Witness Name: Dr Kieran Morris
Witness Number: WITN3922001
Exhibits: WITN3922002 - 03
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DOCTOR KIERAN GERARD MORRIS

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 November 2019.

I, Doctor Kieran Morris, will say as follows: -

Section 1. Introduction

1. My full name is Doctor Kieran Gerard Morris and I reside at GRO-C GRO-C Belfast GRO-C My date of birth is GRO-C 1962 and my professional qualifications are as follows:
    - MB BCh BAO, 1985, University College, Dublin.
    - MRCP, 1990, United Kingdom.
    - FRCPath (Transfusion Medicine), 1997.

2. I commenced employment at the Northern Ireland Blood Transfusion Service ("NIBTS") on 1 October 1995. I was employed by the NIBTS for 24 years, during which time I held the following positions and responsibilities:
    - 1 October 1995: Senior Registrar specialty training and qualification in transfusion medicine.
    - 18 January 1999: Consultant grade with responsibilities for all aspects of the service reporting to the Chief Executive/Medical Director.

- 1 April 2006: Deputy Medical Director.
- 22 September 2009: Chief Executive, Consultant in Transfusion Medicine and Accountable Officer, responsible for regularity and propriety of the service; reporting to the Permanent Secretary of the Department of Health Social Services and Public Safety (which was renamed the Department of Health Northern Ireland ("DHNI") in 2016), as well as specific Consultant responsibilities 0.3.
- 4 August 2014: Medical Director; I had responsibility for all medical and scientific aspects of the Service, reporting to the Chief Executive.

3. I notified the NIBTS of my intention to leave on 2 July 2019 and my termination date was 30 September 2019.

4. I am currently employed as a Consultant with the Irish Blood Transfusion Service, having taken up the position on 1 October 2019.

5. I can confirm that I have not provided evidence nor have I been involved in any other inquiries, investigations, criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products.

Section 2: Concerns raised on 15 November 2018

6. I exhibit WITN3922002, which is a meeting note from the Employer Liaison Service of the General Medical Council ("GMC"). It minutes the two meetings that I had with Joanne Donnelly (Employer Liaison Advisor) at the NIBTS Headquarters, Lisburn Road, Belfast, on 15 November 2018 and 29 March 2019. Joanne Donnelly met with me in my capacity as the Responsible Officer for the NIBTS. It is Employer Liaison Service protocol to ask the Responsible Officer whether they have any concerns about their employer; they are also required to inform them of whistleblowing procedures. After I expressed concerns about the NIBTS, Joanne Donnelly took it upon herself to raise my concerns with the GMC. It should be noted that I would not have raised these

concerns with the GMC on my own accord, as I did not feel that I had sufficient evidence to support the allegations.

7. I confirm that the meeting note is an accurate record of the conversations that took place between myself and Joanne Donnelly.

8. On 15 November 2018 I met with Joanne Donnelly and raised various concerns relating to the NIBTS and their response to requests made by the Infected Blood Inquiry ("the Inquiry"), which I will outline below.

9. I raised the concern that I was only afforded limited opportunity to engage with the Inquiry (p.13, WITN3922002). There were a number of events that I believe restricted my interaction with the Inquiry.

10. Firstly, the interim Chief Executive ("CEx"), Karin Jackson, asked me not to attend the Inquiry's preliminary hearings in London on 24 - 26 September 2018. Instead she requested that I remain in Belfast to receive a colleague who was returning from leave. What seemed strange to me was that the Locum, who had only been with the NIBTS for a year, was asked to attend the preliminary hearings. It should be noted that the Locum did not feel competent to deal with this request. In the end Ivan Ritchie (Head of Human Resources and Corporate Services) and Alphy Maginness (Chief Legal Advisor of the Directorate of Legal Services) attended the hearings, so there was no medical representation from the NIBTS there.

11. Secondly, I was not invited to the initial meeting of the Inquiry coordination group that was organised by the DHNI and held on 15 November 2018. The coordination group consists of all of the Inquiry core participant health bodies in Northern Ireland; two representatives from each of these organisations attend. The representatives for the NIBTS are Karin Jackson and Ivan Ritchie. Because I was not invited to this meeting I had to get myself an invitation and did so through Karen Simpson and Seamus Camplisson from the DHNI. I essentially gatecrashed the meeting.

12. Thirdly, I was not facilitated to attend a meeting that was held with Health and Social Care legal counsel on 16 April 2019, after requesting that the date be changed due to a clash with my diary. In the end my colleague, Dr Kathryn Maguire, attended instead.

13. I do not know the reason or rationale as to why the interim CEx actively excluded me from the preliminary hearings and the two meetings. This is in contrast with medical director colleagues in the other United Kingdom blood transfusion services.The decision to exclude me conflicts with the job description for Medical Director, which states that the post-holder sits on and attends board meetings.

14. I believe that the interim CEx was the most appropriate person to provide the Inquiry with a written statement on behalf of the NIBTS. However, when the interim CEx submitted the statement she did not consult with me or ask me for any advice or guidance. I did not see this statement until after it had been sent to the Inquiry and when I finally did see it was because I had requested to do so.

Section 3: Concerns raised on 29 March 2019

15. On 29 March 2019 I met with Joanne Donnelly again. During this meeting I discussed further concerns that I had about the NIBTS, in relation to the handling of documents that are of potential relevance to the Inquiry. I explained to Joanne Donnelly that the NIBTS were asked by the Inquiry to provide all relevant documents to them and that the Inquiry had a general direction that no documents should be destroyed or disposed of (p.1, WITN3922002).

16. I expressed concerns that despite this direction the interim CEx, excluded NIBTS medical staff from the search process and changed the locks, so that NIBTS medical staff (including myself) could not access the store room. They brought in four additional staff to assist. I do not believe they were suitably qualified staff with the knowledge required to undertake the task.

17. On 30 September 2018 the NIBTS commenced a decluttering process of their document archive located in the plant room of their Headquarters. It was completed on 26 October. There followed an additional process of cataloguing files and documents which largely concluded in March 2019. Both exercises were completed by agency administrative and clerical staff. The entire process took the four staff members around six months. I suggested that the medical team should be involved as subject experts but this offer was not accepted. It was stated that this was not feasible or practical because of the volume of material. I, in my capacity as Medical Director, with the relevant subject knowledge, was excluded from this process.

18. The four agency administrative staff, mentioned above, were recruited by the NIBTS to carry out the task of decluttering the plant room and identifying relevant documents. Their qualifications, training competency assessment and suitability were not discussed with me or any other member of the medical team. I am not sure what their professional qualifications were, however, I do not believe that they had a medical background. I felt concerned when I was in Paula Johnston's (Information Governance Officer) office and one of them came in and asked her what c22 and c33c are. This is concerning because c22 and c33c are viral peptides expressed on recombinant immunoblot assays for confirmation of hepatitis C antibody detection These staff members were employed for a period of up to six months. One left in November, one in January, one in March and one was retained as a permanent employee.

19. I believe that the medical secretaries and staff from within the Quality and Compliance Department of the NIBTS could have performed this task and would have been better suited because of their subject knowledge. It is not normal NIBTS practice to bring in external people. The interim CEx did not discuss the employment of external staff with me.

20. The locks to the plant room were changed and access restricted sometime between 3 and 10 September 2018. Previously anyone on the medical team

could obtain a key to the plant room from the Facilities Manager, Denise Edgar. After the locks had been changed everyone had to go through Paula Johnston to get a key, this made it more difficult to access the plant room. The locks in the old donor grouping laboratory (location for cataloguing) were changed and access restricted in the last two weeks of September 2018. No files or documents were referred to the medical team during this period.

21. I am fastidious when it comes to the retention of documents, so I know that all of my records should have been in the plant room document archive. I was excluded from the decluttering exercise and the assessment of identifying records that are relevant to the Inquiry. Furthermore, I was not given a say in what was kept or destroyed. The exclusion from the process was the main thing that increased my concern that documents and files were being disposed of , and this made me anxious.

22. I was off work on sick leave from 11 October 2018, but was given the all clear to return on 18 October 2018. I intended to raise my concerns about the decluttering process at the agency board meeting on 25 October 2018 and emailed the then chairman, Jim Lennon, to ask that this be added to the agenda. I was instructed not to return to work until 26 October 2018 by the interim CEx, as she was seeking further clarification from Occupational Health.

23. The interim CEx sent me four text messages which asked me to confirm that I would not be attending the board meeting; she texted me three times on the evening of 24 October and once on the morning of 25 October. I wish for these four text messages to be included in my statement and exhibited as WITN3922003, which is a copy of the four text messages. Jim Lennon subsequently replied to my email and said that this was an operational matter for the interim CEx and therefore it was not discussed at the board meeting. It is not correct for me to state that documents were provided to the inquiry at this time.

24. In November and December 2018 myself and Dr Kathryn Maguire were asked to conduct an initial trawl through the documents in the plant room that had been identified as potentially relevant to the Inquiry. I have always stressed that the most important files for the Inquiry to see are look-back, trace-back and product recall records. In relation to the trace-back notifications, I was a Consultant for Donor Medicine for this period and the notification would have come to me. Any blood establishment would be expected to hold such records securely and make them available upon request.

25. At the time neither myself nor Dr Maguire were able to find any trace-back notifications for the period 2000-2006, nor were we able to locate records related to the plasma recall by the Scottish National Blood Transfusion Service ("SNBTS") of batch pools containing plasma from two donors who subsequently developed vCJD. Consequently, I thought that documents and files were missing. I was subsequently informed by Paula Johnston (Information Governance Officer that during the decluttering of the plant room, which is where these documents would have been located, documents were disposed of as confidential waste and that no lists of removed items were recorded. I was worried about this and so emailed the interim CEx and Information Governance Officer on 28 December 2018 to raise my concerns.

26. I initially considered raising my concerns externally through whistleblowing/public interest procedures. However, in the end I decided not to make a protected disclosure for the following reasons:

    a) The retained files were presented to me for a detailed review in May 2019. During this review I was tasked with composing a narrative of the contents of seven boxes of records. I completed this review on 7 June 2019.

    b) Whilst undertaking the review a trace-back file, dated 2001, was discovered and this may have been the only one. The file showed that the donation was excluded, as was the donor.

c) If one trace-back file is retained it is less likely that others would have been discarded.

d) While there were between one and two trace-back notifications on average annually for the period from 1980 - 2000, there were only two for the subsequent period from 2006 - 2013, and there have been none since 2013.

e) This is consistent with enhanced blood donor screening and decreased likelihood of transmission of infection.

f) In relation to meetings (related to product recall) with the Belfast Health and Social Care Trust ("BHSCT") or its predecessor organisations during the 2000 - 2003 period, minutes may not have been recorded, as this was the practice at the time.

g) I visited the plant room on my last day of employment at the NIBTS (30 September 2019) at the request of the Information Governance Officer and I was reassured that files were catalogued and secured in an appropriate manner, and there was a general impression of an orderly system.

If I still believed that relevant records were inadvertently destroyed then I would have raised my concerns publicly. At the time that I raised concerns I felt as though I was in an information vacuum and was worried that relevant documents were missing or had been destroyed, but for the above reasons I subsequently felt reassured and content that nothing was missing.

Section 4: Other issues

27. I believe that the following issues that are associated with my work at the NIBTS may be of relevance to the Inquiry.

28. I was informed by the Head of Microbiology Testing, Mr Brian Webb, shortly after I joined the NIBTS that they had been testing in shadow form for anti-HCV antibodies from 1 June 1991. He also told me that repeat reactive blood donations were discarded and that donors may not have been informed. Formal testing and appropriate donor management protocols were introduced on 1 September 1991, which was the national go live date. A number of regional directors were extremely disappointed by the fact that tests were available from March 1990, but were not deployed until a year and a half later. In particular, Dr Huw Lloyd (Director of the Newcastle Regional Transfusion Centre), left the United Kingdom and went to Canada for this reason.

29. The NIBTS introduced mini pool testing for HCV RNA in November 1999 and for HIV RNA in December 2002, which along with the SNBTS was the earliest in the United Kingdom. Transfusion services in England implemented later.

30. The permanent deferral from donating blood for men who have sex with men (MSM) was only relaxed to one year from date of occurrence in Northern Ireland in September 2016. In the rest of the United Kingdom the relaxation was implemented in September 2011 and a further relaxation to three months from date of occurrence in in 2017.

31. In relation to plasma product recall for vCJD , Dr Morris McClelland (Chief Executive/ Medical Director of the NIBTS at the time) asked me to attend meetings with BHSCT colleagues on behalf of the NIBTS. The two donors of the vCJD infected plasma donated blood in Scotland. The SNBTS would have been meticulous in their record keeping. They attempted to conduct a silent look-back; identifying potential recipients, but not informing them. The decision was informed by the lack of a confirmatory test and no defined treatment pathway

32. It is my recollection that the BHSCT's records for traceability of human albumin solutions and intravenous immunoglobulin products were both inadequate and incomplete. You could not identify which patients either of these products had been allocated to because it was not recorded. However, I

cannot make any comments on the Haemophilia Centre's records, they should have recorded which patients were allocated specific units of factor VIII and factor IX.

33. The Penrose Inquiry stated that the last day of collection for a blood donation in a Northern Irish prison took place at Crumlin Road Jail on 26 October 1983. However, I have heard some discussion that blood donation sessions in prisons continued until 1985 and that the last prison that collected was HMP Maghaberry.One of the key issues for the Inquiry is that stopping collection in 1985 could potentially have been sooner because of risk profile of prison inmate donors. It is my personal opinion that collecting blood from prisoners was not best practice (p.3, WITN3922002).

34. In the 1970s there were outbreaks of jaundice in haemophiliacs receiving factor concentrates and there was a widely held belief in the medical and scientific communities of the existence of an as yet undiscovered hepatitis virus (non-A non-B hepatitis). Commercial plasma companies collected blood from paid donors including the prison population and the effect was observed much less in plasma collected from altruistic blood donors.

35. In Northern Ireland approximately two thirds of the haemophilia blood products that we used were sourced form NI donor plasma altruistic and one third were from commercial sources. Dr Elizabeth Mayne (Director of the Northern Ireland Haemophilia Reference Centre at the Royal Victoria Hospital) and Dr McClelland carefully selected commercial suppliers of haemophilia blood products from professional paid donors and this is consistent with reported infection rates of HCV (100 percent) and HIV (44 percent)in NI haemophilia cohort

Statement of Truth

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

Signed GRO-C

Dated 13 January 2020