Witness Name: Christine Murphy
Statement No.: WITN4047001
Dated: 20 October 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF CHRISTINE MURPHY

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

I, Christine Murphy, will say as follows: -

Section 1: Introduction

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

   Name: Christine Murphy
   Date of birth: GRO:C 46
   Address: GRO:C Glasgow, GRO:C

   Professional Qualification: Registered Sick Children's 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.**

   August 1964 – August 1967 Paediatric Nurse training Yorkhill Hospital Glasgow.
   Qualified November 1967

December 1967 – April 1968 Ayrshire Central Hospital Irvine – staff nurse in paediatric unit of Maternity Dept.
April 1968 – February 1969 –Yorkhill Hospital - part time staff nurse in Accident and Emergency Department.

Break in Service

May 1974 – April 1975 – part time staff nurse in Accident and Emergency Department and Intensive Care.

Break in Service

April 1977 – December 1978 Mearnskirk General Hospital Glasgow – part time staff nurse in children's Ear, Nose and Throat ward.
January 1979 – September 1983 – Yorkhill, part time staff nurse in Accident and Emergency and Intensive Care.
September 1983 – September 1993 – Haemophilia Department Yorkhill. – part time staff nurse then, from May 1997, part time sister.
September 1993 – November 2001 – School Nurse which at that time was under the auspice of Yorkhill Hospital.
December 2001 – July 2008 – I worked in the Genetics department in Yorkhill. I was a Family Care Officer giving advice and support for children and adults with Muscular Dystrophy and other neuromuscular conditions. I also attended the respective clinics in Yorkhill and what was the Southern General Hospital. This was not a nursing role but a background in nursing or other health related experience was required.

I retired in 2008.

3. **Please set out your membership, 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.**

I was a member of the Haemophilia Society while I worked in the department. I attended their meetings if possible and requested information booklets to make available to patients.

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 ("HBV") 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 submitted a witness statement to the Penrose Inquiry.

Section 2: The haemophilia department at Yorkhill Hospital "the department"

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 in the haemophilia department from September 1983 till September 1993. I was a part-time staff nurse and then part time sister which was equivalent to post of charge nurse. My job was to treat the children when necessary, to train parents and older children to administer treatment at home.

   Also to educate, advise and support parents and school staff. I assisted at the weekly haemophilia clinics by taking blood, giving advice on ongoing treatment and dealing with any problems the children or their parents had encountered. I liaised with the school, social work departments and any other agencies if required. I visited schools to inform staff on the condition and how to respond should any problems arise. My role after promotion did not change a great deal. My hours were increased but I remained part time. I had a staff nurse to help which allowed me to do more home visiting. I continued, as before, with the duties as listed above.

   Dr Hann, Dr Pettigrew and later Dr Gibson were working in the department at various times.

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.

My memory is that that these decisions were made by the consultants.

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?**

   As far as I can recall F VIII and F IX were used for more severe bleeds and for prophylaxis.

   Cryoprecipitate was used for newly diagnosed children and those who rarely needed treatment eg more mildly affected children.

   I think this continued till the advent of heat treated blood products.

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?**

   Some home therapy and prophylaxis was already established when I started in the department. Home therapy meant children could be treated swiftly when bleeds occurred and there was no need for a hospital visit.

   Prophylactic treatment usually resulted in less use of blood products as, in general, patients had fewer bleeds.

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?**

   As far as I can recall this continued to be encouraged.

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.**

I do not recall these policies.

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 time? How did your knowledge affect your nursing practice?**

I had worked in Accident and Emergency and was aware of the risks of infection being transmitted by blood. When I worked in the department I attended study days and seminars relating to this subject. These could be in the department or in other venues around the country. Contact with other professionals increased by knowledge and this was beneficial to my nursing practice.

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?**

As in Question11, my attendance at various study days, seminars and conferences increased my understanding, knowledge and in turn improved my nursing practice. My involvement was mainly with HIV patients.

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 time? How did your knowledge affect your nursing practice?

I understood the risks for patients using blood products to be significant. I became aware of the transmission of HIV from blood and blood products in approximately 1984 as a result of discussion with colleagues. There were training days in the department and some organised by the health board and other agencies.
All were very helpful and as time went by I developed a good understanding of the risks and problems associated with the infection. I came in contact with nurses and other professionals dealing with HIV patients and that assisted with my nursing practice.

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?**

My understanding was that NHS blood and blood products were safer. I only used Scottish F VIII/F IX during my time at Yorkhill.

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?**

I cannot recall this in any detail.

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 wearing of gloves and an apron when taking blood and when in contact with bodily fluids. Careful disposal of equipment and any soiled items. Department meetings to keep staff updated on procedures.

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?**

They were advised to treat any blood spillage carefully using disposable gloves, to dispose of anything bloodstained in a plastic bag and keep away from children. This advice was given by me if I was available but as I worked part time it could be another member of staff. There was also written advice supplied by the Haemophilia Society.

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

This information would be given by a clinician. I can't recall the specific information given.

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

Parents began learning about haemophilia when their child's condition was diagnosed. Doctors, haemophilia nurses and other staff took every opportunity to teach parents about the condition when they attended the department for treatment and at clinic. Some parents were already familiar with haemophilia as family members had the condition. By the time home therapy was indicated the parents had acquired a fair amount of knowledge. I planned a home visit when the parents were competent and comfortable to start the treatment. They had already been practising under supervision in the department so were usually very competent. I also checked there was suitable storage for blood products and other equipment, eg needles and syringes, they would require. Parents were advised to be very vigilant and make sure the equipment was safely out of reach of siblings. I assured them we would be available to give advice or further help should they have any problems.

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?**

Due to the passage of time I have no recollection of this.

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 cannot recall these details with any accuracy.

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?**

As far as I recall I was never told to withhold any information from parents about these matters.

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?**

Blood samples were taken at clinic and apart from newly diagnosed children most parents were aware of the reasons for these blood tests. If it was a new test the doctors would explain to the parents what it was for and why it was being done.

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

The information as far as I can remember was given by a doctor.

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?**

I cannot recall if this was the case.

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?

Parents were informed of test results as soon as possible. This would be given at a clinic appointment if one was due or a specific appointment could be made. A consultant always gave the results. I was present at the meeting where possible to support the parents.

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?**

Advice was given to observe strict hygiene. Any blood spillages were to be dealt with swiftly and gloves to be worn. Anything bloodstained was to be disposed of safely in a plastic bag. The advice did not change over 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 am unable to recall the specifics of this with any certainty.

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.**

We had psychologists available for both parents and children but not everyone wanted this intervention.

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.**

There was a dedicated social worker within the department who was available at clinics and could be contacted by 'phone or pager. She also did home visits if required.

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?**

The HIV patients were seen regularly in the department and any concerns or difficulties would be discussed. They would have blood taken and their general health monitored. They would be seen by a doctor and any health problems could be referred to other specialists within the hospital if necessary. When any HIV symptoms became apparent they were referred to an infectious diseases consultant in Ruchill Hospital who monitored them in conjunction with the haemophilia consultant. They would attend clinics at Ruchill when they started treatment for HIV. I would liaise with the community nurses who were supervising their HIV treatment at home. At this time the social worker and I did home visits if requested.

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?**

Initially there was some nervousness with the HIV patients and gowns, masks and gloves were worn when dealing with them. This, however, soon calmed down and aprons and gloves became the normal as it had been before. I cannot remember what measures were taken re cross infection.

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

I cannot remember if this was the case.

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.

I can only speak of those affected by HIV. I was involved in their haemophilia care and also in a supportive role. I had come to know the affected families very well as they attended clinics most frequently. Some of the families had more than one child affected. 'Parents were, of course, understandably upset, angry and extremely anxious when they learned their child had been infected with HIV and they held the hospital to be in some way responsible. Some non compliance was demonstrated by missing appointments and some parents stopped prophylaxis as they didn't want their child to be exposed to more blood products than was absolutely necessary. This resolved over time and the families attended a dedicated clinic for those affected by HIV. Most families were to some extent affected by the stigma associated with the infection. The media publishing inaccurate information was very upsetting for them. Some parents confided in their family and close friends but others kept it to themselves which was very stressful. It was undoubtedly a very hard time for those affected.

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.**

I have no recollection of any research.

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?**

I cannot recall if that was the case.

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?**

I have no recollection of hearing this term.

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?

I was no longer working in the department so had no involvement with vCJD.

39. 3What 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?

See Q38.

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

See Q38.

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

See Q38.

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, HGV and vCJD infections posed to clinical staff?

My main contact was with HIV patients and the practice was to treat all patients having blood taken with the same precautions.

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?

I have no memory of reporting any concerns or complaints.

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

It was difficult to go from seeing haemophilia patients go from their lives improving with home treatment and prophylaxis and far fewer joint problems to having an infection which could kill them. Treatment of HIV was not as advanced as it is now. Dealing with the families was difficult as one could not be positive with any certainty about the patients' outcome.

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)?

I was aware of the McFarlane Trust and what they could provide for families.

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?

There was written information from the McFarlane Trust with details of how to apply for help. The department social worker was involved in helping the families with this.

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

I can remember attending conferences and meetings held by the McFarlane Trust. This helped to improve my knowledge as usually experts from other areas spoke at these events.

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

As far as I recall medical records were kept in the medical records department and brought to Outpatients for clinics, to the 'department' or the ward by the medical records staff.

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?**

I was not aware of this being the case.

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.**

I cannot recall if that happened or with whom.

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.infectedbloodinguiry.orq.uk. If you are in doubt as to whether or not to include something, do not hesitate to contact the Inquiry Team.**

There is nothing I can recall that may be relevant.

Statement of Truth

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

Signed GRO:C

Dated 20.10.20

Table of exhibits:

Date	Notes/ Description	Exhibit number