. I am a member of the United Kingdom Haemophilia Centre Doctors Organisation and attend advisory committee meetings.

Section 2: Responses to criticism of W0653

4. I first met witness W0653 in my haemophilia clinic on 13th February 2013. He had previously been seen in clinic by my consultant colleague Dr Elliott on 20th December 2012. At this appointment he was advised to be tested for hepatitis and HIV, and blood was sent for these investigations. When I saw witness 0653 on the 13th February 2013 he had been informed – I believe by his GP, that he had been infected with hepatitis C. At that appointment I established that he had been treated with blood products between 1980 and 2000. This is the period that patients who have received blood products are considered to be at risk of nvCJD. I recorded in my notes that clarification was required regarding whether the witness was "at risk for public health purposes". This was dependent on what products he had received and when and the current guidance for the department of health.

As the witness had received blood products around 1990 (as I thought from my notes) then it is possible he may not have been "at risk" dependent on exact dates of transfusion. The guidance also refers to factor 8 and 9 and it was my responsibility to check if the witness had been exposed to either after 1990. If not then he would not be at risk. Hence my reasoning for not informing him at that time given the uncertainty.

Notes from consultation 13th February 1013 below
Letter attached as evidence (**WITN3775001**)

Date	Notes	Initials
13/2/13	1990 – Rx last time Rx for haemophilia possibly not risk nvCJD Hep C. Needs referral Skipton Not haemophilia A GRO-C: GE	

Guidance from HPA on notification of risk of nvCJD

> *I enclose a letter from the HPA which sets out the results of their deliberations on the reassessment of risk from UK produced plasma products.*
> *The key recommendations are:-*
> *1 Individuals who received Factor VIII and Factor IX between 1990 and 2001 should remain notified as 'at increased risk of variant CJD for public health purposes'.*
> *2 Individuals who only received plasma products between 1980 and 1989 should now have their treatment history reassessed to confirm this fact and if it is confirmed, they should be de-notified.*

*I have attached evidence of this communication (**WITN3775002** and **WITN3775003**).*

There was no test available to offer the witness and it did not impact on his current physical health or transmission to others. I did however feel it necessary to record the possibility in the notes and letter to the GP in case surgery or dentistry was required in the interim when infection control precautions would be required. I arranged to see the witness in 6 months hopefully with the information required to make a decision regarding nvCJD. In the interim the witness appears to have received a copy of the letter for which I apologise as I would have intended to see the witness and explain the potential risk "face to face".

5. It was uncertain whether the witness was at risk of nvCJD when I saw him on 13th February 2013 as we did not have accurate records of products received and dates available to us as the transfusions had all occurred at other hospitals. I did not think it appropriate to inform him until I had the correct information particularly as no test is available for nvCJD. It is recorded in hand written notes that "possibly not at risk of nvCJD". I think there was enough doubt in my mind at the time regarding risk not to inform the patient without first checking for further information.

6. I cannot comment on the follow up arrangements from the national prion clinic. The witness had an appointment with me on 12th March 2014 where the issue of at risk for nvCJD was discussed. It was explained that we considered this a risk for public health purposes in terms of possible transmission on surgical instruments and that no further investigation was warranted at that time.

7. I reviewed the witness on several occasions between 2013 and 2019. On 12th March 2014 I discussed with him the letter he had received regarding his possible "at risk" status for nvCJD. It is documented clearly at this consultation that his medical problems were causing him considerable anxiety.

> *Mr McLean had a number of concerns which the consultant Dr Evans went through with him in detail. In particular he was very anxious about a letter he received saying that he may be at risk of new variant CJD; Dr Evans explained to him that we only consider this from a public health point of view for patients who might undergo surgery and that we have not seen any significant transmission of nvCJD to our haemophilia patients. She tried to reassure him that no further investigation is warranted.*

At a further consultation in 2019 we again discussed the issue and I informed him that I did not inform him of the potential for being at risk of nvCJD until I had tried to clarify if this was the case rather than giving unnecessary information which may have been incorrect and caused further distress. Once I had established there was a possible risk the witness was reviewed by me in clinic on 12th March 2014.

This is excerpt from a letter on 10th May 2019 detailing this discussion

> *Further to your appointment in the Haemophilia Centre this morning I enclose what I feel is a summary of what was discussed for your record. I understand that you have been attending the Infected Blood Inquiry and understandably this has caused you some distress. This has been further exacerbated by the inability to obtain batch numbers of products for which you were treated I believe in Maidstone Hospital a number of years ago prior to being referred to Canterbury. I understand that you have not requested your medical notes from Canterbury*

and if you wish to do so then there is a request form on the Infected Blood website and process within East Kent Hospitals to ensure that you receive your notes promptly.

I understand that you are upset that you feel I did not warn you about your possible risk of new variant CJD when I saw you on the 13th February 2013. This was the first appointment that we had met and at that stage we had just informed you that you had been infected with hepatitis C virus following previous treatment at another hospital. At that stage it is clearly documented that I stated I would try to find out some further information about your previous treatments. I also thought that as you may have had pooled clotting factor concentrates between 1980 and 2000 and therefore, as stated in the letter, that it was possible that you were at increased risk of new variant CJD. I did not inform you of this possibility at that stage as I wished to obtain further information about what treatments that you had had in the past rather than worrying you unnecessarily if you had not been exposed to the relevant products within that timescale. However it was important that I documented this in your notes in case you required surgery in the near future. I am sorry that you feel that I should have warned you of your risk at an earlier stage but I did not feel it appropriate to worry you unnecessarily until I had further clarification of whether you were at risk, particularly as there was no test to be performed at that stage to determine if you were at risk and there was no impact on your current health at that stage or likelihood of transmitting any infection to other individuals other than through surgical instrumentation. Once we had established that you were possibly at risk of new variant CJD I reviewed you in clinic and we discussed it in some detail.

Evidence **WITN3775004**

There was no intent on my behalf to withhold the diagnosis but to make sure with thorough checking that the information was correct as far as I could determine from any records available. I was concerned about the witness's mental health throughout this period. The witness in his statement to this inquiry point 83 has stated that:

In 2013, I stood on the top of a motorway bridge and moved to the edge. Final thoughts were running through my mind and I thought of my grandson – it was this thought that stopped me from jumping but I still regularly have suicidal thoughts.

I was not being arrogant withholding information but would not wish to cause harm by giving incorrect information without checks being made regarding previous treatment. There was no test available to offer the witness with regard to nvCJD.

8. All patients who were treated with pooled plasma products between 1980 and 2000 were at the time considered to be "at risk" of nvCJD for public health purposes irrespective of batches. By checking with West Kent hospitals I was trying to clarify products and dates of transfusion- unfortunately specific products and dates are not available to me. However on the basis that the witness was treated around 1992 following surgery I had to consider the necessary precautions as is my responsibility to public health. This concurs with the opinion of the national prion clinic.

9.

a. The reference to his mental health may refer to notes made on 24th January 2013 when the witness attended for further blood tests it was noted the witness was "very upset" and "very anxious" and again on the 13th February 2013. It does not refer to the appointment with

his GP when he was informed of the hepatitis C blood tests. I cannot see a reference to his mental health in my letter of 10th May 2019 which is enclosed (**WITN3775005**).

b. The notes referred to in my letter are notes held at East Kent Hospitals

I understand that you have not requested your medical notes from Canterbury and if you wish to do so then there is a request form on the Infected Blood website and process within East Kent Hospitals to ensure that you receive your notes promptly.

c. I apologise for the inaccuracy. This refers to a record from his original appointment at the haemophilia centre where it was documented that the witness:

"also has a cartilage tear in his right knee and from your letter it seems that at that time he was treated for possible von Willebrands deficiency and given fresh frozen plasma and factor VIII concentrate.".

I mistook this for surgery to repair the tear in the cartilage

Section 3: Other Issues

Statement of Truth

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

Signed GRO-C

Dated 15th Oct 2019

Table of exhibits:

Date	Notes/ Description	Exhibit number
13.02.2013	Clinic letter	WITN3775002
24.01.2013	Notification of change to nvCJD guidance	WITN3775003
04.02.2013	UKHCDO notification to centres	WITN3775004
10.05.2019	Clinic letter	WITN3775005