Witness Name: Aileen Gibson
Statement No.: WITN4046001
Exhibits: Nil
Dated: 20 January 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF AILEEN GIBSON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 24th April 2020.

I, Aileen Gibson, will say as follows: -

Section 1: Introduction

1. **Please set out your name, address, date of birth and professional qualifications.**

   I am Aileen Gibson. My address is GRO:C. My date of birth is GRO:C 1960.

   Professional Qualifications:

   - Registered Sick Children's Nurse;
   - Registered General Nurse.

2. **Please set out your employment history as a nurse, including the positions you have held, the dates that you held these positions, the haemophilia centres and other organisations in which you held these positions and your role and responsibilities in these positions.**

   Employment history as a nurse:

- 1978-1981 – Paediatric Nurse training, Royal Hospital for Sick Children (RHSC), Yorkhill, Glasgow

- 1981-1982 – Staff Nurse (night duty) Ward 7a (medical/ cardiology), RHSC, Yorkhill, Glasgow. I worked as part of the team caring for babies, children and young people with various cardiac and medical disorders, both pre and post cardiac surgery.

- 1982-1983 – General Nurse training, Western Infirmary/ Gartnavel Hospital, Glasgow

- 1983-1996 – Staff Nurse Ward 7a (medical/ haematology), RHSC, Yorkhill, Glasgow. I worked as part of the team providing care for babies, children and young people with a range of medical and haematological conditions, including haemophilia. From approximately 1986, ward 7a, became a ward for only patients with various haematology and oncology conditions and a small day unit was established within the ward area, which I was heavily involved in. The day unit provided an area where patients with haemophilia would attend for treatment of any bleeding episodes and prophylactic treatments. Occasionally I would be required to administer Factor replacement products, if the haemophilia sister/staff nurse were not on duty.

- 1996-2018 – Haemophilia sister/ Nurse Specialist Ward 7a; Schiehallion Unit, Yorkhill, Glasgow; and then relocated to Ward 2B, Royal Hospital for Children (RHC), Queen Elizabeth Hospital, Glasgow. I worked as part of the team involved in the care and management of babies, children and young people with bleeding disorders in the West of Scotland Haemophilia Centre. The role included initial diagnosis and management of the bleeding disorder; support patients and their families in managing day to day life with a bleeding disorder. This included home visits; home teaching; home treatments and where/when necessary.

3. **Please set out your Memberships, past or present, of any committees, groups, associations, societies or working parties relevant to the Inquiry's Terms of Reference (which can be found on the Inquiry's website at**

www.infectedbloodinquiry.org.uk), including the dates of your membership and the nature of your involvement.

Memberships:

- Royal College of Nursing: Haemophilia Nurses' Forum. Peer support: Teaching/ training and education

- Scottish Haemophilia Centre Directors' Organisation: Nurses' group. Peer support: teaching: training and education: Collaboration in the development of teaching aids for staff and families

- Haemophilia Society: Peer support: information source for families and staff.

- West of Scotland haemophilia centre staff group: Peer support: teaching / training and education. Collaboration with adult services in the review of product use and distribution and collation of figures for service managers both at local and National level

4. **Please confirm whether you have provided any evidence or been involved in any other inquiries, investigations, criminal or civil litigation in relation to human immunodeficiency virus ("HIV") and/or hepatitis B virus ("H BV") and/or hepatitis C virus ("HCV") infections and/or variant Creutzfeldt-Jakob disease ("vCJD") in blood and/or blood products. If you have, please provide details of your involvement and copies of any statements that you made.**

I have had no involvement in any of the Inquiries mentioned in question 4.

Section 2: The haemophilia department at Yorkhill Hospital

5. **Please provide details of your role within the department, including the dates when you worked there, your responsibilities and, if you can remember, names of significant or senior staff members who were working there at the time.**

I worked as a staff nurse within medical/ haematology ward, Ward 7a 1983-86, providing nursing care to meet the needs of each individual patient and their family.

My duties included bathing; feeding; administration of drugs; treatments and therapies as per medical instructions and prescriptions. Along with observing, recording and reporting patient conditions. I worked with the multidisciplinary team to provide appropriate care and support to patients and families. Support given would for example be to assist the parents in administering factor products; perhaps attending to siblings whilst the parent attended to the needs of the haemophilia patient; accessing other members of the MTD team when needed, eg dentist/ social works services. Within the day care setting I was taught how to venipuncture children, by Sister Murphy and the day care doctors, and was able to administer IV treatments to the haemophilia patients

Approximately 1986 - Ward 7a became a haematology/ oncology ward, which no longer had general medical patients within the ward. Also within the ward there was a day care facility established, which I was mainly now involved with, providing day care and support to haematology/ oncology patients in between their chemotherapy blocks. Within the day care space there was an area where haemophilia patients could be reviewed, treated and given a sense of continuity to the patients and families, where the same staff members would be providing care and support.

The haemophilia team members included:
Dr Ian Hann (consultant haematologist)
Dr Brenda Gibson (consultant haematologist)
Dr Anna Murphy (out patient / clinic doctor)
Dr John Kelt (out patient/ clinic doctor)
Sister Christine Murphy haemophilia sister
Staff Nurse Iris McKinlay (deceased)

At some point between 1986 and the early nineties sister Murphy spent much of her time caring for and supporting those boys who were HIV positive, within their homes and if required at another hospital within the city, where the boys would be treated for health issues arising from their HIV and Hep C. At this point Staff Nurse McKinlay was employed to provide the care and support for the haemophilia patient group. Sister Murphy left the RHSC, to go and work in the community setting at some point in the early to mid-90s to work with those people who had developed Hep C and who were going through the various treatment regimes.

6. **Please explain the hierarchy and dynamics within the department, identifying in particular who was responsible for (a) decisions as to the selection and purchase of blood products, (b) decisions as to use of blood products (including factor Viii and IX concentrates) for patients' treatment and (c) decisions as to what information to provide to patients about treatment, testing and/or diagnosis.**

Whilst I was the staff Nurse within the day care setting (from approx 1986), I had little knowledge of the following: the decisions to select and purchase factor products; the decisions as to the use of blood products, including factor replacement products, and the decisions as to what information to provide to patient about treatment/ testing and diagnosis. This was the responsibility of the Consultant in charge of the haemophilia team. In 1996 (following the tragic death of Staff Nurse Iris McKinlay), I applied for and was given the role of haemophilia sister. Ward 7a moved to a purpose built haematology/oncology facility within the RHSC Schiehallion Unit, with a much larger daycare facility, which included a larger haemophilia space. At some point in the mid/late 1990's Dr Hann left his post. Dr Elizabeth Chalmers (consultant haematologist), became consultant responsible for haemophilia care around 1996. From 1996, my role as haemophilia sister was to work within the multidisciplinary team and involved the following: to provide and promote practical and emotional care; to administer factor replacement for bleeds; the provision of prophylaxis; patient and family education and support on bleeding episodes including how and when to treat; and providing information on prophylaxis pros and cons. It would involve teaching parents / carers to venepuncture, to facilitate early treatment of bleeds, and about reducing joint damage; and also information on prophylaxis, to reduce frequency of bleeds and eliminate, where possible, spontaneous bleeds. I would also collate factor usage numbers for individuals and specific groups, both for local and national bodies. This would facilitate the purchase of the recombinant products. Decisions as to the selection of product were based on the needs of the patient, the availability of product, the product details and the cost. This was decided at a national level using national guidelines and studies.

Section 3: Knowledge of risk

7. **What was the department's approach and the approach of senior clinicians to the use of blood products (in particular factor Viii and IX concentrates)? How did this change or develop over time?**

Recombinant products were used as and when they became available, with the PUP's being given the first products available and as more product became available all paediatric patients, where possible, went to recombinant products. I have no knowledge of the approach to use of blood products prior to my appointment. Recombinant products, as they became available, became the treatment of choice where available.

8. **What was the department's approach and the approach of senior clinicians to home treatment and to prophylactic treatment for patients with bleeding disorders? How did this change or develop over time?**

Within our unit we were very active in promoting home treatment and prophylaxis and explaining the benefits of the approach. We used historical information and experience, national and international reports, and national guidelines to ensure patients had access to appropriate prophylaxis regimes. With a view to minimising joint damage, minimising time spent attending hospital; facilitating almost full time education and reducing disruption to family life. Our objectives were: supporting families to establish home therapy in a safe and supportive manner; supporting both families and the education service to have an inclusive education package for each boy; and supporting everyone in the usual milestones through the education journey. This included home visits and visits to schools and nurseries to provide appropriate information and training. Written guidelines were supplied, along with hospital/ haemophilia nurse/ daycare unit contact numbers, for both routine and emergency advice.

9. **What was the department's approach and the approach of senior clinicians to the use of factor concentrates for children with bleeding disorders? How did this change or develop over time?**

The team approach was to use factor replacement products to achieve the best effective response. This included: minimising pain, discomfort, immobility, reducing time spent away from school, affecting education goals, and most importantly, minimising/ reducing the long term effects of joint bleeds. Promoting a healthy life style, was important, where appropriate use of factor replacement can and did support this. When independent nurse prescribing became available, I undertook the course, along with a paediatric examination course to allow me to examine a child with a bleed,

diagnose and prescribe appropriate treatment and administer products. This speeded up the time to treat bleeds significantly. The extended nurse prescribing course became available in early 2000s, I undertook the course in 2003-04 at the University of Paisley. Audits undertaken both pre and post this service development supported this, and also patient/parent satisfaction improved.

To further reduce time attending hospital and interference in home life, a home delivery service of factor products was considered, and put in place, using third party pharmaceutical companies. This would have been some time in the 2000s. Pharmaceutical companies had no involvement in the care of the haemophilia patients other than to deliver their factor products via the established cold chain home delivery systems. The service only became available with the recombinant products. All appropriate safeguards were put in place to protect the patients and their information, written information given to the service users, all consents obtained, and patient satisfaction studies carried out by the service providers.

10. **Do you recall any policies or standard operating procedures (written or otherwise) relating to the use of blood products being in place? If so, please describe what they were and whether they changed or developed over time.**

Within in the unit, we used the UKHCDO treatment guidelines. They changed and developed as products changed from plasma to recombinant, where possible, as clinical studies produced information as to best treatment option

11. **What was your general understanding as to the risks of Infection associated with the use of blood and blood products? What was the source of your understanding? Were you provided with any information or training, whether within the department or elsewhere, about the risks of infection and if so when? How did your understanding develop over lime? How did your knowledge affect your nursing practice?**

Nurse education provided general understanding to the risk of infection when using blood products. Working within the field of paediatric haematology enhanced this information, with regular teaching sessions/seminars, informal education, self-education using various methods reading, attending meetings and electronic systems. When HIV was first discovered and the children had to come into hospital, looking back, how they were treated, paper sheets/ paper plates/ TV covered in plastic, staff /

parents with gowns gloves face masks was awful for the patients. Everyone's knowledge was limited; it did relax and change to appropriate infection control measures, depending on the procedure being carried out. As more knowledge about virus transmission became available and people's experience in dealing with these viruses increased, infection control measures became more realistic and patient friendly. The paper sheets, plates and masks were no longer used. Looking back and reflecting, what was done was deemed appropriate at the time given the lack of knowledge and experience of this virus.

12. **What was your understanding as to the risks of the transmission of hepatitis (including Hepatitis B and Non A Non B Hepatitis/Hepatitis C) from blood and blood products? What was the source of your understanding? When did you first become aware that hepatitis could be transmitted by blood or blood products? Were you provided with any information or training, whether within the department or elsewhere, about the risks of the transmission of hepatitis and if so when? How did your understanding develop over time? How did your knowledge affect your nursing practice?**

Nurse education provided a basic understanding of the risks of hepatitis transmission from blood products. Training and education within the haematology ward was provided as more information became available throughout the 80's and 90's. The Infection Control Team within the hospital also provided training and support. Written guidelines were developed by senior staff, (nursing and medical).

13. **What was your understanding as to the risks of the transmission of HIV from blood and blood products? What was the source of your understanding? When did you first become aware that HIV could be transmitted by blood or blood products? Were you provided with any information or training, whether within the department or elsewhere, about the risks of the transmission of HIV and If so when? How did your understanding develop over lime? How did your knowledge affect your nursing practice?**

I became aware of the transmission of HIV, when patients were being diagnosed as being positive, which, from memory, was in the mid to late 80's. The hospital provided information and training. As more information and experience developed, practices changed and people became more aware of risks involved and how to appropriately manage those risks.

When HIV first emerged, dealing with those infected was an anxious time for all involved, but with the passage of time and more knowledge becoming available, there were more appropriate measures put in place. Universal infection control measures were put in place for all patients where the use of blood products were involved, and where 'any' blood', eg blood sampling was involved.

14. **What was your understanding of the relative risks of infection from (a) the use of commercially supplied blood products and (b) the use of NHS blood and blood products? How did your understanding change or develop over time?**

The use of commercially supplied products was a necessity, where there were no appropriate NHS products that could be used. This has changed over time as recombinant products became available. When I first used commercially supplied products, or the NHS products, one thought that they were fit for purpose, the doctor had prescribed it and it was my job to administer it. When I assumed the role of Haemophilia Sister and my depth of knowledge of these products increased, I became aware of the drive to move to recombinant products.

15. **Was any training or advice provided (and if so, what training or advice) to clinical staff in the department in relation to advising patients of the risks of infection associated with the use of blood and blood products? Who provided this training or advice?**

Training was provided through various sources: on line training; product information leaflets; in house training by senior staff; counselling courses e.g. the Haemophilia Society National Symposium and Paediatric HIV Infections (1989).

16. **Were any steps taken in or by the department to mitigate or reduce the risk of infection from the use of blood or blood products? If so, please detail what steps were taken and when.**

The Department followed national guidelines in these matters.

Section 4: Testing, treatment and care of patients

17. **What information was provided to patients treated within the department about the risks of infection (generally and/or specifically in relation to hepatitis and/or HIV) associated with the use of blood and blood products, and by whom?**

At diagnosis parents as part of the discussion around haemophilia and management of the condition, product use and type would be discussed and information given as to which product the child would receive. Whilst I was in post many of the newly diagnosed patients would go on to recombinant products as the product of choice, where there was no recombinant product available the most appropriate / available product would be allocated, (in some conditions there was very little choice). As to the type what risks there may potentially be, with any product would also be discussed. For some patients I would see them more often than others. The reason for this could be geographical as the patient catchment area covered the west of Scotland. It could have also been due to the patient requiring little hospital treatment. Also as the patients grew up to be able to manage their own conditions, then these discussions would and did go on for years to refresh and reinforce previous information given.

This information would be given by the consultant in charge. I would then follow up these discussions, over many months, and sometimes years to ensure that parents, and then the patients themselves, were aware what risks there may be and what choices there may be available. Written information was also provided.

18. **What information was provided to patients within the department about alternatives to treatment with factor concentrates, and by whom?**

This information was provided by the Consultant in charge at time of diagnosis.

19. **What information was provided to patients within the department before they began home treatment, and by whom?**

Home treatment and start dates were patient specific. They would have been mentioned in the initial diagnosis discussions with the Consultant in charge. These discussions would continue with myself, haemophilia nurse specialist and the family. The needs of individual patients would be discussed at regular multi-disciplinary team meetings, which the families were aware that took place. I could and would go back to the families with information from these meetings. Regular clinic visits, gave the families a chance to have discussions with the Consultant.

Home treatment started when it was appropriate for the needs of the patient. Written guidelines were provided, that had been developed by the Scottish Haemophilia Nurse Group.

20. **What was the department's approach and the approach of senior clinicians to obtaining patient consent to treatment and to testing? What information would be provided to patients and by whom? To what extent were decisions about treatment and testing taken by the doctors rather than the patients? Did this change or develop over time and If so how?**

In paediatric patients testing is required to establish the diagnosis of the bleeding disorder. This is done with the permission of the parent (legal guardian). Ongoing testing and treatment is part of the condition management and is done in collaboration with the parents and the patient.

These conditions are for life so it was important that that patient had some knowledge not only of their medical condition but also the products used to treat any potential bleeding episodes. Is was not always easy to engage with adolescents, but every effort was made to engage with them.

In the context of the 1980s, I cannot comment, as I was not in post at that time.

21. **Was any training or advice or Instruction provided to you in the department in relation to obtaining patient consent to treatment and to testing? If so, please describe the training, advice or instruction given.**

I undertook training in counselling and consent in paediatric patients.

22. **Were you ever told to withhold information from a patient or patients about risks, or treatment, or testing, or diagnosis, or their condition? If so, by whom and in what circumstances?**

No.

23. Was it customary to take blood samples from patients when they attended the department and for what purpose? What information was given to patients about the purposes for which blood samples were taken, and by whom?

Yes. It was customary to take blood samples from some patient groups, checking general haematology / biochemical blood profile, factor levels/ inhibitors screens. Information about screening was given to the patient or their parents by medical staff and nursing staff. Information was given at diagnosis and then recapped at clinic visits. The parents and the boys would be given the results, especially when we were checking factor levels as this would needed to be arranged pre the clinic visit to ensure the information obtained was correct. Treatment decisions were made having reviewed leading histories in factor levels, so open dialogue between medical, nursing staff and the families was essential.

24. What information would routinely be given to patients about liver function tests and the results of such tests?

LFT's form part of routine biochemistry profile. Abnormalities were not generally expected in this patient group. In my time as a Haemophilia Nurse, the products being used would not be expected to cause irregularities. If there were it would be rechecked and discussion with parents as to any possible concurrent illness e.g. cough / cold. Routine childhood viral infections can cause abnormalities in LFT's which correct with no intervention.

25. Were patients informed if their blood was going to be tested for HIV, HBV and/or HCV and, if so, by whom? Did the approach to informing patients change over time?

Routine Testing for HIV; HBV; HCV, in my period as haemophilia Nurse specialist, was not considered necessary as many of the patients had never been exposed to a plasma derived product, therefore not at risk of a blood borne virus. If and when for any reason I had to test for any of these conditions, discussions and consent would be obtained by the medical staff, written consent became mandatory for a HIV test.

26. What was the practice within the department about informing patients of test results (whether positive or negative or inconclusive) for HIV, HBV and/or HCV? Were patients informed of the test results promptly or were there delays in test

results being communicated to them? How, as a matter of usual practice, were they advised of their test results (e.g. by letter, or by telephone, or in person at a routine appointment or at a specific appointment) and by whom? What, if any, involvement did you have in informing patients of test results?

I have nothing to submit which would assist the Inquiry. Testing for these conditions predates my time in post and I had no involvement in these procedure.

27. **What information or advice was provided to patients diagnosed with HIV, HBV and/or HCV regarding the management of their infection including the risks of infecting others? How did this change or develop over time?**

I have nothing to submit which would assist the Inquiry. I was not in post at this time.

28. **What was the practice within the department as regards testing and/or providing information to the partners and/or family members of people known or suspected to be infected with HIV, HBV or HCV?**

I have nothing to submit which would assist the Inquiry. I was not in post at this time.

29. **Was any form of counselling or psychological support made available to patients infected with HIV, HBV and/or HCV or to their families? If so, please detail what support was available.**

I have nothing to submit which would assist the Inquiry. I was not in post at this time.

30. **Was any form of social work support made available in the department to patients infected with HIV, HBV and/or HCV or to their families? If so, please detail what support was available.**

I have nothing to submit which would assist the Inquiry. I was not in post at the time, although I was aware that there was a social worker involved with the families, from memory her name was Christina Leitch.

31. **How was the care and treatment of patients diagnosed with HIV, HBV and/or HCV managed within the department? What treatment options were offered over the years to those diagnosed with HIV, HBV and/or HCV? What follow-up and/or ongoing monitoring was arranged? To what extent were patients in the department referred for specialist care elsewhere? How did any of this change or develop over time?**

Sister Christine Murphy, became a nurse dedicated to the care and support of the patients and their families affected by HIV/HCV, and a second Staff nurse was employed to support the rest of the haemophilia patient group. Other than this, I have no other specific information to submit. The care and management of this patient group was not part of my remit.

32. **Do you recall patients diagnosed as HIV, HBV and/or HCV positive being treated differently to others? If so in what respects? What if any measures were implemented to address any risks of cross-infection?**

When this patient group were admitted to the ward, they were isolated in a patient cubicle, and not allowed to mix with other patients. This happened throughout the 1980s. People, staff/family members would be limited, be instructed in the use of gloves, gowns, and hand washing and how to dispose appropriately of anything that needed to come out of the cubicle. Blood samples would be labelled as high risk, double bagged, placed in brown envelopes to protect patient details and sent to the lab via portering system; the lab would be forewarned to expect the blood sample.

33. **To your knowledge, were clinical staff made aware of patients' Infected status in relation to HIV, HBV and/or HCV?**

Yes. If a patient with HIV, HBV and or HCV, were for example going for an invasive procedure, then it was essential that the staff who were caring for the individual were able to take appropriate actions to ensure the safety of the patient, other patients and staff members.

34. **Please describe as fully as you can your involvement in the treatment and care of those who were infected with HIV, HBV and/or HCV and what you can recall about the impact of the Infection(s), and/or of treatment for the infection(s),**

and/or of the stigma associated with the infection(s), upon them and upon their families over the years.

My involvement in caring for this patient group and their families was minimal. I worked as part of the multidisciplinary team to provide a caring service. My involvement was minimal. These boys were rarely in hospital as inpatients as they were not 'sick' at this point. They were in the main on Home Treatment for their haemophilia and this was managed by Sister Murphy and the medical team. When I was appointed to my Haemophilia Sister post, many of this patient group were now no longer attending the RHSC.

Throughout my time as Haemophilia Sister I was always aware of the impact that these infections had on the haemophilia community, both the negative and positive.

Negative aspects included, suspicion of medical and nursing staff; suspicion of new treatments and their possible side effects; some families felt they were being marginalised by the NHS system, promised much by government but hospitals struggled to fulfil theses promises. At some haemophilia meetings where patient representatives were included, I felt often there was some hostility on the part of the patient representatives directed at the staff. As I came into post, the Consultant also changed and some families found this hard and awkward. We did not know the patients and their histories and it took some time for them to feel more comfortable with the new team. This is not uncommon when dealing with chronic conditions and there are team changes, it takes time for trust and bonds to develop.

Media coverage of HIV/Hep C raised fears in the wider community that all haemophilia patients had these conditions and would pass it onto others. New haemophilia families often needed a lot of emotional support at these times. They had no knowledge of what had gone before and were now being looked at / pointed at, and this they found hard. Positive aspects, the government commitment to fund new Factors, that no longer posed the risk of blood borne viral contamination.

A positive drive to include patients and patient representatives in the decision making processes when it came to home delivery services; local and national auditing of the haemophilia services.

Section 5: Research

35. **Please detail any knowledge you have of any research that may have taken place within the department including the names of clinicians who were Involved in or leading the research.**

The Haemophilia unit at the RHSC, was active in taking part in factor replacement trials. Dr Chalmers was the investigator.

36. **To your knowledge, were patients made aware of their being involved in research? What was the approach taken with regards to obtaining their consent to such involvement?**

To take part in any of these trials, required consent from both the parents and the patients. There would be lengthy discussions with possible participants both with Dr Chalmers and myself. Written information was provided, which the families took away from the hospital to read and return with any questions/ concerns, before consent was obtained.

37. **What does the term 'PUPS', an acronym for a category of patients referred to as 'Previously Untreated Patients', mean to you? Was the term used within the department and if so by whom and in what respects?**

PUPS, we used this when referring to the babies who were born with haemophilia until they received their first factor infusion.

Section 6: vCJD

38. **Were you aware of the risks of transmission of vCJD associated with the use of blood and blood products? If so, when and how did you become aware?**

Yes. I, became aware as the evidence became apparent. I don't remember the dates.

39. **What was the process in the department for informing patients about possible exposure to vCJD? When and how were patients told of possible exposure to vCJD?**

Records were checked to asses who had been exposed to plasma derived products. Lists were compiled, including batch numbers of products. These lists were checked against lists of affected products. Letters were sent to parents/patients telling them they had been exposed to plasma derived products (of which they were aware), but they had not been exposed to the affected batches of product. These letters were drafted at a national level by the UKHCDO.

40. What information was provided to patients about the risks of vCJD?

As described above.

41. What counselling, support and/or advice was offered to patients who were informed that they might have been exposed to vCJD?

The aforementioned letter had a reply slip asking families to confirm receipt and if they wished they could have a meeting with the Consultant to discuss any concerns/ worries that they had. I also spent time talking with the parents, listening to their concerns / worries, providing time and support to help allay their worries.

Section 7: Effect on clinical staff

42. If you haven't already answered further above, how did the department's practices change over time to reflect the risk that HIV, HBV, HCV and vCJD infections posed to clinical staff?

Increased teaching, awareness of blood borne pathogens, using posters, on line training and support. Mandatory training in infection control for all staff.

43. What was the department's protocol for reporting concerns or complaints about staff and/or patient safety? Did you ever report any concerns or complaints? If yes, who did you report these to?

The RHSC had a complaints procedure and would be used as and when needed. I never used this system for any issues pertaining to these events.

44. What impact did treating haemophilia patients who subsequently contracted infections from their treatment have on you both personally and professionally?

The tragedy of these events, caused me some stress both as it was emerging and as time went on to see these young people get so sick and the effect their deaths had on their families.

Many years later, when their young relatives, now had to come to the hospital with the same haemophilia that had caused so much pain and anguish previously, it took some time to get the trust of these families. To get them to trust and believe the new products would not have the same effects on their child, some families struggled with the fact that it was me still here treating haemophilia patients.

Working with the new 'haemophilia' families to adjust to life with a child with a chronic health condition, can be stressful enough, but when 'haemophilia' hits the headlines, I would find myself going back over old ground with some families, their child was not at risk from blood borne viruses.

This re-living of old ground not only caused the families a great deal of stress, it also caused me a great deal of stress and sleepless nights. I was wanted to move forward with the new treatment modalities, to engage with the families and work with the multidisciplinary team to promote and encourage a healthy and bright future for the patients with these conditions. What had happened previously with the product contamination was awful and tragic, but it helped to move these conditions to get these newest and best possible treatment products, and moved the condition from being hospital based to a conditions that were in the main treated as outpatients and giving families much greater control of their lives.

The stress of reviewing old records, looking for information for Inquiries. I was sometimes asked to go through old patient notes, looking for product batch numbers or to review which products had been given. This information was then passed to consultants for review and then passed on to whoever had made the request.

It felt as though you were being asked to point the finger. Some patient groups could only focus on looking back to see who they could blame for all of this pain and hurt. In my area of paediatrics, it was about looking forward and ensuring the boys could have a long safe life, minimising the effect haemophilia has had on previous generations, not just from HIV/Hep C, but from the actual haemophilia. Previous generations of

haemophilia patients spent weeks/months in hospital/at home with bleeds, which reduced schooling, impacting on job prospects etc. Now the focus on prophylaxis means for many haemophilia patients they spend very little time in hospital, at school full time, better education, better job prospects, better life.

Section 8: Other issues

45. **Were you aware of any of the trusts or funds that were set up to provide financial assistance to people who had been infected (such as the Macfarlane Trust, the Eileen Trust, the Skipton Fund and the Caxton Foundation)?**

    Yes, I was aware.

46. **Were patients in the department provided with any information about these organisations or with any assistance to obtain financial support from them? If so, what information and/or assistance was provided?**

    Information was given, I recall seeing leaflets, and the haemophilia society magazine provided information and contact details.

47. **Please detail any involvement or dealings you had with any of these organisations.**

    None.

48. **What were the retention policies of the department in regards to medical records during the time that you worked there?**

    The Department followed the hospital policy for record retention.

49. **Did the department, or any clinicians in the department, keep any separate records or files or information about patients who had been treated with factor concentrates and/or patients who had been infected with HIV, HBV and/or HCV?**

    Not that I am aware of.

50. **If you have had, at any time, any discussions or conversations or interactions with senior clinicians in the department, about any of the matters set out in paragraphs 5 to 46 above, please provide (to the extent that you are able to) details of those discussions or conversations or interactions.**

Over the years I was in post there were many discussions; there were meetings with senior colleagues within the Department and with those within the West of Scotland haemophilia group. We discussed everything previously covered within this document.

51. **Please provide, in as much detail as you are able to, information about any other issues associated with your work in the department that may be relevant to the Inquiry's investigation. You will find the Inquiry's Terms of Reference and List of Issues on the Inquiry's website www,infectedbloodinquiry.org.uk. If you are in doubt as to whether or not to include something, do not hesitate to contact the Inquiry Team.**

I have nothing to submit which would assist the Inquiry.

Statement of Truth

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

GRO:C

Signed _____

Dated 20 January 2021