Witness Name: Dr Paul Winwood
Statement No.: WITN4573001
Exhibits: WITN4573002 to WITN4573012
Dated: 24 August 2020

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PAUL JOHN WINWOOD

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 8 October 2019.

I, Paul John Winwood, will say as follows: -

Section 1: Introduction

1. My name, date of birth and professional qualifications are as follows:

   Paul John Winwood, GRO-C 1961, University Hospital of Northern BC, Edmonton Street, Prince George, BC, V2M 1S2, Canada. MB BS, DM, FRCP, FRCP Edin, FRCPC.

2. Positions held as Consultant Gastroenterologist:
   April 1996 to July 2008: Royal Bournemouth and Christchurch Hospitals NHS Trust.
   August 2008 to the present time: University Hospital of Northern BC, British Columbia, Canada.
   In both positions, I have been responsible for the provision of specialist secondary care to patients with gastrointestinal and liver disorders, including hepatitis C, in outpatient and inpatient settings alongside other Consultant Gastroenterologists working at those hospitals.

3. I have not been a member of any committees or groups relevant to the inquiry's terms of reference.

Background

4. Thank you for asking me to participate in this inquiry and for the opportunity to respond to the statement of witness W2819. Blood borne transmission of Hepatitis C has led to serious physical, mental health and social issues for many patients and I am pleased that this inquiry is being undertaken. I have carefully read the witness statement of witness W2819 regarding his late wife's care. I understand and am sympathetic to the distress and trauma that witness W2819 and his late wife suffered and would like to address the concerns raised about the care that I provided in his witness statement. I will start by providing a record of my care of the late wife of witness W2819 based on a review of the medical records at the Royal Bournemouth and Christchurch Hospitals NHS Trust which I undertook with permission and support from their Health Records Manager, during a recent visit to the UK (I now live in Canada), my recall of events and the contemporaneous correspondence.

5. I first became involved in the care of the late wife of witness W2819 in October 2004 when I was asked to see her to investigate the symptom of dysphagia (difficulty swallowing). As part of my assessment, I noted that the late wife of witness W2819 had evidence of chronic liver disease on physical examination and arranged for her to have some blood tests to evaluate her liver. These demonstrated elevated liver enzymes and subsequent tests confirmed that the late wife of witness W2819 had hepatitis C. Dr Nigel Cowley, GP for the late wife of witness W2819, wrote to her on 02 November 2004 to inform her that the tests had confirmed a diagnosis of hepatitis C **(exhibit WITN2819003)**. I understand that late wife of witness W2819 was initially seen at Poole Hospital and I then saw her on November 22, 2004 at the Royal Bournemouth Hospital. I explained to her that the tests indicated that she had antibodies to hepatitis C.

6. Witness W2819 states at paragraph 18 in his statement that no medical professional advised them that the HCV infection was likely caused by a previous blood transfusion in 1978. This does not tally with the medical records. Based on my review of the written medical records, I discussed the possible risk factors with the late wife of witness W2819 at the appointment on 22 November 2004, when attempting to identify how she could have acquired the infection. During this discussion, the only risk factor I could

identify was a blood transfusion that she had received in 1978. Following that consultation, I wrote to her GP, Dr Cowley **(exhibit WTN2819005)** and set out in that letter that the blood transfusion in 1978 was the only likely risk factor, we had identified at the appointment.

7. At this appointment, I also explained that she needed further investigations to evaluate her hepatitis C status including a blood test for hepatitis C RNA (PCR) to confirm active infection, an ultrasound of her liver and a liver biopsy if the PCR was positive. The late wife of witness W2819 was very distressed by this news during her appointment, something to which I also alluded to in my letter to Dr Cowley **(exhibit WTN2819005)**.

8. The late wife of witness W2819 was next seen by Ms Hazel Allen, Hepatitis Nurse Specialist, at the Royal Bournemouth Hospital on 17 December 2004. During this visit the late wife of witness W2819 was informed that the hepatitis PCR was positive and that the next steps would include an ultrasound of her liver, an ultrasound guided liver biopsy and further blood tests. The blood tests were to determine the genotype of the hepatitis C virus that late wife of witness W2819 was infected with, which would impact the type and likely effectiveness of treatment. Ms Hazel Allen also provided information on the risks of transmission, prognosis and treatment. Ms Hazel Allen noted that late wife of witness W2819 was anxious about the liver biopsy and may need sedation or possibly a general anesthetic in order to have the procedure **(exhibit WITN4573002).**

9. Ms Hazel Allen also helped coordinate and complete an application from the late wife of witness W2819 to the Skipton fund **(exhibit WITN4573003)**, signed by her on January 11, 2005, for an *ex gratia* payment on the basis of transmission of hepatitis C from a blood transfusion in 1978. In order for an application to be made to the Skipton Fund, it was necessary to provide evidence that the applicant had been infected as a result of blood transfusion received.

10. I saw the late wife of witness W2819 for a follow up consultation on 28 February 2005. I informed her that she was infected with a genotype 1 hepatitis C virus and that, in order to determine the need for treatment, the next step would be to have a liver biopsy. At that time, liver biopsy was the only established method for determining the severity of inflammation and liver fibrosis due to hepatitis C and was used to determine the need for treatment. I also discussed the treatment options and their success rate which all included weekly subcutaneous injections of pegylated interferon alpha. During this visit, the late wife of witness W2819 told me that she was terrified of needles and did

not think she could tolerate either a liver biopsy or weekly subcutaneous injections for therapy. Although I can no longer clearly recall the details of each consultation, according to my letter, the late wife of witness W2819 asked about the possibility of doing a liver biopsy under general anaesthetic and I offered to explore whether this was possible **(exhibit WITN4573004)**. Then, as now, liver biopsies were routinely performed using local anesthetic without sedation. I asked one of my colleagues, Dr Simon Jones, Consultant Radiologist, if he would be willing to do a liver biopsy and he agreed to arrange it **(exhibit WITN4573005)**. My written notes state that the late wife of witness W2819 would be followed up by Ms Hazel Allen in the hepatitis clinic.

11. During the same consultation on 28 February 2005, the late wife of witness W2819 asked whether serological markers for liver fibrosis, which she had read about, could be measured in her blood. Again, although I can no longer clearly recall the details of each consultation, according to my letter **(exhibit WITN4573004)** I explained that, at that time, we did not know how accurate they were. Nonetheless, I did tell the late wife of witness 2819 that I could arrange for her to have serum levels of procollagen-3 N-terminal peptide (P3NP) and hyaluronic acid measured, 2 markers of liver fibrosis which were being researched at that time, as these were available at the Royal Bournemouth Hospital and may have provided some helpful information. There is no record in the written notes or my letter of any discussion about the use and availability of fibroscan but it is possible that we discussed it. At that time, fibroscan technology was not available for routine clinical use in Bournemouth or any surrounding hospitals that I was aware of. It was still being evaluated in research studies for its accuracy in assessing the severity liver fibrosis.

12. From the medical records, I can see that the late wife of witness W2819 did not attend the Royal Bournemouth Hospital between 28 February 2005 and 7 June 2007. This gap in her care was brought to my attention by a letter from Mr Tobias Ellwood MP dated 4 June 2006 **(exhibit WITN4573006)**. The matter was investigated locally, which found that the gap was likely because the liver biopsy had not been done which, in turn, had not triggered a follow up appointment. Mr Ellwood was notified of these findings in a letter dated 13 July 2006 **(exhibit WTN2819004)** in which I also described funding difficulties. I informed Mr Ellwood that I would make arrangements for the late wife of witness W2819 to have further investigation in the near future. This was to be a liver biopsy under general anaesthetic with follow up in clinic. I also sent a letter to the late wife of witness W2819 dated 14 July 2006 in which I apologized for the lack of

follow up **(exhibit WITN4573007)** and explained that she should receive an appointment for a liver biopsy within 2 months and a follow up appointment in 3 months.

13. According to the medical records, the late wife of witness W2819 did not attend for a liver biopsy under general anaesthetic. She was next offered a follow up appointment with me on 20 November 2006 which she did not attend either. As per my usual practice, following the late wife of witness W2819's second non-attendance I wrote to Dr Cowley, her GP, discharging her from my care because I did not feel able to monitor her but, offered that, if there had been some misunderstanding, I would arrange to see her **(exhibit WITN4573008).**

14. The late wife of witness W2819 was next seen at the Royal Bournemouth Hospital by Hazel Allen, Hepatitis Nurse Specialist, on 7 June 2007. In Hazel Allen's letter to Dr Cowley she acknowledged that we had lost contact with the late wife of witness W2819 and suggested that it may have been because of confusion about her address **(exhibit WITN4573009).** During this visit, the late wife of witness W2819 was offered antiviral treatment without the need for a liver biopsy, but she declined it because she did not want to have weekly injections because of her needle phobia and concerns about side effects. During this visit, we were made aware for the first time by the late wife of witness W2819 that she had travelled to France in 2005 to have a fibroscan which may have shown some liver fibrosis. In response to a request for a follow up fibroscan, Ms Hazel Allen offered to explore getting one done in London as we did not have a fibroscan technology available in Bournemouth. She arranged blood tests and follow up to be in 1 year.

15. In May 2008, we received a copy of a referral to Frenchay Hospital from the late wife of witness W2819's GP, Dr Cowley, for a second opinion regarding her hepatitis C. Correspondence was received from Dr Prezmioslo at Frenchay Hospital following clinic visits in June and July 2008 **(exhibit WITN4573010).** The advantages of a liver biopsy over a fibroscan were discussed and a fibroscan and ELF test were arranged, which, it was noted, were not the gold standard. In a letter dated 5 September 2008 **(exhibit WITN4573011)**, a recommendation for antiviral treatment was made, which, at that time, would still have included weekly injections with pegylated interferon and regular blood tests. Witness 2819's late wife was referred back to Bournemouth to myself and the hepatitis nurses for this. I had left Bournemouth for a new position in Canada at the end of July 2008 so did not receive this but normal practice would have been for the hepatitis nurses to arrange an appointment and continue care with another

specialist at the hospital. There is no record of the late wife of witness W2819 being seen in the liver clinic at Bournemouth after 2007.

16. During the whole timeframe that I provided care for the late wife of witness W2819, patients seen in secondary care at the Royal Bournemouth and Christchurch Hospitals NHS Trust were assessed for eligibility for antiviral treatment based primarily on presence of liver fibrosis, assessed using histopathological scoring of a liver biopsy, if they met all other criteria. There was considerable research being undertaken on non-invasive markers of liver fibrosis at the time, including the use of the fibroscan and serological (blood) markers, but these were not validated or in routine use and not available to specialists in Bournemouth until after 2008. All antiviral treatments available at that time included pegylated interferon alpha which is administered by weekly injection. The need for a liver biopsy and injection-based therapy was a considerable impediment to the care of the late wife of witness W2819 who had a serious phobia of needles as described in the witness statement.

Section 2: Responses to criticism of witness W2819

17. At paragraph 9 of the witness statement, the Witness claims that I: "*advised them to use condoms during sex with their spouse, despite the fact that transmission of HCV through sexual intercourse is very rare*." There is a record in the hospital notes of the risk of transmission being discussed at an appointment with Ms Hazel Allen, Hepatitis Nurse Specialist, on 17 December 2004. This is referenced in her letter dated 29 December 2004 **(exhibit WITN4573002),** but there is no comment about the use of condoms. I agree that the risk of sexual transmission is very low and my usual practice (and that of Ms Hazel Allan) at that time (and now) is to advise that, for partners of individuals with hepatitis C infection who are in a long-term monogamous relationship, it is not necessary to use a Condom. Given that this occurred more than 15 years ago, I cannot recall the specific details of the conversation now, but, as it does not concord with my usual practice, I cannot see any reason why or how I would have given different advice to my normal advice.

18. Further, whilst I do not know if the late wife of witness W2819 received it, I can confirm that at the time of these events our clinic used an information leaflet prepared by Ms Hazel Allen in 2002 **(exhibit WITN4573012),** which states that "the risk of contracting hepatitis C from a sexual partner is considered low" and advises patients only to

"consider barrier methods of contraception, especially when in a new relationship with a partner."

19. The witness alleges that I: "*indicated that when their spouse died, their body would need to be placed in a hermetically sealed coffin so that the ground wouldn't be infectious around them.*" I agree that a comment such as this would be inappropriate and am sad and shocked that witness W2819 believes that I said this. However, I do not believe I did so. Firstly, my patients' wellbeing was always my foremost priority, and I cannot ever imagine me making a comment as insensitive, as has been described. Secondly, there is no infection risk from the dead body of an individual with hepatitis C in a coffin, so there would be no reason for me to have said that. There is no reference to this in the medical records and I do not recall this conversation or ever discussing burial arrangements with any patient that I have provided care for.

20. I can understand and empathize with the distress that the witness and his wife no doubt felt following her diagnosis. I would like to apologize if anything I did say, or the way in which I said it caused distress, or if I did not communicate effectively with them. There is evidence that the late wife of witness W2819 was very upset by the news of the diagnosis on more than one occasion and I now wonder, having read witness W2819's statement, whether there was some misunderstanding or miscommunication. Ideally, I would have recognized and taken account of this in my communications with witness W2819's late wife. These misunderstandings may have been amplified by the suffering endured during the illness of the late wife of witness W2819 and the inevitable grief that witness W2819 has experienced since her death.

21. The witness claims: *"that their spouse tried to obtain an appointment with me for 16 months after scarring of the liver was confirmed. They eventually obtained help from me after seeking help from their local MP.*" Having reviewed the medical records and as documented above, it is true that the late wife of witness W2819 was not seen after 28 February 2005 until after her MP wrote to me on 4 July 2006.

22. I believe that the circumstances around the gap relate to the fact that the late wife of witness W2819 had a severe needle phobia and wanted to have a liver biopsy under general anaesthetic. This did not take place as planned and it seems that a follow up clinic appointment, which would have been prompted following the biopsy, did not happen either. The reasons for this are not clear from a review of the medical records.

23. As documented in my letter to the MP, Mr Tobias, on 13 July 2006 **(exhibit WTN2819004)** and in a letter to the late wife of witness W2819 on 14 July 2006, I did acknowledge the lack of follow up and apologized for it.

24. I can find no record that I was made aware of a diagnosis of *liver scarring* at that time (2005-2006). I assume that this statement is based on the result of a Fibroscan performed in Paris sometime after February 2005. The first time the Bournemouth team came to know of the late wife of witness W2819's privately obtained fibroscan was during the clinic visit with Ms Hazel Allen on 7 June 2007. If my office or the hepatitis nurse specialist (Ms Allen) had been contacted with this information or with a request for follow up for hepatitis C, it would have been our normal practice to arrange a clinic appointment in a reasonable time frame and certainly less than 16 months.

25. It is unfortunate and, to be greatly regretted, that follow up for the late wife of witness W2819 did not happen in a timely manner. However, it is unlikely that follow up during this time would have changed the outcome of her hepatitis C infection because all effective treatment at that time was interferon based, requiring weekly injections and regular blood tests which the late wife of witness W2819 did not feel that she could tolerate (**exhibit WITN4573004**). The late wife of witness W2819 also later declined treatment because of her needle phobia and concerns about side effects when it was offered on 7 June 2007 **(exhibit WITN4573009)** and did not follow through with a recommendation to have interferon based antiviral treatment made by Dr Prezmioslo at Frenchay hospital on 31 July 2008 **(exhibit WITN4573011)**. I also note that the late wife of witness W2819 was "not keen to jump into treatment" when seen in Southampton on 15 June 2009 **(exhibit WITN2819006)**. Witness W2819 acknowledges this in paragraph 31 of his statement. Successful treatment with regimens using only oral antiretroviral drugs became available several years later and I note that the late wife of witness W2819 was treated with a combination therapy (ribavirin, sofosbuvir and ledipasvir) via an early access programme in 2014 which was not licensed at that time **(Exhibit WITN2819008)**. To the best of my knowledge, anti-retroviral drug therapies using only oral medication for chronic hepatitis C genotype 1 were recommended for the first time in the UK in draft guidance by NICE in March 2015; NHS bodies were left to make decisions locally on the funding and availability of treatments.

26. The witness asserts that I *told them that fibroscan technology was not yet available in the UK. However, they later discovered that it was available in Bristol at Frenchay*

hospital in Bristol. When the late wife of witness W2819 was first seen in 2004, fibroscan was an emerging technology and was not readily available in the UK. Most of the world literature which has validated the technique has been published since 2005. It was not accepted in national guidelines at that time as being of sufficient reliability to make a diagnosis of liver fibrosis on which to base treatment for hepatitis C and so was not standard practice and not available to patients in Bournemouth. I do not know when Frenchay hospital acquired fibroscan technology and would not have known if they had it in 2005 but, even in 2008, as Dr Przemioslo states in his letter dated 2 July 2008 **(exhibit WITN4573010)**, non-invasive tests, such as the fibroscan and ELF (enhanced liver fibrosis) test were not the gold standard and he advised a liver biopsy. In the letter dated 5 September 2008 **(exhibit WITN4573011)**, from Dr Przemioslo's clinic it also states that the fibroscan score for the late wife of witness W2819 "could" be in keeping with cirrhosis and that "there are so many reasons for her stiffness score to be high". Much of the research on fibroscans was being done in Paris at that time which is probably why the late wife of witness W2819 heard that it could be done there. By 2007, I was aware of hospitals in London that had access to fibroscan technology, primarily as a research tool, as indicated in Hazel Allen's letter dated 7 June 2007 **(exhibit WITN4573009)**. By that time, the evidence for supporting its use in the assessment of hepatitis C was growing and we were hoping to be able to acquire the equipment ourselves in Bournemouth.

Section 3: Other Issues and Summary

27. It is very clear from the witness statement that the illness of the late wife of witness W2819 with hepatitis C was a source of great distress and suffering not only for her but also for her family. If she presented now, she would have been investigated with tissue elastography (e.g. Fibroscan) and other non-invasive markers of liver fibrosis and would have been treated early with highly effective oral treatments for hepatitis C. Unfortunately, these technologies were in their infancy, and were not established as being reliable for the assessment of liver fibrosis at the time when I was involved in the care of the late wife of witness W2819. Also, the only effective therapies available required injections with interferon and regular blood monitoring which the late wife of witness W2819 declined because of a severe needle phobia. Taking this into consideration, the course of her illness would not have been changed even if there had been no gap in her follow up and we had access to fibroscan technology. Nonetheless, I accept that the unexplained gap in care of the late wife of witness W2819 fell short of my usual standard of care.

28. I am deeply saddened to now learn that there were some major and inexplicable misunderstandings about the information I provided. I can only surmise that perhaps, as the late wife of witness W2819 and the witness were receiving information at a time when both were likely feeling overwhelmed, distressed and anxious, this may have led to the difficulties described and experienced. It goes without saying that this was not at all what I would have intended. I can understand that this would have added to the distress caused by the illness of the late wife of witness W2819 and am sorry for this. I would like to express my heartfelt sympathy and condolences for the late wife of witness W2819 and her bereaved family and apologize if my actions and those of my team added to their distress.

Statement of Truth

To the best of my belief, the facts stated in this witness statement are true.

Signed GRO-C

Dated 24 August 2020

Table of exhibits:

Date	Notes/ Description	Exhibit number
2 Nov 2004	Letter from GP, Dr Cowley to wife of witness 2819	**exhibit WITN2819003**
25 Nov 2005	Letter from Dr Winwod to Dr Cowley, GP	**exhibit WTN2819005**
29 Dec 2004	Letter from Ms. Hazel Allen to GP Dr Cowley	**exhibit WITN4573002**
1 Jan 2005	Application to Skipton Fund	**exhibit WITN4573003**
8 March 2005	Letter from Dr Winwood to GP Dr Cowley	**exhibit WITN4573004**
15 March 2015	Letter from Consultant Radiologist to Dr Winwood re carrying out a liver biopsy under	**exhibit WITN4573005**

	general anaesthetic	
4 July 2006	Letter from Tobias Ellwood MP, to Dr Winwood	**exhibit WITN4573006**
14 July 2006	Letter from Dr Winwood to wife of witness W2819, following receipt of Mr Ellwood's letter	**exhibit WITN4573007**
23 Nov 2006	Letter from Dr Winwood to Dr Cowley GP, re non-attendance at clinic	**exhibit WITN4573008**
29 June 2007	Letter from Ms. Hazel Allen, Clinical Nurse Specialist, to Dr Cowley GP	**exhibit WITN4573009**
17 June 2009	Letter to Dr Cowley GP	**exhibit WITN2819006**
31 July 2014	Letter to Dr Cowley, GP from Nurse Specialist	**exhibit WITN2819008**
2 July 2008	Letter from Dr Przemioslo, Consultant Gastroenterologist and Hepatologist to Dr Cowley, GP	**exhibit WITN4573010**
Dated typed: 5 Sept 2008	Letter from Dr Przemioslo, Consultant Gastroenterologist and Hepatologist to Dr Cowley, GP	**exhibit WITN4573011**
January 2002	Patient Information Leaflet- Hepatitis C	**exhibit WITN4573012**