Witness Name: Dr Nicola Anderson
Statement No.: WITN3872001
Exhibits: WITN3872002-005

Dated: 3rd December 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF NICOLA ANDERSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 28 October 2019.

I, Dr Nicola Anderson, will say as follows: -

Section 1: Introduction

1. May I first of all express my sincere apologies to Mr Root's family for the fact that he became infected with HCV through a blood transfusion and for what appears to have been an error by me in the completion of the Lookback form in relation to the section on "*other potential risk factors*". As document WITN2028003 shows, Mr Root's infection with HCV was identified during the Lookback exercise on the basis that he had received a transfusion from a donor who had subsequently tested positive for HCV and that was why he was asked to come in to be tested, leading to his diagnosis.

2. I have no actual recollection of events and do not have all the relevant information or complete copies of all the forms which would have been part of this process, but I will do my best to try to explain what may have happened. I should say again, that I can only assume now that I have made a mistake for which I am truly and deeply sorry. I wish to stress that any inaccurate information in completion of the form would have been a mistake and not an intentional lie or deliberate untruth on my part.

3. Name: Nicola Anne Bridget Anderson
   Address: NHS Blood and Transplant, 500 North Bristol Park, Filton, BS34 7QH
   Date of birth: GRO-C 1953
   Professional qualifications: MBChB, MMed (Path Haem), MSc, FRCPath

4. From 1991-2014 I was a Consultant Haematologist based in Bristol where I worked for the South West Regional Transfusion Service which later became Blood Services South West and then the Midlands and South West Zone of the National Blood Service before amalgamation into NHS Blood and Transplant. When I started as a Consultant in 1991 my responsibilities included donor medicine, red cell immunology and therapeutic apheresis. I later concentrated on donor medicine, including donor selection, managing adverse events and post donation information and resolving complaints. I also conducted post-test discussions with donors with positive microbiology test results and performed lookback investigations on their previous donations where required.

5. From 2014-2016 I was the Clinical Director Blood Donation in NHS Blood and Transplant, reporting to the Associate Medical Director Blood Supply. Between 2016 until I retired in 2018 I was the Associate Medical Director Blood Donation in NHS Blood and Transplant. These were national managerial positions where I managed a team of Donor Consultants and their Clinical Support Teams. As the Associate Medical Director Blood Donation I was responsible for Clinical Governance in the Blood Donation Directorate and chaired the Blood Supply Care and Effectiveness Committee (BSCARE) reporting into the Care and Effectiveness Committee (CARE).

6. **Membership, past or present, of any committees or groups relevant to the Inquiry's Terms of Reference.** I was a member of the Donor - Blood and Tissue Transfusion Safety Assurance Group (Donor BTSAG) for approximately 6 months from January 2004, deputising for Dr E Caffrey whilst she was on sickness absence. During this time, I provided medical input into the operational implementation of the decision to exclude blood donors who had received a blood transfusion themselves and I was responsible for writing the policy document that covered this process.

Section 2: Responses to criticism of W2028

7. I have been asked to comment on the statement by witness W2869 at paragraph 12 of her second statement which states that I recorded her late father as having a history of injecting drug use, suggesting he was a drug addict; she further states that her father never injected drugs.

8. I note that on the section of the LBF3 form (Lookback 3 form) part of which has been provided to me, where there are boxes to tick in answer to the question: "*Does the patient have any other potential risk factors for HCV (tick if appropriate)*", I appear to have ticked all four of the following potential risk factors:

Other transfusion episodes		*Occupational exposure to blood*	
History of injecting drug use		*History of skin piercing*	

9. Below this box is a section: "*If answered yes to any of the above, please give details below*". In that section I have noted: "*During other operations*". This would clearly be intended to relate to the potential risk factor of "*other transfusion episodes*". I have noted in the form above this, in completing the previous section, that there were several surgical procedures as follows:

   "*Ongoing problems relating to right knee – had original procedure 1991 – (index Tx* [transfusion*]) then 1992 (*or 3 it is overwritten*) removed and replaced. 1993 removed. 1995 another replacement.*"

10. My practice was to add some information about any other risk factor identified and as there is no further information for any of the other risks and the family members who have given evidence to the Inquiry are certain that there were no such factors I can only assume that I have completed the form incorrectly which distresses me greatly and for which I am sincerely and deeply sorry. I would not have had medical records available to me. I can produce two further records for Mr Root, which I attach marked WITN3872002 and WITN3872003 which I understand to be spreadsheet entries extracted from a central Hepatitis C, Epidemiology database and the local Bristol database respectively. Columns AA to AH and AA to AU respectively show that the information recorded was that there was one other risk factor which was "other transfusions". As far as I can recall, the only information I would have had with me was the green form LBF 3 with the first page already completed for me by my assistant

(from the yellow form LBF 1) and the leaflet to give to the patient. WITN2028003 is part of the yellow form, a full copy of which I attach as an example marked WITN3872004. For me the focus of the discussion was always the communication with the patient. The green form guided the discussion and was completed as I went along. My practice was to speak initially solely to the patient but once I had complied with the duty of confidentiality, I would have invited their partner, or whoever had accompanied them, to come in for support if that was what the patient wished. I should stress that the recipients were all patients but I was not strictly seeing them on a conventionally therapeutic basis and had no prior relationship with them. I was however always very conscious that it was very shocking for them to have received the letter asking them to come for tests and I always did my best to give explanations. My intention was to treat everyone I saw with sensitivity and compassion. I always ensured that I had at least an hour to spend with each person. I usually only saw one person per day so I took as long as they needed. In general people were very calm and quite stoical during these discussions and the taking of blood for testing, but I fully appreciated that the possibility that they might have HCV infection was at the least bewildering and for many extremely shocking and distressing.

11. I would like to add that identification of a *history of injecting drug use* does not suggest to anyone involved in blood donation or Lookback exercises that someone is a 'drug addict'. In the course of discussions with donors (as opposed to recipients, as Mr Root was), who were found to be infected, it would not be uncommon for the only risk factor identified as the means by which they had become infected to be a single episode of injecting drug use perhaps in their youth which they could barely even remember and were often horrified to discover so many years later could have caused harm not just to themselves but also to others by means of their donated blood.

12. My own experience was that there was never any judgment negative or otherwise on those who were potentially infected if other potential risk factors were identified. The whole purpose of the Lookback was to identify those who may have been infected by a transfusion and to arrange for them to be tested and then to have access to whatever medical or other assistance could be made available for them. I am not aware of anyone ever categorising those who had suffered such a potentially life-changing illness through no fault of their own, as drug addicts. Certainly my experience as part of the blood service was that we wanted to do the best we could for those who had suffered harm in this way.

13. I have also been asked to comment on the fact that at paragraph 13 of her second statement, witness W2869 states that I incorrectly recorded her late father as having other blood transfusions as a potential risk factor. I cannot add to my explanation above. I have given some further detail in relation to this risk factor which would be my usual practice where the discussion reveals the potential for another source. That information was also what was entered on the system as WITN3872002 and WITN387003 show. I can only say again however, that the discussion with Mr Root was only taking place because he had been identified as being at risk of infection via a transfusion from a donor who was known to be infected. That would therefore be the presumed source.

14. I have also been asked to comment on the fact that at paragraph 14 of her second statement witness W2869 states that I incorrectly recorded her father as having piercings. I do not know why I would have ticked this box. I have not added any detail to suggest this as having been identified as a possible risk factor during the discussion and can only assume that this was a mistake for which I apologise unreservedly.

15. I have been asked to comment on the statement by witness W2869 at paragraph 15 of her second statement that despite the form's suggestion, neither of her parents was given any counselling.

16. The form is described as "Documentation of Recipient Counselling". This was not however in-depth counselling of the nature that would perhaps be understood today. It was an early stage of the process of Lookback being the point at which, having been identified as someone who had received a blood transfusion from a donor later tested as positive for HCV, the recipient would be asked to make an appointment so that the process could be explained to them and they could be tested and then referred for appropriate treatment of whatever nature was needed if the tests were positive for infection with HCV. I think it is important that the basis of the Lookback exercise is understood and I hope it will help if I try to explain this. I have attempted to do so below in **section 3 – Other Issues.**

17. My role in this part of the process was to explain, factually but always compassionately I hope, the need for the blood test, then to take the blood for testing and go through the information in the Chief Medical Officer's guidance, which is discussed further and exhibited below. I would then refer the patient to the GP so they could be referred for

treatment. I would generally phone the GP to explain the importance of it so they didn't just get a letter in the post as they weren't all very familiar with Hepatitis C.

18. I have been asked to comment on the statement by witness W2869 that untruths on the form have consequently helped healthcare professionals form an opinion on her father. I can only apologise again for apparent mistakes in completing the form and reiterate that they were most certainly not deliberate untruths. I very much hope that the mistakes will not have affected how Mr Root was viewed by anyone in the medical profession. I have already set out that my own experience of dealing with those identified as having been infected inadvertently was that they should be treated with the utmost sympathy, at least by the Transfusion Centre where I worked, and that our desire was to do what we could to try to help. I provided the GP with an extra copy of LBF3 form, which may have been used for onward referral to the specialist. Whilst the LBF 3 form would be kept with the GP records, once the diagnosis had been made, I do not know what reason there would be to review it. If other potential risks had been identified, which the GPs who knew the patient far better considered should be addressed, then that would be a matter for them to deal with clinically. I assume that Mr Root's GP, who might have known him well, would either have queried the mistaken ticks with me or directly with Mr Root, or assumed they were mistakes.

19. Each medical practitioner has a duty to take their own medical history when seeing a patient and to treat accordingly. They would not rely on a form completed as part of a lookback exercise at some point in the past as any kind of guide to the treatment required or offered. The letters and extracts from Mr Root's records which have been provided to me do not seem to suggest that any adverse view was formed or that the ticked boxes on the LBF 3 had come to their attention. WITN2028002 is one such letter. It is the referral from the GP Dr Meads dated 24 August 1995 to the hepatologist, Dr Barry, who was a senior hepatologist in the region. It notes in the first paragraph that the reason for the referral is that Mr Root had been diagnosed with hepatitis C "due to blood transfusions during operations on his right knee". I note this refers to both transfusion**s** and operation**s** in the plural. It continues that I had been in touch to say that the antibodies were strongly positive and the PCR was positive. It also sets out the basis of the discussion Dr Meads had had with Mr Root, going through the Government information, which was based on what was known at the time about the disease, its potential progression, the risks for onward transmission and available treatments. Dr Barry's response dated 23 October 1995 is document WITN2028005. It begins "Thank you for referring this pleasant man..." and specifically says that his

infection with hepatitis C was picked up as a result of the National Lookback Programme following a potentially infected transfusion. There does not appear to be any suggestion of a negative view being taken of Mr Root. WITN2028009 is a letter of 13 February 2003 to Dr Christie. The letter is incomplete so the author is not apparent but this letter also refers to the source of the infection with HCV being "as a result of treatment" at the RD&EH (albeit the hospital might not be correct).

20. I have been asked to comment on the statement by witness W2028 at paragraphs 25-26 of his statement where he states that the form appears to declare that his father had a history of drug use, occupational exposure to blood, and a history of skin piercing which was incorrect. I can only repeat my answer above which is that the form was completed in error and that I am very sorry indeed for my mistake and the concern it has caused to the witnesses and Mr Root's family. It is possible that with the full forms or papers I could offer a better explanation and will of course do so should that be the case.

21. I have been asked to comment on the statement by witness W2028 at paragraph 27 that: '*this form and the lies it contains makes my family wonder if dad was even present when it was completed*'. I would only ever complete the form with the patient present as I went through it with them. My practice was to add further detail of any other *possible* risk factor identified. In light of the evidence of the family I can only assume that I have completed the form incorrectly and offer my deepest and sincerest apologies for that. I can also give an absolute assurance that my sole intention was to offer compassion and arrange for the onward referral of those who were infected so that they could have all available and appropriate treatment which was the whole purpose of the Lookback exercise.

22. I have been asked to comment on the statement by witness W2028 at paragraph 28 of his statement that this form may have been used by decision makers for treatments, drug trials and other care services in deciding what services his late father was offered.

23. I can only say again that the very purpose of the Lookback exercise was to facilitate appropriate treatments. I do not think it likely that the form would have been seen by professionals caring for the patient clinically, other than his GP, and the Hepatologist if the GP had decided to send a copy of the form on initial referral. These clinicians would have his full medical history, probably knew him well and I hope, where relevant, would have raised the points on the form with the patient.

24. It is the duty of every medical professional under relevant codes of conduct to make their own assessment of a patient which includes taking a full history and examination.

Section 3: Other Issues

The HCV Lookback exercise – background

25. The HCV Lookback exercise was announced in Parliament on 11 January 1995 and information was communicated to all doctors by letter of the Chief Medical Officer dated 3 April 1995. I attach marked exhibit WITN3872005 a copy of the letter and the procedural guidance attached.

26. The purpose of the Lookback exercise was: *"to trace, counsel and if necessary, treat those people who may have been inadvertently infected with hepatitis C through blood transfusions"*. The Department of Health set up an ad hoc working party of experts to draw up guidance on the procedures for undertaking the Lookback exercise and for "counselling" those identified as being at risk, as well as guidance on the treatment options available. The procedural guidance identified the actions to be taken by the Regional Transfusions Centres and the hospital departments of Haematology in order to identify those patients exposed to blood transfusions and possibly infected as a result with HCV

27. **Action by Regional Transfusion Centres**
The National Blood Service commenced screening of blood donations for evidence of hepatitis C in September 1991. When the Lookback exercise was announced, the transfusion centres were able to identify donors who had since been tested and found to be positive for evidence of hepatitis C infection.

28. For each HCV infected donor, a list of all donations up to the time of the positive hepatitis C test was drawn up from transfusion centre records. Each blood donation could have been processed into a number of blood components (red cells, platelets, fresh frozen plasma (FFP) and cryoprecipitate). Each individual component from each individual donation was identified and the fate of each component traced through Blood Transfusion Centre records. The Transfusion Centres produced a complete list of components as far back as records allowed. In general, this was back to the early

1980s. Some of the information for the earlier years would be held on paper or manual records; later records were on computer.

29. The Transfusion Centre having identified the list of donations and components to be included in the Lookback exercise, established the destination (hospital) of each component from the records. For each hospital, a composite list of all components issued and included in the HCV Lookback exercise was prepared. For each of the individual components a standard enquiry form (LBF1 – Lookback Form 1 which was yellow) was prepared. The hospital then received the complete list of components to be included in the exercise, together with the LBF1 form for each component.

30. The LBF1 form identified the unique donation number assigned to the original blood donation, the identity of the blood component in question (red cells, platelets etc.), the date of issue from the transfusion centre and the name of the hospital.

31. **Action at the hospital blood transfusion laboratory**
When the hospitals received the list of components and the individual LBF1 forms, they were required to trace from their records the fate of each individual component. Although some of this information in the later years was held electronically, the majority of the information in the early 1980s would have been in manual records.

32. The transfusion laboratory could identify the individual components, and the name of the recipient for whom the component was issued, together with date of issue. This information was entered on the LBF1 form.

33. The next step was that the consultant in charge of the blood transfusion laboratory was required to obtain the medical records for the identified recipient and ascertain whether there was documented evidence in the records that the blood component issued for use on the patient was in fact transfused. The consultant was asked to note the name of the clinician caring for the patient at the time of the transfusion, whether the patient was discharged from hospital alive and the name of the GP and/or hospital clinician currently caring for the patient. When all this information was complete, the LBF 1 was returned to the transfusion centre. The consultant in charge of the hospital transfusion laboratory was asked to communicate with the clinician who cared for the patient at the time of the transfusion. to inform the clinician of the situation and to ask whether the clinician wished to be responsible for contacting the patient using a standard letter and then to 'counsel' the patient in terms that they may have been infected with

hepatitis C. If the clinician decided to undertake the notification, an information package was provided by the transfusion centre with the necessary information. If the clinician declined to carry out the notification and 'counselling,' the transfusion centre contacted the patient's general practitioner and enquired whether it would be appropriate for the patient to be notified. The general practitioner was also asked whether he/she wished to do the notification and 'counselling'. If not, the transfusion centre would do it. In the majority of cases the hospital clinicians and GPs declined and so this part of the process had to be done by the transfusion centres who had no prior or therapeutic relationship with the patients.

34. The identification, treatment and counselling of such patients was the express purpose of the Lookback. It was designed to do as much as we could to ensure that those who were infected through no fault of their own, and often in the course of life-saving treatment, were identified and provided with whatever help was available. Whilst there is no doubt that the system was not perfect; it was never possible to trace all recipients and undoubtedly mistakes – including here - were made which I cannot now explain, there was absolutely no benefit in anyone lying or completing the forms with information they knew to be untrue.

35. I am deeply sorry for having completed the form incorrectly. I apologise for the errors in completing the LBF 3 form.

Statement of Truth

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

Signed GRO-C

Dated 3/12/2019.

Table of exhibits:

Date	Notes/ Description	Exhibit number

1995	Spreadsheet entry for KR - central	WITN3872002
1995	Spreadsheet entry for KR - Bristol	WITN3872003
1991	Sample form LBF1	WITN3872004
3 April 1995	Letter of Chief Medical Officer dated 3 April 1995 and procedural guidance	WITN3872005