Witness Name: Dr Malcolm Liddell
Statement No.: WITN4144002
Dated: 13 January 2021

INFECTED BLOOD INQUIRY

STATEMENT OF
DR MALCOM BRANDON LIDDELL

I, Dr Malcolm Brandon Liddell, will say as follows: -

I provide this statement in response to a request for further information under Rule 9 of the Inquiry Rules 2006 dated 27 November 2020.

Section 1: Treatment of Inquiry Witness GRO-B

Please consider the attached documents:

WITN4144001: Written statement of Dr Liddell dated 25 September 2020

GRO-B

GRO-B

1. **Please recount, in as much detail as you are able to, the circumstances in which you believe you may have administered commercial factor concentrates to a patient (witness GRO-B at the Cardiff Haemophilia Centre in 1983 ("the Treatment"). Please ensure that your answer addresses the following:**

   1(a) **The date and location of the treatment;**

   1(b) **The reason(s) you believe that Witness GRO-B is the patient you treated;**

1(c) **The product you believe you administered to the patient, and the reasons for choosing that particular product, including your knowledge of the relevant policies in place at the Cardiff Haemophilia Centre;**

1(d) **What you believe to have been the consequence(s) of the treatment and how you came to know of the consequence(s);**

1(e) **An account of all contact and communications between you and Professor Bloom in connection with the treatment, in as much detail as you are able to recall.**

1(f) **Actions taken in response to the treatment by you, Professor Bloom, and any other person at or on behalf of the Cardiff Haemophilia Centre.**

1(g) **Any other information that you believe to be relevant to this incident.**

In or about autumn 1982 or early 1983, when I was a relatively inexperienced Registrar in haematology at UWCM/Cardiff Royal Infirmary working out of hours on call, I recall an occasion when I administered commercial factor concentrate to a child patient.

UWCM/Cardiff Royal Infirmary was a large hospital with c 500 – 600 beds. I was the only on call haematologist in the hospital at the time. I had recourse to my then consultant, Professor Bloom, if I needed to but as a Registrar one did not usually wish to trouble a Consultant if possible when on call.

As a Registrar in haematology at that time, my primary focus was general haematology. My role included working in the haematology laboratory, dealing with coagulation, any blood bank emergency, treatment of leukaemia and sourcing blood products for surgery. I was not fully part of the haemophilia team. I was rarely called on to administer blood products. I rarely saw child patients.

I have a memory of, early one evening, being requested to assess a boy, possibly about GRO-B years old, with Haemophilia A, with a haemarthrosis of, I recall, the elbow. I remember that his surname began with GRO-B He had been brought to the Centre by his mother. My identification of GRO-B with GRO-B may be mistaken. I can say that it is based on no more than GRO-B being about the right age and an intuition on my part.

I had not had much experience of treating haemophilia patients. This was not a usual presentation for me to deal with. I think at that time any previous administration of blood products to haemophilia patients by me or seen by me would have been to adults. As the on call haematologist, I had the keys to access the Haemophilia Centre. I would have physically gone to get a blood product from the fridge in the Centre to treat this patient. I gave commercial Factor VIII concentrate as that is what I thought at the time was the appropriate treatment as I had seen this given to other haemophilia patients. I recall this was effective in stopping the bleed.

A few days later Professor Bloom took me aside and told me that I should have contacted him before treating a child with haemophilia and that I should have used cryoprecipitate or the NHS Factor VIII concentrate rather than commercial concentrate because the risk of transmitting hepatitis was much higher with the commercial product. I recall the preferred procedure explained to me was to admit such a child to the paediatric ward where an iiv line could be set up to allow the infusion of cryoprecipitate. I think he may also at that time have drawn my attention to printed treatment guidelines which were available in the Haemophilia Centre. I believe this treatment took place before there was an awareness of the risk of HIV transmission via factor concentrates. Professor Bloom did not ask me to take any further action regarding this patient.

I do not recall whether at the time I was aware of the preferred procedure for dealing with a paediatric patient or the treatment guidelines but I believe had I been I would have followed them.

Other than from this conversation, I am not aware of any actions taken by or any further communications with Professor Bloom or any other person in response to my treatment of this patient. I cannot recall any further involvement with the treatment of this patient.

I would have made sure that in future I kept to the guidelines for the treatment of all haemophilia patients.

GRO-B

Reading the witness statement of **GRO-B** and the documents referred to me by the IBI has brought back the circumstances of my treatment of this patient to me (if this was the infant treated by me). I was not aware until then that the patient had contracted HIV as a result of being treated with commercial concentrate.

I can recall nothing else relevant to this incident.

2.

GRO-B

3. GRO-B

3(b) **Was there a policy in place at the Centre setting out guidance for the treatment of people with bleeding disorders, including the type of product and/or nature of the treatment to be administered? If so, what was the treatment policy, and what steps were taken, if any, to make staff at the Cardiff Centre aware of the policy?**

As referred to above, there were treatment guidelines available but I do not recall being aware of these when treating the child patient referred to in paragraph 1 above. I did become aware of treatment guidelines. I recall these were contained in a ring binder located in the Haemophilia Treatment Centre. New registrars were shown the location of the folder. I do not remember ever been given an introductory talk on the treatment of haemophilia. My recollection is that my knowledge of treatment with factor concentrates came from seeing more senior clinicians treat haemophilia patients. A specialist nurse in the haemophilia centre was also available to give advice.

3(c) **Did you follow this policy when treating GRO-B?**

See above.

4. **At paragraph 64 of WITN4144001, you state that at the Cardiff Centre, Professor Bloom would decide the type of treatment for each patient and that any deviations from the treatment plan had to be discussed with him and consented to by the patient/their parents. As far as you are able to recall, please explain whether such a treatment plan existed for Witness GRO-B If so, did you follow this plan and was consent sought and obtained for any deviations to the plan?**

As I recall, generally children with haemophilia were meant to be treated with DDAVP or cryoprecipitate in the first instance, although I do not remember DDAVP being used very much for treating haemophilia patients. As set out above, they were meant to be admitted to the paediatric ward for the infusion to be administered. NHS Factor VIII concentrate was to be used for more severe bleeds.

I do not recall having followed any existing treatment plan when treating GRO-B in an on-call situation. I was not aware of a treatment plan for GRO-B I am sure that had I been aware of a treatment plan for this patient I would have followed this. I maintain that at the time I was not aware of the correct treatment protocol. I acknowledge I could have contacted Professor Bloom or a more experienced clinician for advice. At the time, I believed I was managing the treatment of this patient correctly and in his best interests.

Section 2: Haemophilia Treatment Policy Guidelines for Cardiff Haemophilia Centre

Please consider the documents below and address the following questions:

HCDO0000003_008: Minutes of a Special Meeting of the UK Haemophilia Reference Centre Directors held on 13 May 1983.

WITN4029002: Haemophilia Treatment Policy Guidelines for Cardiff Haemophilia Centre, dated 18 May 1983 (the Inquiry is not currently aware of any earlier policy guidelines for Cardiff Haemophilia Centre).

PRSE0004440: Minutes from a meeting of the UKHCDO held on 17 October 1983.

5. **During your time at the Cardiff Haemophilia Centre, were you aware of the May 1983 guidelines [WITN4029002]?**

   As above. I became aware of treatment guidelines, although I cannot remember exactly the date of those guidelines.

6. **Did similar guidelines exist at the Cardiff Haemophilia Centre prior to May 1983? If so, what were they, and did the May 1983 guidelines introduce any changes to the previous guidelines? If not, on what basis were treatment decisions made prior to the introduction of these guidelines?**

   I cannot recall. I presume similar guidelines existed. I have no recollection of what they were. I do not know on what basis treatment decisions were made prior to introduction of these guidelines.

7. **During your time at the Centre, were any new policies introduced which superseded the May 1983 guidelines?**

   I am sure that new policies were subsequently introduced from time to time but I cannot now remember when or in what ways they changed.

8. **To your knowledge, what involvement did Professor Bloom have in the creation and implementation of these guidelines? In answering this question, you may find it useful to consider the enclosed minutes of a Meeting of the UK Haemophilia Reference Centre Directors [HCDO0000003_008] held several days prior to the implementation of the May 1983 guidelines.**

   I have no recollection. However, I cannot imagine that any guidelines would have been produced without Professor Bloom's close involvement.

9. **Please explain any other conversations you can recall involving Professor Bloom regarding the selection and use of blood products. If you are able to provide specific dates, please do so.**

I cannot recall any other conversations concerning the selection and use of blood products although I am sure that we must have had such discussions.

10. **Prior to the treatment described in Question 1 did Professor Bloom ever share with you any concern regarding the risk of HIV infection by blood products, commercial or otherwise? If so, please describe such communication in as much detail as you are able to recall, including the date.**

I remember that the potential for transmission of AIDS (as it was known then) by blood products began to be talked about in the haematology departmental seminars from late in 1982. I cannot remember any specific communications solely between me and Professor Bloom.

11. **At page 10 of the enclosed meeting minutes dated 17 October 1983 [PRSE0004440], Professor Bloom stated 'there was no need for patients to stop using the commercial concentrates because at present there was no proof that the commercial concentrates were the cause of AIDS', and later the minutes record that it was agreed by the Directors that, "patients should not be encouraged to go over to cryoprecipitate for home therapy but should continue to receive the NHS or commercial concentrates in their usual way."**

11(a) **Do these statements reflect what you knew, or believed to be, the recommended method of treatment for people with haemophilia at the time of the treatment referred to in question 1?**

My recollection is that at the time these guidelines were formulated in the autumn of 1983, opinion had definitely moved away from the recommending the use of commercial Factor VIII concentrate. However, I do not think that there was enough NHS concentrate available to treat every haemophilia patient and, moreover, I think that

its potency was considerably less than that found in the commercial concentrate. So, it was a necessary, less than ideal, compromise to go on treating previously exposed individuals with the commercial concentrate: the risk of serious bleeding episodes being of more immediate concern than that of the potential of developing AIDS at some point in the future.

11(b) **Were you aware at the time that in late 1983, Professor Bloom supported the continued use of commercial concentrates to treat haemophilia patients?**

My recollection is that in late in 1983 there was no realistic option of not continuing the use of commercial factor VIII concentrate in those patients who had already been exposed to them. I cannot now recall if I was aware in late 1983 whether Professor Bloom supported the use of commercial concentrates to treat haemophilia patients.

Section 4: Other issues

12. **Please explain, in as much detail as you are able to, any other issues that you believe may be of relevance to the Infected Blood Inquiry.**

My personal experience was Professor Bloom was probably the wisest and kindest clinician I ever had the privilege of working for. It is all too easy to scapegoat individuals with the knowledge of hindsight. The definition of accepted practice and the correct procedure for obtaining consent for treatment has changed considerably in the 35 or more years since the events that the IBI are concerned with took place. Bear in mind also that at the time the amount of plasma collected by the Blood Transfusion Service (BTS) in England and Wales was insufficient to allow the production of sufficient NHS Factor VIII concentrate and, even it were sufficient, the infrastructure was not yet present to process such plasma. The failure of the system to respond more swiftly to the infected blood crisis was, in my opinion, as much due to failings in funding and political will as due to clinicians failure to realise in time the gravity of the looming AIDS epidemic in haemophilia patients.

Statement of Truth

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

Signed GRO-C

Dated: 13 January 2021