Witness Name: Dame Deirdre Hine
Statement No.: WITN5713001
Exhibits: None
Dated: 23 February 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DAME DEIRDRE HINE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20 December 2022.

I, Dame Deirdre Hine, will say as follows: -

Section 1: Introduction

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

1.1 My name is Deirdre Joan Hine. My address is GRO-C Cardiff, GRO-C My date of birth is GRO-C 1937. My professional qualifications are MB BCh FFCM FRCP.

2. Please set out your employment history including the various roles and responsibilities that you have held throughout your career in medicine and government, as well as the dates.

2.1 My employment history is set out below:

- Junior Doctor Cardiff Royal Infirmary 1961-1962

- Clinical Medical Officer Glamorgan County Council 1962-1974

- Specialist in Community Medicine, South Glamorgan Health Authority 1974-1984

- Principal Medical Officer/Deputy Chief Medical Officer, Welsh Office 1984-1988

- Director, Welsh Breast Cancer Screening Service 1988-1990

- Chief Medical Officer, Wales 1990-1997

2.2 In addition to the above, I was a senior lecturer in the University College of Medicine from 1988 to 1990.

3. Please provide details of any business or private interests you have or have had which are relevant to the Inquiry's Terms of Reference.

3.1 None.

4. Please set out your membership, past or present, of any committees, associations, parties, societies or groups relevant to the Inquiry's Terms of Reference, including the dates of your membership and the nature of your involvement.

4.1 Post-retirement I was a member of various groups and societies including:

- Member, Audit Commission 1998-2001

- Chair, No Smoking Day

- Vice-President, Marie Curie

- Chair, SCOPME Review Dept of Heath 1997-1998
- Chair, Commission for Health Improvement 2000-2004
- Member, House of Lords Appointment Commission 2000-2005
- President, the Royal Society of Medicine 2000-2002
- President, BMA 2005-2006
- Chair, Bupa Foundation 2004-2011
- Non-Executive Director, Dwr Cymru Welsh Water 2001-2010
- Chair, Public Inquiry into C.diff outbreak NI 2008-2010
- Chair, Review of UK Government Response to H1N1 Flu Pandemic 2009-2010
- President of the Royal Medical Benevolent Fund 2008-2017. President, Age Cymru 2011-2014. Chair Cardiff and Vale Dementia Taskforce 2014-2017

5. Please confirm whether you have provided evidence or have been involved in any other inquiries, investigations, criminal or civil litigation in relation to the 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. Please provide details of your involvement if so.

5.1 I provided evidence in writing and in person to the Phillips Inquiry into BSE/CJD.

Section 2: The role of the CMO and the Welsh Office's structure, role and relationships with others

6. The Inquiry understands that in 1984 you were Principal Medical Officer at the Welsh Office, Deputy Chief Medical Officer ("DCMO") from 1985 to 1988 and held the post of Chief Medical Officer ("CMO") from 1990 to 1997. Please explain the position of the CMO within the Welsh Office, the administrative structures that were in place to (i) support the CMO for Wales, and (ii) administer health policy more generally, and the position of the medical division within the Welsh Office.

6.1 The CMO was the head of the Health Professionals Group reporting to the Permanent Secretary through the Deputy Secretary. The group under the CMO comprised 2 Deputy CMOs, a variable number of 6/7 Medical Officers, the Chief Dental, Pharmaceutical, Scientific and Environmental Health Officers supported by secretarial staff. The HPG worked in conjunction with the Director of the NHS and the Chief Nursing Officer and other Divisions in both advising Ministers and developing health policy.

7. Please explain the role and responsibilities of the CMO for Wales. Please comment, in particular, on the following areas:

a) The extent to which the CMO was responsible for informing ministers about risks to public health.

b) The extent to which the CMO was responsible for shaping policy and informing ministers of policy options.

c) The extent to which the CMO was responsible for issuing guidance, advice or instruction to clinicians.

d) The extent to which the CMO was responsible for issuing guidance or advice or information to patients or the public

7.1 The CMO working with other senior level officials was responsible for informing ministers of risks to public health usually as a result of information gained from the Department of Health or other Government Departments. Similarly the CMO contributed to the shaping of policy options and where

required the issuing of advice, guidance and instructions to clinicians, patients and the public.

8. Please describe in broad terms your interactions with ministers within the Welsh Office. How would the CMO raise issues of concern? Were there regular meetings with ministers?

8.1 The CMO could raise matters of concern with ministers where necessary but there were no regular meetings.

9. Please describe in broad terms your relationship with, and the extent to which you interacted with, the CMOs in England, Scotland and Northern Ireland.

9.1 The relationship with the other UK CMOs depended to some extent on personalities but during my time as CMO I had close and cooperative relations with all the successive CMOs of England, Scotland and Northern Ireland with regular meetings of the 4 CMOs.

10. Please explain in broad terms how information and issues were brought to your attention as CMO. In particular, please explain:

a) **What criteria determined whether a matter was of sufficient importance to be brought to your attention?**
b) **How effective the process was, in your experience, in ensuring that you were suitably informed of the key issues relevant to your post during the period of your tenure as CMO for Wales?**

10.1 There were no set criteria.

10.2 It is impossible to tell, many years on, how effective the process was in identifying what the key issues for the CMO were to consider.

11. To what extent did any of the following matters come to your attention during your time in office:

a) **The risks of serious viruses being transmitted by blood and blood products.**
b) **The introduction of screening of blood donations for HCV.**
c) **The circumstances in which people receiving NHS treatment in Wales were infected with HIV/HCV/HBV.**
d) **Whether or not compensation or some form of financial support should be provided to those infected with HIV/HCV/HBV from blood or blood products.**
e) **Whether there should be an inquiry into the circumstances in which people receiving NHS treatment in Wales were infected with HIV/HCV/HBV.**

11.1 In my role as DCMO from 1984-88, I was responsible for amongst other things maternal and child health, care of the elderly, mental health and some oversight of acute hospital services but not blood or blood products, or haemophilia. This was the responsibility of others (see paragraph 40 below). Although, the above matters did come to my attention at a meeting of senior medical officers in November 1984 (see question 25 below) at which risks of infection were discussed. However I had no further involvement in any of these matters during the rest of my tenure as DCMO and have no recollection of any of them surfacing during my time as CMO.

11.2 In respect of questions 11(d) and (e), both matters were raised during my time as CMO but both were determined by UK wide decisions in which I played no substantive part.

12. If such matters did not come to your attention, should they have done?

12.1 I believe this is impossible to answer after such a long time.

13. Please identify by name other senior colleagues involved (during the times you worked at the Welsh Office) in decisions about blood and blood products,

the assessment of the risks of infection arising from blood and blood products, and the response to such risks.

13.1 Professor Gareth Crompton, Dr AM George, Dr D Ferguson Lewis, Dr John Pritchard, Dr Stephen Palmer PHLS, Dr A Napier WBTS, Professor A Bloom and Professor A Jacobs.

14. Please describe, in broad terms, the relationship between the Welsh Office and the Department of Health (Westminster) in respect of health policy in Wales during your time in office, with particular reference to policy related to blood, blood products, haemophilia and other bleeding disorders, HIV/AIDS and hepatitis. How did the division of responsibilities between the Welsh Office and the Department of Health work (in theory and in practice)?

14.1 The Department of Health was recognised as the senior health arm of the Civil Service during my time as CMO with particular reference to the matters concerning the Inquiry. In both theory and practice this worked well since the English Department had a much higher staff ratio to individual health problems. Occasionally, as evidenced in the BSE Inquiry Welsh Office staff disagreed with the views of English colleagues and made this clear; however it was acknowledged that the English Department would generally set policy affecting the rest of the UK.

15. How much oversight, if any, did the Department of Health (Westminster) retain over health policy decisions made in respect of Wales? Please provide any relevant examples.

15.1 The Department of Health retained oversight in a very general way but rarely intervened in policy decisions in Wales (the BSE example being a notable exception).

16. To what extent did the Welsh Office attempt to align its policies and activities with those of the Department on such matters and on health policy more generally?

16.1 As already stated, the greater number of staff of the English Department meant that they had more time and ability to pursue such matters so that in the majority of cases the Welsh Office aligned its policy with that of the Department of Health.

17. In your experience, how did the Welsh Office and Department of Health communicate and share information, and was this communication effective? How were you informed of important developments in health policy (and in particular policies relating to blood and blood products) that were taking place in Whitehall?

17.1 Communication and sharing of information were generally good. I am not aware of any deficiencies in communication on policies relating to blood or blood products.

18. Please describe the working relationship, if any, between the Welsh Office and the Cardiff Haemophilia Centre. In particular please describe the following:

a) The lines of communication between the Welsh Office and the Cardiff Haemophilia Centre.

b) The frequency and regularity of interactions between the Welsh Office and Cardiff Haemophilia Centre.

c) Any areas of overlapping responsibility and how these were navigated.

18.1 I am unable to answer these questions as I cannot recall the necessary information. I do though add that as CMO and certainly in my role as DCMO, I would not necessarily have been aware of these matters.

19. The Inquiry understands that Professor Bloom was Professor at the Department of Haematology at the Welsh National School of Medicine and Director of the Cardiff Haemophilia Centre during your time as CMO. Please describe the professional relationship between Professor Bloom and you, and between Professor Bloom and the Welsh Office more generally.

19.1 I do not recall any communication or meeting with Professor Bloom during my time as CMO. I can recall meetings with Professor Alan Jacobs who I assume was Professor Bloom's successor, but these were not about blood or blood products.

20. Did Dr Bloom have a specific advisory role in respect of blood product and treatment of haemophiliacs, and if so, please describe the nature of that role. Did Dr Bloom ever represent the Welsh Office in meetings, and if so, in what capacity?

20.1 As above.

21. Please describe the working relationship, if any, between the Welsh Office and the Blood Transfusion Service in Wales.

21.1 For most of my time as CMO, the Welsh Blood Transfusion Service was run by the Welsh Health Common Services Authority (WHCSA) and prior to that, by the South Glamorgan Health Authority.

22. Please describe the working relationship between the Welsh Office and the Cardiff Regional Transfusion Centre. In particular please describe the following:

a) The lines of communication between the Welsh Office and the Cardiff RTC.

b) The frequency and regularity of interactions between the Welsh Office and Cardiff RTC.

c) Any areas of overlapping responsibility and how these were navigated

22.1 See answer to question 19 regarding the Cardiff Haemophilia Centre.

Section 3: Knowledge and Response to Infected Blood Risks

23. Please describe when and how you first became aware of HIV/AIDS, and when you first became aware of a possible link between AIDS and blood and blood products.

23.1 I first became aware of this at the meeting on 19 November 1984.

24. How did the spread of AIDS in general, and the link between AIDS and blood and blood products in particular, affect your professional role at the Welsh Office?

24.1 Since this was not my area of responsibility it did not affect my professional role as DCMO.

25. On 19 November 1984 you took part in a meeting of the Welsh Office on the issue of AIDS. Please consider the minutes of the meeting [HSSG0010054_008]. In a briefing note dated 19 November 1984, Mr A.S. Dredge summarised the views reached in the meeting [HSSG0010054_005]. It may also assist to read the newspaper article referred to in the meeting, regarding the death of a haemophiliac patient in Newcastle Upon Tyne from AIDS which Mr Dredge noted "led to speculation in the press that the source of the infection was a blood transfusion" [HSSG0010054_006].

a) **To the best of your recollection, what involvement had you had in matters relating to AIDS and blood and blood products at this time?**

25.1 None at all. I was merely present at the meeting of senior medical officers.

26. The briefing note states:

- **"There are at present a very few haemophiliac patients in South Wales, but it is likely that some may have received treatment with Factor 8 which might have been contaminated. The number at risk is estimated in single figures"**
- **"The risk to other types of patient from the use of whole blood is negligible: there is no evidence that any patient has contracted the disease in the United Kingdom from this source."**
- **There is little that the Department can do which will immediately affect**

the present situation."

a) **What sources of information were relied on to make an assessment of the level of risk at that time?**
b) **Why did the meeting come to the conclusion that the numbers of those at risk of infection was in single figures? Was this view challenged? What was your view at the time?**
c) **Why did the meeting come to the view that the risk of infection through whole-blood transfusion was "negligible"? Was that view challenged? What was your view at the time?**
d) **Why did those present conclude that there was little that the Welsh Office could do immediately to affect the present situation? Did those at the meeting consider that steps could be taken by other departments – for example the Department of Health – to affect the situation? If so, what were those steps, and what efforts were made to seek to persuade others that they should be taken?**

26.1 I cannot now recall the discussion and am therefore not able to answer the above questions or provide any information that would be helpful to the Inquiry.

27. In respect of "the second donor" discussed in the meeting, whose blood appeared to have contaminated 200 batches of Factor VIII including one batch used in Wales:

a) **Were you involved in decisions made on whether and how to inform the recipients of the batch used in Wales of the risk they had been exposed to?**
b) **Please provide any evidence that you can of what those decisions were, and how and why they were taken.**

27.1 As above. I cannot now recall the discussion and am therefore not able to answer the above questions or provide any information that would be helpful to the Inquiry.

28. The minutes indicate that there was a discussion of the policy of clinicians reporting suspected AIDS cases to you and to the CDSC, and the tracing of such cases, but that the "mechanism devised had however not worked well in respect of the last South Glamorgan case". Do you know why the meeting reached that view? Please explain, insofar as you are now able to do so, what happened in this case.

28.1 I note that the minutes refer to clinicians reporting to Dr Crompton and the CDSC, not me. I do not recall the discussion of the South Glamorgan case.

29. Please describe what steps were taken to make the reporting system more robust following the meeting. It may assist to consider [HSSG0010056_009], a letter from Professor Crompton to all Consultant NHS staff in Wales dated 23 November 1984 regarding the surveillance of AIDS.

a) **Please explain who had overall responsibility in Wales at this time to trace blood donors who might carry AIDS and prevent potentially contaminated donations being added to batches of blood products.**
b) **Please explain how (i) you, and (ii) the Welsh Office more generally, interacted with the CDSC, the NBTS and other relevant bodies on this matter at this point in time.**

29.1 As above. My role as DCMO at this point time would not have involved any interaction with either CDSC and NBTS and as a result, I am unable to comment on their interaction with the Welsh Office.

30. The minutes indicate that the use of leaflets in blood donor sessions was thought insufficient to ensure donations were safe and it was agreed "the matter of a more detailed questionnaire could usefully be pursued". Please describe what steps were taken after the meeting to strengthen the screening procedures in order to minimise the risk identified.

a) **How much autonomy did the Welsh Office and the regional transfusion centre have to develop their own leaflet and/or process for questioning donors? What agreement or consultation would have been necessary**

with the DHSS or other bodies were it to be decided to introduce a "more detailed questionnaire"?

b) What views, if any, did you have on how robust the system of donor screening was in Wales and/or the UK at this time?

30.1 As above. I am unable to comment.

31. The minutes of the meeting indicate that a statement would be prepared, "to deal with media questions directed to the Department". Was any thought given to issuing a statement to provide information to patients and the public on the then current thinking on the risk of AIDS to those receiving blood and blood products?

31.1 As above. I am unable to comment.

32. Please consider the following documents:

a) Minutes of a meeting of the South Glamorgan District Health Authority regarding AIDS, dated 4 December 1984 [HSSG0010054_004].

b) Statement to be used in response to requests on reports of AIDS deaths in South Glamorgan, signed "BC/JFS/SMB", dated 10 December 1984, [HSSG0010053_009].

32.1 As above. I am unable to comment.

33. A statement to be used in response to requests on reports of AIDS deaths in South Glamorgan dated 10 December 1984 asserts "...a small group of patients suffering from haemophilia has been treated with imported manufactured blood products. While this treatment is now recognised to have carried some risk of the transmission of AIDS, it is a very small risk compared with that of withholding such life-saving treatment in this group of patients, many of whom would undoubtedly have died from uncontrolled haemorrhage had it not been available or had it been withheld.".

a) Please describe what input, if any, you had into this statement and whether it was, or is likely to have been, approved by you.

b) Did this statement reflect your views, at the time, of the balance of risks involved? If not, please explain how your views differed.

c) If the statement did reflect your views, please explain the basis for your views, including the information or advice on which they were based?

33.1 As above. I am unable to comment.

34. On 21 December 1984 a Western Mail article was published reporting that over 50 people, including 9 from South Wales, had been exposed to blood (or blood products) from a donor infected with AIDS [HSSG0010052_006]. Comments from Professor Bloom featured in the article. He was reported to have said that the *"chances of them contracting the disease were almost negligible".*

a) Did you have any involvement in this issue? If so, please explain the nature of your involvement.

b) Were you or the CMO's office consulted by Professor Bloom before he made public comments on the case? Would you have expected to have been so consulted?

c) Did you agree with Professor Bloom's analysis of the risk posed to these patients?

It may also assist, by way of background, to read a follow up article which featured in the Sun newspaper in January 1985 [HSSG0010076_007]

34.1 As above. I cannot recall any involvement in the above matters.

35. On 10 January 1985 a minute from Dr Ferguson Lewis to Professor Crompton, copied to you, refers to two press reports on AIDS [HSSG0010053_003]. In one report, Professor Bloom had been quoted about the health of a group of haemophiliac patients who had received contaminated blood, one of whom was dying of AIDS.

a) Did you have any concern at this time that the public statements made by Professor Bloom minimised the risk of AIDS from contaminated blood to the public?

b) Were you, as DCMO, receiving advice on the risk of AIDS to those transfused with blood and blood products from sources other than Professor Bloom at this time? If so, who was providing such advice, and did they share the view of Professor Bloom about the relevant risks?

c) To the best of your knowledge, what steps were taken as a result of the concerns Dr Ferguson Lewis raised?

35.1 As above. I cannot recall any involvement in the above matters.

36. Please describe your role, and that of the Welsh Office, in the process by which decisions were taken in 1984 and 1985 on when and how to evaluate, select and implement screening tests for HTLV-III antibodies in blood donations in Wales.

37. What were your views at the time about the approach being taken to the introduction of tests, and in particular on the issue of whether a UK evaluation exercise should be undertaken even though that would lead to a delay in the introduction of the tests?

36.1 To the best of my memory I had no role in the implementation of these decisions and I am unable to recall any views I may have had on the introduction of tests or a UK evaluation.

38. Please describe your understanding of the risks associated with blood transmission of hepatitis, in particular Non A Non B hepatitis, and how your understanding of the extent of the risks or severity of Non A Non B hepatitis developed over time.

38.1 I have mentioned that I returned to the Welsh Office in 1990 as CMO, having been away from 1988. I cannot though with any certainty describe how my understanding of the risks evolved at this time, save that I would have been aware of the advice of the ACVSB and I note that members of HPG who may have included myself were pressing for the introduction of testing in Wales ahead of that in England.

39. What role, if any, did you/the Welsh Office play in disseminating information about the risks associated with hepatitis, in particular Non A Non B hepatitis, to other organisations, clinicians or the wider public?

39.1 See answer to question 38.

40. During the period from 1989 -1991, what consideration was given (to your knowledge) by you, and others within the Welsh Office to the fact that HCV testing had been or was being introduced in other countries? Why, in your view, was the UK slower to introduce HCV testing than a number of other countries? You may wish to consider the document [HSSG0000141_120].

40.1 See answer to question 38.

41. Do you consider that HCV testing should have been introduced earlier than it was? Please explain your answer

41.1 See answer to question 38.

42. Please explain what role, if any, the CMO played in decisions on the funding of haemophilia treatment in Wales. Insofar as you are able to do so, please provide an overview of how that system worked, and what role was played by the Department of Health, the Welsh Office and Regional Health Authorities.

42.1 Once again I am unable to recall discussions on the funding of recombinant Factor VIII in Wales.

43. Please consult the following documents: [DHSC0006588_003], [HCDO0000278_127], [GLEW0000300], [GLEW0000302_001], [HSOC0017795_006], [HSOC0017795_008]. Please outline the Welsh Office views and relevant policies adopted in Wales with regard to the provision of Recombinant Factor VIII for the treatment of haemophilia. Were policies adopted in Wales different from those adopted in Scotland and Northern

Ireland? How?

43.1 As above.

Section 4: Work of Welsh Office post - 1985 and other issues

44. There was a high-profile public education campaign about the risk of AIDS from the mid-1980s. Please describe, in broad terms, the role if any the Welsh Office played in contributing to the content or development of the campaign. It may assist to review the note written by the Welsh Office on its AIDS campaign policy dated 6 October 1986 [HSSG0010218].

44.1 During this period the area of AIDS and its risks did not form part of my responsibilities as DCMO, being in the remit of my fellow DCMO (successively Dr AM George and Dr D Ferguson-Lewis).

45. Please consider a letter from JAF Napier to Professor Crompton dated 13 March 1987, regarding the risk of AIDS in blood transfusion [HSSG0010204]. The marginalia indicates that this minute was also provided to you. Please explain what consideration was given to the issue of autologous transfusion and what action was taken at this time.

45.1 See answer to question 44.

46. Please consider the note written by the Welsh Office on its AIDS campaign policy in response to the letter of Sir Kenneth Stowe dated 6 October 1986 [HSSG0010218], at paragraph 5: "From beginning Welsh Office has pressed the view that AIDS is primarily a social / educational / behavioural / community problem, rather than a medical / clinical one."

a) **What do you understand this comment to mean?**
b) **How did this view shape the way in which the Welsh Office approached AIDS policy? In particular, what effect (if any) did it have on the approach taken to the risk of transmission of AIDS through the use of blood and blood products?**

c) Is it a view that you shared at the time? Please explain your reasons for agreeing or disagreeing with it.

46.1 See answer to question 44.

Section 5: HCV/Lookback

47. Please consult the following documents [DHSC0002553_169], [DHSC0003555_090], [DHSC0032208_149] [DHSC0002551_147], [DHSC0003555_236], [DHSC0006819_097] [WITN6876072]. Please outline your knowledge of and the involvement of the Welsh Office in the work of the Working Party on Hepatitis C Lookback and provide details of your own involvement, if any

47.1 It is clear that I authorised the involvement of the Welsh Office in the lookback exercise and that I nominated Dr Diana Westmoreland to take part in this, in the light of staff shortages in the HPG.

Section 6: Further Information

48. I regret that over 25 years post-retirement I am unable to assist the Inquiry further as I do not recall many of the details of the events surrounding the issue of contaminated blood.

Statement of Truth

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

Signed GRO-C

Dated 28 February 2023