Witness Name: Catherine O'Brien
Statement No.: WITN6876066
Exhibits: WITN6876067-91
Dated: 28th October 2021

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF [CATHERINE O'BRIEN]

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 1 March 2021.

I [Catherine O'Brien], will say as follows:

1. I am the Chief Operating Officer of Velindre University NHS Trust, having previously been seconded from my post as Director of the Welsh Blood Service (WBS). I have held the latter position since November 2013.

2. As the scope of the Inquiry covers many events which occurred in the late 80s or 90s, these pre-date my time in the Service. I have prepared the information in this statement with the assistance of Dr Geoff Poole who is a Blood Transfusion Scientific Consultant and was previously a director of WBS between June 2007 and November 2013. As we have not contacted other former members of staff of NBTS (Wales) or WBS, our knowledge of specific matters relating to earlier periods is limited to the organisational knowledge of those currently employed by WBS, who were in junior roles at that time, together with that from Geoff.

3. The work of myself and Geoff, in preparation of this statement, has necessarily had to rely heavily upon historical documents. In that regard, other than patient

and donor data, the historical records of NBTS (Wales) are not held electronically in any searchable format. They are effectively microfiche photos of documents created at the time. We have provided access to all of these documents to the Inquiry and we have sought to identify the most relevant documents to the information requested, however due to the nature of the storage format and the volume of documents this has been challenging and to date we have not been able to identify all documents relating to specific lines of inquiry. This response is based on the documents we have been able to identify. Documents may also be located in the Glamorgan Archive where they were previously held by South Glamorgan Health Authority ("SGHA") during the period when NBTS (Wales) reported to it between 1982 and 1991. We cannot guarantee that we have located all of the relevant documents and to the extent that if further relevant documents are discovered after the provision of this statement those will be provided to the Inquiry team. We have not been able to locate the WHCSA document archive.

4. As the WBS was formed in 1999 and the questions relate mainly to predecessor organisations, I have provided a brief overview of the organisation's history. The WBS predecessor was the National Blood Transfusion Service (Wales) (NBTS (Wales)), which reported to the Welsh Office (which was the funding authority) via its parent NHS organisation, the Welsh Health Common Services Authority (WHCSA) from 1991 to 1999 and South Glamorgan Health Authority (SGHA) from 1982 to 1991. In 1999, WHCSA was abolished and the Welsh Blood Service was formed as a division of Velindre NHS Trust, which later became Velindre University NHS Trust (VUNHST) reporting directly to the Welsh Government.

5. NBTS (Wales) was a single Regional Transfusion Centre (RTC) which served hospitals in South Wales. Hospitals in North Wales continued to be served by the Regional Transfusion Centre in Liverpool, part of NHS Blood and Transplant (NHSBT) up until 2016 when management of North Wales Blood Service provision transferred from NHSBT to WBS.

6. Whilst NBTS (Wales) was responsible for the provision of services to hospitals in South Wales, in line with the other RTCs, it did not generally act independently or set its own policies but followed UK government policy which itself was based on recommendations from the professional advisory structure, or it followed professional guidance. This guidance was provided through the meetings of Regional Transfusion Directors up until 1988 and through the National Directorate after its formation in 1988. NBTS (Wales) had representation at the Regional Transfusion Directors' meetings and as part of the National Directorate.

7. In 1994 the National Blood Authority (NBA) took executive control of English RTCs. NBTS (Wales) was not however incorporated into the NBA and retained its accountability (and funding mechanism) as part of WHCSA to the Welsh Office. In practice however there would have been professional links to the NBA after 1994, via discussion forums and professional groups with the other Regional Transfusion Centres.

8. In many cases where specific advisory or collaborative groups were set up to advise on specific issues, NBTS (Wales) and WBS (as one RTC) would not necessarily have expertise within that specific area and therefore would not form part of the advisory group. NHSBT, and NBA before that, by reason of its size, would therefore tend to take the lead on such issues and WBS would rely on our ability to discuss with peers and keep abreast of developments and understand the work coming out of advisory groups. NBTS (Wales) and WBS has therefore in many cases been involved in the implementation of policy or initiatives developed by others. Further as a tertiary service provider WBS (and NBTS (Wales) before that) are not directly "patient facing" and do not provide direct ongoing clinical patient care. Responsibility for delivery of direct clinical patient care lay with NHS Health Authorities and Trusts.

Q1. In the document titled 'Draft Report from the MSBT Subcommittee' (NHBT0005791 page 2) discussing the merits of introducing an HCV "Look-Back" policy, it is stated:

"Despite these reservations it is recognised that there is a duty of care that needs to be exercised towards these patients and the implicated donors"

a. When was this duty of care to patients and donors first recognised by WBS?

9. From a search of our archive documents to date we have not been able to identify specific discussions within NBTS (Wales) relating to the identified duty of care. The earliest record of the term 'duty of care' in this context is identified in the draft letters produced by Dr Gillon in January 1995 and included in the minutes of the first Ad Hoc Hepatitis C Look-back Working Party (Look-back Working Party) of the Advisory Committee on the Microbiological Safety of Blood and Tissues (MSBT), received by NBTS (Wales) via the Welsh Office Health Services Division (WITN6876067).

10. Without sight of any NBTS (Wales) documentary evidence we are not able to ascertain what specific discussions took place in NBTS (Wales). A search of our archives to date have not revealed documents relating to discussions that might have occurred within NBTS (Wales), or with the National Directorate or the NBA, regarding this matter other than that relating to the establishment of the MSBT Working Party and subsequent reports.

11. We can find no record of representation from the NBTS (Wales) in the professional advisory groups that considered the look-back exercise, although there was a Consultant Virologist representative from the University Hospital of Wales.

b. Please provide an account of how this duty of care was discharged:

i. prior to the look-back in 1995.

12. Notwithstanding paragraph 9-11 above, an overview of the position of NBTS (Wales) relating to the question is given below.

13. As part of the NHS, NBTS (Wales) operated within the quality and safety standards and processes in place in the NHS which would have changed and developed over the years.

14. NBTS (Wales) worked in collaboration with the other RTCs as a means of achieving best practice in the safety of blood. It was an active participant in the regular meetings of the Regional Transfusion Directors until 1988, when the National Directorate was created to formalise general guidance for RTCs amongst other functions.

15. In 1987 the Joint Professional Advisory Committee of the UK Blood Transfusion Services (UKBTSs) was formed to standardise professional guidance for UK regional transfusion centres. This guidance developed into the Red Book Guidelines in 1990. The Red Book contained guidelines reflecting best practice, set standards to be met by the products, described technical details of the processes involved and stated the legally binding requirements relating to blood safety (https://www.transfusionguidelines.org/about/constitution-of-jpac).

16. In 1991, NBTS (Wales) implemented anti-HCV testing for all blood donations, in addition to the microbiological tests (including tests for hepatitis B, HIV and syphilis) already in place. The test that was introduced met UK requirements for sensitivity and specificity for anti-HCV. Equivocal or positive results were confirmed and referred as necessary to the Public Health Laboratory Service (**PHLS**) Wales for final confirmation. The TRACE computer system (in place at that time), our procedures and our Quality system ensured that red cell and other blood components were not issued in the event of anti-HCV positive test results.

b. ii. in respect of those patients not identified by the look-back exercise.

17. A search of our archives to date have not identified any documents relating to discussions on those patients not identified by the look-back exercise internally within NBTS (Wales). As discussed further in paragraphs [24] below the approach to the Look-back exercise was determined by the experts on the

Look-back Working Party providing advice to the four UK territorial Health Departments and a copy of the notes of the first meeting of which, provided by the Welsh Office, (WITN6876067) indicates that decisions on this were made by this group.

Q2 In the document titled 'Summary: Intervention and Options, Impact Assessment of Better Blood Transfusions' (DHSC0004109_008), on page 3, under the subheading 'The most important aspect is SAFETY', it is noted that:

"Blood transfusions Plasma and platelets are all potentially infected. In the 1990s blood transmission of HIV was a major problem. At the same time Hepatitis C was transmitted but only in 2000 has the problem been recognised as serious."

a. Please comment on the view expressed that HCV transmission through infected blood components was only recognised as a serious problem in 2000.

18. The document titled 'Summary: Intervention and Options, Impact Assessment of Better Blood Transfusions' is a 2007 Department of Health impact assessment for the document Better Blood Transfusion, HSC/0001 2007, Safe and Appropriate Use of Blood. This is a UK government document and because health was by then a devolved matter, it would not have related directly to WBS but would have been relevant to NHSBT which supplied blood for Betsi Cadwaldr University Health Board in North Wales until 2016. The basis for the statement in relation to recognition in 2000 is not clear and as set out below, is not one that is recognised by WBS.

b. Does this represent the view of WBS either then or now?

and

c. If so, why was HCV transmission not recognised as a serious problem earlier?

19. NBTS (Wales) actions show that the seriousness of Hepatitis C was recognised prior to 2000. NBTS (Wales) began routine anti-HCV testing of blood donations in 1991, and the HCV Look-back exercise in 1995. Both of these activities

illustrate that the seriousness of the HCV transmission through blood components was recognised prior to 2000.

Q3. An account of all steps taken to identify and warn patients who may have been treated with HIV infected blood and/or blood products, since the virus was conclusively identified in 1984. Please include any 'look-back' patient notification exercises and details of any awareness campaigns to publicise the risk, including exercises and campaigns that were considered but rejected.

20. Whilst I am aware that a look-back exercise was conducted we have, to date, not been able to identify any records in the WBS archives that date back to this time and would enable us to answer this question.

21. Documents considered by the Penrose Inquiry (PRSE0000623) and released to this Inquiry (DHSC0002365_002 and CBLA0002212) illustrate that the look-back exercise was taken at the introduction of testing with aligned information provided.

22. Any exercise conducted would have been in line with UK government policy based on recommendations from the Regional Transfusion Directors' meetings or the National Directorate. We have no reason to believe that NBTS (Wales) did not implement this in a similar manner to the implementation across RTCs in England.

Q4. An account of the steps taken to warn patients of the risk of HCV being transmitted through the use of blood and/or blood products since 1989 when the HCV virus was first isolated. Please include any 'look-back' patient notification exercises and details of any awareness campaigns to publicise the risk, including exercises and campaigns that were considered but rejected.

23. From our archives, to date we have only been able to identify records that relate to discussions on HCV from circa 1995 and the look-back exercise.

24. NBTS (Wales) participated in the UK wide 'look-back' exercise, which we believe was formulated following advice to the Department of Health and the three other territorial Health Departments by the Advisory Committee for the Microbiological Safety of Blood and Tissues (MSBT). The advice of the advisory committee led to the establishment of the Look-back Working Party. As stated above there was no NHBTS (Wales) representation on the working party but a consultant virologist from Wales was a member. The Look-back Working Party developed the protocol for the look-back exercise working group and shared it with RTCs including NBTS (Wales). This was outlined in a letter of 19th January 1995 from the Medical Director of the National Blood Authority to all Regional Transfusion Centre (RTC) Directors (NHBT0011115). NBTS (Wales) followed this UK wide approach as applied across the other RTCs in England. We have not been unable to locate any information on the nature of the role, if any, that NBTS (Wales) took in informing discussions other than one indirect contribution as outlined in correspondence to the Welsh Office CMO in February 1995 providing views on the Working Party "action sequence" and "draft standard letters" (WITN6876068). The guidance on the Look-back exercise was issued by the Department of Health (NHBT0002796_002).

25. The 1995 look-back exercise was designed to identify blood donors who tested anti-HCV+ and then identify patients who had previously received blood components donated by these donors before testing was introduced. The involvement of NBTS (Wales) in donor care is outlined in the response to Question 5. In line with its remit as a Blood Service, the WBS and its predecessor NBTS (Wales) did not provide for the direct ongoing provision of clinical services to patients as this care was provided by Health Authorities and Trusts. This includes those patients who had been blood donors and who had been identified as anti-HCV+ by NBTS (Wales), however these donors were referred for care to their General Practitioners and onward to specialist care as required.

26. Records show that NBTS (Wales) medical staff involved in look-back actively supported hospital blood banks by offering assistance in tracing through blood

bank records. Given that NBTS (Wales) had no remit for direct patient care in Wales, permission was sought from the Welsh Office to contact hospitals (WITN6876068) and an early letter sent to hospital haematologists seeking information about their record keeping systems (WITN6876069).

27. In relation to the raising of public awareness, a letter from the Chief Medical Officer of the Welsh Office on 17th January 1995 recognises that NBTS (Wales) had a role in supporting the Welsh Office raising public awareness of the look-back exercise through help with publicity arrangements for the lookback exercise (WITN6876070). Our records indicate a 'Briefing for Media and Press Correspondents' from 11th January 1995 (WITN6876071) annotated for the Chief Medical Officer Welsh Office, and the NBTS (Wales) Managing Director, indicating a Wales press engagement in addition to the UK one led by the UK Department of Health, which was subsequently reported to WHCSA by the Managing Director on 31st January (WITN6876072). From this it can be seen that extensive engagement with the Welsh media was undertaken.

28. For the launch of the exercise, general practitioners were provided with information by the Welsh Office Chief Medical officer, (NHBT0002768_001 and DHSC0002502_007) the public in Wales were able to access the single national helpline number and the medical team at NBTS (Wales) provided support for members of the public who called them directly (WITN6876072).

Q5. After the introduction of HCV screening, what, if any, guidance and assistance was provided to donors found to be HCV positive in relation to the management of their illness and was this different in Wales to that in England? Please include all anti-HCV screening, pre and post September 1991, and any pilot screening programmes.

29. Our archives reveal the general process that NBTS (Wales) followed, prior to the look-back exercise in 1995, for situations in which a donation was found to be positive for a mandatory microbiological test. The NBTS (Wales) test result was checked by the Public Health Laboratory Service (Wales) and, if confirmed, no blood components would be issued for transfusion. The blood donor would

be contacted and a face-to-face counselling session would take place between the donor and a member of NBTS (Wales) medical staff. At this session general advice and guidance would be offered, on the understanding that the doctor-donor relationship differed significantly from the doctor-patient relationship. The donor would be asked if they would agree to their GP being contacted, and if agreed, the NBTS medical officer would write to the GP suggesting that they contact the donor. Onward referral to specialist clinical care would usually occur via the GP. This is in line with the process today in which donors that test positive for the mandatory virus tests carried out are referred to a WBS Medical Consultant (WITN6876073).

30. A search of our archives to date have not yet revealed documents dated 1991-1995 containing correspondence with, or counselling of, donors found by NBTS (Wales) to be anti-HCV+ but the search has not been able to be exhaustive as outlined in paragraph [3]. We have been able to locate correspondence with donors found to be HBsAg+ or syphilis positive, and subsequent reference to personal counselling by medical staff of NBTS (Wales), and have no reason to believe that these exercises were not carried out on donors found to be anti-HCV+ during 1991-1995. Examples that illustrate the process are attached from May 1996 (WITN6876074) and December 1999 (WITN6876075). Comparison of the records show that the recording of the process evolved and that a checklist was introduced.

31. We have identified information that was produced to support the engagement with donors who tested positive for HCV. We have located a booklet entitled *Welsh Blood Service, Hepatitis C Information Booklet* (WITN6876076) and although no contextual information is available regarding its formulation, date or distribution, its content suggests that it was a leaflet to support donors who were identified as HCV positive when testing was introduced. Some of these donors would become patients.

32. The principles in these historic documents underpin the current process for the management of positive test results, and our engagement with and support for

donors (WITN6876073) Dealing with Donors with a Positive Microbiology Result', WBS SOP 104 MOI.

33. Regarding the comparison between processes for donor care in Wales with those for England, we have no documentation relating to the NBA service. Between 1988 and 1994, the blood transfusion centres in England and Wales would have taken advice from the appropriate national advisory committees of the UK Health Departments.

34. We have not been able to identify any documents relating to a pilot screening programme in Wales.

Q6. Please identify and explain any differences between HIV/AIDS and HCV Look-back patient notification exercises and awareness campaigns in Wales.

35. We have been unable to find any records relating to the HIV / AIDS look-back exercises and awareness campaigns within our own files, so our awareness is limited to the documents identified from the Penrose Inquiry and documents submitted to this Inquiry by others (PRSE0000623, DHSC0002365_002 and CBLA0002212) and are therefore unable to respond to this question more fully other than to note the alignment of the lookback with the implementation of donor testing.

Q7. Please explain the impact that any HCV and HIV/AIDS look-back patient notification exercises and awareness campaigns had on the volume and number of blood donations in Wales.

36. We have not been able to identify documents that relate specifically to an analysis of the impact of HIV/AIDS or HCV on blood donations, or identify any notes of meetings where this was discussed internally to the blood service within the WBS archive. However within a limited record from the Glamorgan Archives located by WBS in 2018 to aid our preparation for this Inquiry, we have a copy of minutes from the SGHA meeting held in November and December

1984 (CVHB0000001_040 & CVHB0000001_042) which identify measures taken by the Blood Transfusion Service to discourage unsuitable donors through redesign of its process, instructions given to donors and a draft education leaflet. Minutes of the February 1985 meeting notes the introduction of a questionnaire for all donors (CVHB0000001_050). In a SGHA meeting on the 16th October 1985 (CVHB0000001_052) a report from the Welsh Regional Blood Transfusion Service (NBTS (Wales)) states that *'the excessive amount of publicity given by the media to AIDS adversely affected the attendance of donors because many of them thought they could actually contract the disease by giving blood – this will require a long re-education programme to reverse.'* By October 1986, it was reported that *support from the donor population remained undiminished despite the anxiety and uncertainty from AIDS* (GLAR0000073).

37. We have been able to identify the numbers of blood donations in south and mid Wales covered by NBTS (Wales) during the relevant periods and these are shown in the table below. (The figures from 1984 begin in March when records were computerised).

Year	Total donations
1984	60,703
1985 (HIV testing starts)	79,995
1986	90,664
1987	90,437
1988	88,782
1989	98,765
1990	108,734
1991 (HCV testing starts)	116,056
1992	114,209
1993	113,381
1994	110,372
1995	110,113
1996	114,607
1997	120,174

1998	118,870
1999	121,796
2000	123,949

38. It is not possible to gauge from these figures the effect caused by the introduction of HIV and HCV testing. Small differences in the numbers of donations collected may have reflected small differences in demand, with consequent adjustment of the numbers of donors called for donation.

39. During the period 1984 to 1992 the number of blood donations collected in south and mid Wales by NBTS (Wales) rose steadily to meet the increasing demand by clinicians for effective new treatments for a variety of haematological disorders.

40. During the period 1991 to 1995 the number of blood donations collected by NBTS (Wales) fell slightly. It is possible that HCV awareness campaigns may have affected this. However, there are many contributory factors that relate to blood collection, including: demand from clinicians; stock rotation and blood compatibility testing in hospital blood banks; and alternative methods in blood transfusion centres for platelet collection. In the absence of contemporaneous documents it is not possible to analyse these figures in more detail.

Q8. Please explain how, if at all, concerns over the need to ensure sufficient supply of blood donations to meet clinical demand influenced the nature and scope of any HCV and HIV/AIDS look-back patient notification exercises and awareness campaigns.

41. As set out above we have not identified any records that relate to the HIV/AIDS look-back patient notification exercises.

42. We understand that the nature and scope of HCV look-back patient notification exercises and awareness campaigns were discussed and agreed by the advisory committees referred to in paragraph [24] above. We have been unable

to locate details of any representation of NBTS (Wales) on these committees or details of any discussions which may have taken place other than notes of meetings (WITN6876067).

43. We understand that, following the MSBT recommendations, the Department of Health (DH) accepted the need for lookback, resulting in the establishment of the Look-back Working Party to provide a recommendation to Ministers on the exercise. Guidance from the working party was issued to blood centres early in 1995 for the subsequent introduction of the lookback exercise (NHBT0011115, NHBT0012007_006, NHBT0010810, NHBT0002796_002). NBTS (Wales) undertook implementation of the look-back, in line with this guidance under the direction of the Welsh Office and in collaboration with NBA to ensure a UK wide approach.

Q9. Please provide an account of the role played by the NBA in the decision to implement a UK-wide HCV look-back patient notification exercise in 1995 ("the 1995 look-back exercise").

44. The National Blood Authority (NBA) was set up as a Special Health Authority in England in 1993, assuming executive control of the English blood services in 1994. The NBA had no jurisdiction over NBTS (Wales).

45. Correspondence in our records (NHBT0011115, NHBT0012007_006, MODE0004465, NHBT0010810) indicate that the Medical Director of the NBA was a member of the Working Party and communicated regularly with the Regional Transfusion Centres including NBTS (Wales), sharing the updates from the Working Party and acting in a coordination role for sharing information and collation of data (MODE0004454).

46. This was through the inclusion of the NBTS (Wales) Medical Director in correspondence with the NBA Regional Transfusion centres (NHBT0011115, NHBT0012007_006, MODE0004465, NHBT0010810).

Q10. In a memo from Dr Contreras to Dr Thomson and Dr Brennan, North London Blood Transfusion Centre Colindale, dated 17 December 1990 (NHBT0000052_003), Dr Contrearas states:

"I think that we should apply as soon as possible to the MRC and/or to the Welcome Foundation for a grant to enable us to do "look-back" of those recipients of units of blood or blood components who are now confirmed positive for HCV antibodies. What I mean is that we should be able to go back to recipients of previous donations given by donors who now test positive for anti-HCV."

a. What funding applications for a look-back, if any, were made by WBS?

47. The memo from Dr Contreras to Dr Thomson and Dr Brennan, North London Blood Transfusion Centre Colindale, dated 17 December 1990, is an internal note relating to that blood transfusion centre. At this time, the blood centres in England and Wales were independent of each other in the sense that there was no overarching management structure; they were managed via their local NHS organisations. NBTS (Wales) was accountable during this period to the Welsh Office; between 1982 and 1990, this accountability was discharged through the South Glamorgan Health Authority; between 1990 and 1999 accountability was discharged through the Welsh Health Common Services Authority (WHCSA).

48. Searches of our archives have identified documents that relate to the provision of funding by the Welsh Office for the 1995 look-back exercise (WITN6876077,WITN6876078). We have not identified documents relating to funding of a look-back exercise prior to this date or local discussions on Look-back.

b. Did the formation of the NBA and consequent reorganisation of the blood services on 1 April 1993 affect the process of seeking funding for a look-back exercise?

49. The reorganisation of the English blood services had no impact on the process of seeking funding for a look-back exercise in South Wales. Funding of NBTS (Wales) continued to be provided by the Welsh Office via WHCSA.

c. Did Wales becoming fully autonomous in 1994 affect the amount of funding received and the process of seeking funding for the look-back exercise?

50. Whilst NBTS (Wales) did not form part of the National Blood Authority on its formation in 1994, the Welsh Office had responsibility for the delivery of government policy for health in Wales and this did not alter in 1994. There was no change for NBTS (Wales) in its reporting or funding arrangements. These arrangements for NBTS (Wales) changed with the Government of Wales Act, passed in 1998, and with the subsequent formation of the National Assembly for Wales in 1999.

51. We have not been able to identify any information in the archives that would enable us to identify any specific discussions earlier than 1995 on a look-back exercise for NBTS (Wales). No information has been identified to enable us to compare or assess the funding received or the process with that in England in 1995. For NBTS (Wales) we do not believe that funding concerns had any particular impact on the lookback exercises which were undertaken or recommended to be undertaken in 1995.

Q11. Despite the absence of a treatment, prior to 1995, why were steps not taken to identify patients infected with HCV, so that they could manage the risks to their health, e.g. by limiting alcohol consumption?

52. The approach taken in relation to HCV was determined by the Government and based on the advice of experts convened through the professional advisory committees. The input of NBTS (Wales) in relation to policy in these areas would have been limited and their role was primarily in relation to implementation.

53. To date we can find no documents that relate to any discussions NBTS (Wales) may have had in this regard, either within the organisation, or with other organisations, professional groups or contribution to advisory groups.

54. Further, as a tertiary service provider, the NBTS (Wales) did not provide direct ongoing clinical patient care or have access to patient details. It would have been unable to implement anything without the agreement of the government and the participation of the Trusts and Health Authorities. We have not located any documents in the WBS archive that relate to any steps that may have been taken by the Welsh Office or Welsh hospitals in this regard.

Q12. In a letter to Dr McGovern dated 19 August 1998 (NHBT0015135_002), Dr Angela Gorman writes:
"However I feel that it is unlikely that all of Mrs [redacted] donors will either be contactable now or will have donated again since the index donation. This is not for any sinister reasons, but simply because a significant percentage of donors cease to donate every year."
Given the awareness that significant numbers of donors ceased to donate blood every year, why was the HCV look-back exercise designed to target only the recipients of repeat blood donors?

55. This is a letter to the UK Department of Health written by Dr Gorman of the National Blood Service Brentwood Centre in England but identifies the UK wide HCV look-back protocol in which blood donors who did not make a subsequent donation after the introduction of testing were not tested for HCV.

56. The protocol for the look-back exercise was developed by an Ad Hoc Hepatitis C Look-back Working Party of the Advisory Committee on the Microbiological Safety of Blood and Tissues (MSBT). Notes of the first meeting (WITN6876067) indicate that this was discussed and a recommendation made.

57. We have not been able to identify any role that NBTS (Wales) had in the development of this protocol, or any representation from NBTS (Wales) on this group other than proposals on the implementation in South Wales made by the

NBTS (Wales) Deputy Medical Director to the Welsh Office CMO suggesting the additional support that could be provided by NBTS (Wales) to reduce the burden on hospital Consultant Haematologists (WITN6876068). NBTS (Wales) was responsible for the implementation of the protocol in South Wales, as directed by the Welsh Office.

Q13. Where a former donor tested anti-HCV positive in some context other than a repeat donation of blood (e.g. during medical treatment), was a look-back conducted on their previous donations?

58. We could find no record of this scenario in our archives, nor can we find any record of discussion or protocol relating to this scenario. NBTS (Wales) would not have had access to such information. However if an individual had contacted NBTS (Wales) directly to inform them of this or had informed the medical professional that they were a blood donor , then a look-back would be undertaken.

Q14. In the article titled 'The contribution of transfusion to HCV infection in England' by K. Soldan (PRSE0000620) it is estimated that:
Page 588: ***"This estimated the number of transfusion-transmitted HCV infections from components that entered the lookback programme but fell out of the process prior to recipient testing to be 3373 HCV infections."***
Page 590: ***"Using this adjustment resulted in an estimated extra 19 525...anti-HCV-positive components issued after 1 January 1980 that did not enter the lookback programme. The entry of these extra anti-HCV positive components into the path - with the use of a 0.75 probability of infection transmission for these components (i.e. the observed proportion of anti-HCV-positive donation also positive for HCV RNA) - predicted an extra 12 606...transfused components, and an extra 9455...HCV-infected recipients of which at least 5794...are expected to have died by the end of 1995."***
Given that, according to Soldan's assessment, the HCV look-back exercise only identified a small percentage of people infected with HCV

through blood transfusions, what steps, if any, were taken to address the deficiencies of the 1995 HCV look-back?

59. We can find no records of any discussions within NBTS (Wales), or of any discussions that NBTS (Wales) may have had with other organisations, that relate to this article, which was published in 2002.

60. Recommendations for extensions to the look-back exercise would have been made by one or more of the relevant national advisory committees. Any such recommendations would have been examined by the Department of Health, and in Wales by the National Assembly for Wales and subsequently Welsh Government. We can find no records that any such recommendations were made.

Q15. Was it possible for Regional Transfusion Centres and Haematology Departments in Wales to opt out of the 1995 look-back exercise?

61. NBTS (Wales) as a single RTC, served hospitals in South Wales and undertook the 1995 look-back exercise with them. Hospitals in North Wales were served by the Regional Transfusion Centre in Liverpool at that time and as such records would be with the NBA.

62. A Parliamentary Question from Rhodri Morgan answered by John Redwood in January 1995 (WITN6876079) articulates that the NBTS will "implement the look-back programme", however it is difficult to assess the sense of mandate for hospitals. NBTS (Wales), actively participated in the exercise and also proposed to the Welsh Office ways in which it sought to provide additional support for the exercise (WITN6876068). From correspondence between NBTS Managing Director and the Welsh Office Chief Medical Officer (CMO), it is clear that from the early stages of the planning, the burden of the look-back exercise on haematology departments was recognised (WITN6876080). Here it is proposed that NBTS (Wales) would support by being "directly involved in as much counselling as possible".

63. In relation to Haematology Departments, they will have received their instruction to participate from their local Trust management.

64. From a letter sent by the NBA Medical Director on 15th May 1995, (MODE0004465) copies of documents initiating the exercise with NHS organisations have been identified. *Health Service Guidance (95) 23* highlights a communication by the Chief Medical Officer *(CMO (95) 1)* (MODE0004465) and asks Chief Executives and General Managers to *'make arrangements for maximum cooperation'* While these relate specifically to England, the circular notes that similar letters had been distributed by the other territorial Health Departments.

If so:

a. Please provide a list of Centres and Departments that did not participate in the 1995 look-back exercise.

65. To date, we have not been able to identify records that relate to any specific non-participation of individual hospitals in South Wales. Our archive records include positive correspondence with hospitals to enable the NBTS (Wales) staff to access medical records to undertake the exercise. An example of this is illustrated by correspondence with the University Hospital of Wales (WITN6876081). Their participation is noted in a letter of 23rd May 1995 from the NBTS (Wales) Consultant Haematologist to the Consultant Virologist in the Public Health Laboratory Service which notes that there was 'no problems liaising with the hospitals' (NHBT0036922).

b. Why was the 1995 look-back exercise not made mandatory?

66. There were a range of mechanisms of communication and instruction from governments to the NHS organisations. For the look-back exercise we have identified copies of the documents HSG relating to England *HSG (95) 23* that were provided by NBA (MODE0004465). The instruction or mandate varies depending on the action and the policy or legal basis for this action. Health

Service Guidance and Chief Medical Officers letters are examples of such correspondence and their status is not within the remit of WBS.

c. What steps were taken to encourage Centres and Departments to participate?

67. Our records show that NBTS (Wales) engaged proactively with hospitals in Wales from the announcement of the exercise providing them with information (WITN6876069,WITN6876082). They also provided considerable direct support to hospitals to complete the exercise.

68. From the outset of the exercise, the challenge that this work would present to hospitals was recognised and requests were made to the Welsh Office for NBTS (Wales) to provide support in terms of review of records and provision of counselling (WITN6876068, WITN6876080).

69. NBTS (Wales) appointed a medical consultant and a clinical scientist to act as a point of liaison between the NBTS and hospital consultants and hospital blood laboratories and actively undertook review of records (WITN6876078). We believe that NBTS (Wales) were pro-active in encouraging a prompt response to queries regarding blood components identified for look-back. NBTS (Wales) sought approval for access to patient records for participation in the exercise with senior officials at each hospital organisation and ensured responses. An example from the correspondence with the University Hospital of Wales is provided (WITN6876081). Correspondence with the Public Health Laboratory Service in May 1995 indicated that there was no problem with hospital engagement (NHBT0036922).

Q16. Please provide an account of the processes and procedures to ensure compliance and consistency in the administration of the 1995 HCV look-back exercise by Regional Transfusion Centres, Haematology Departments and medical professionals across the UK.

70. The procedure for the look-back exercise was developed by the Ad Hoc Hepatitis C Look-back Working Party, a subgroup of the MSBT on behalf of the four territorial Health Departments. A consistent UK approach was noted at its first meeting (WITN6876067). The Welsh Office Health Services Division and Chief Medical Officer provided NBTS (Wales) with updates on the work of the group, which included representation from a Consultant Virologist based at the University Hospital of Wales (WITN6876083, DHSC0003555_013) although not a representative of NBTS (Wales). The minutes of the Working Party state that group members would be preparing pro-formas, standard letters and guidance for use by the blood transfusion services and these were subsequently distributed. This continued as the exercise was rolled out, an example being the provision of a standard letter to Consultants on 18th September 1995 (NHBT0010810).

71. In the period between January 1995 and the launch of the live look-back exercise, NBTS (Wales) received correspondence from the Welsh Office and the NBA to support a standard approach to the exercise (WITN6876067, NHBT0011115, NHBT0012007_006, MODE0004465).

72. It is clear from the records that the way of working between NBA and NBTS (Wales) also facilitated a consistent approach. Although the NBTS (Wales) line of report was via the Wales Office, progress and documentation on the exercise was provided to NBA and culminated in a single update report being produced for England and Wales (MODE0004454).

73. As a further example of standardisation of approach to the look-back within the UK blood services, correspondence dated March 1996 clarified the question of anti-HCV test results classified as 'indeterminate' (NHBT0036529).

74. As outlined in paragraph [69] above our records show that NBTS (Wales) appointed a medical consultant and a clinical scientist to act as a point of liaison between the NBTS and hospital consultants and hospital laboratories. We believe that they were pro-active in encouraging a prompt response to queries regarding blood components identified for look-back. Letters sent by NBTS

(Wales) to the Welsh Office (WITN6876068) and subsequently to hospital haematologists (WITN6876069) illustrate one way in which NBTS (Wales) supported the participation of hospitals in the look-back exercise. Our records indicate that this offer of support was followed up in practice.

Q17. In relation to any deceased persons who were identified as being at risk of HCV infection through the 1995 look-back exercise:

a. What steps, if any, were taken to determine whether the death was caused by or related, either directly or indirectly, to HCV infection.

75. Letters sent by NBTS (Wales) to the Welsh (WITN6876068) and subsequently to hospital haematologists) (WITN6876069) illustrate the approach taken by NBTS (Wales) in obtaining information from hospitals in South Wales.

76. The look-back exercise information was compiled through identification of patients and review of their medical records held by the hospital. The look-back exercise captured details on cause of death where this was available in the medical record. This was undertaken by NBTS (Wales) with permission from each hospital site. The blood service look-back record lists their diagnosis, other reasons for hospitalisation and the date and cause of death if it was in the record. However this information seems to have been limited in some cases. For the 469 patients who were investigated as part of the look-back exercise, but had died previously, the records indicate that in 76 of these patients, the disease or cause of death is unknown. Four patients are noted to be presumed dead, although the basis for that is not articulated.

77. Due to the limited data that was either accessible or recorded for those who were deceased at the time of the look-back, we are not able to identify the number that had been positive for HCV at the time of their death.

78. We have not been able to identify records that relate to the subsequent clinical presentation of those patients who were at risk and tested positive for HCV during the look-back exercise.

b. Please provide their names, date of birth, and date of death.

79. We are not able to provide this information as outlined above.

Q18. Annex A to the letter of the Chief Medical Officer dated 3 April 1995 (BMAL0000022_003) states:
"Where the final HCV test result is deemed to be indeterminate this should be recorded, but no further action is required at the present time."

a. How were indeterminate test results recorded?

80. Indeterminate test results were recorded in the TRACE computer system in use by NBTS (Wales) at the time. The TRACE records were very secure and are currently accessible. We have not identified any additional lists of indeterminate results in our archives.

b. How, if at all, were indeterminate test results followed up?

81. The protocol or guidance developed by the Working Party outlined the process. A letter from the NBA dated 12 May 1995 (MODE0004465) indicated the process by which test results were followed up leading to counselling of the donor. As with previous NBA instructions to English regional transfusion centres regarding the look-back exercise, the protocol requires that the HCV status of donors giving indeterminate results must be established as positive or negative with further testing. There are later documents that we are further investigating that relate to 'indeterminate' results and we have raised this with the Inquiry team.

82. A letter from the NBA Medical Director to NBTS (Wales) dated 25th March 1996 (NHBT0036529) clarifies in more detail the follow up of indeterminate tests.

c. Were donors with indeterminate test results informed? If so, how?

83. The letter from the NBA Medical Director dated 12 May 1995 (MODE0004465) indicated the process by which test results were followed up leading to counselling of the donor.

Q19. Please explain the relationship between WBS and NHSBT after 1994 with regard to the look back exercise;

84. As set out in paragraph [4] above between 1994 and 1999 (by which time the initial aims of the look-back programme had been met), NBTS (Wales) reported through its parent organisation, WHCSA, to the Welsh Office. There were professional lines of communication between NBTS (Wales) and the newly formed Special Health Authority, the NBA (which later became NHSBT). The NBA, with managerial authority for all English RTCs, had replaced the NBTS National Directorate, which gave professional advice and direction to RTCs in England and Wales. That professional advice continued to some extent after the formation of the NBA, particularly during the early years. There was however no line of managerial accountability between NBTS (Wales), and the National Directorate, the NBA or subsequently NHSBT.

85. The look-back exercise was established by the UK Government with the plan for its delivery and ongoing review of progress being undertaken by the Ad Hoc Hepatitis C Look-back Working Party, a subgroup of the MSBT on behalf of the four territorial Health Departments.

86. The National Blood Authority Medical Director was a member of the working party and took the lead in engaging with the regional centres that came under their management. Enabling a consistent approach, NBA effectively included Wales as one of its RTCs for the purpose of the exercise and copied NBTS (Wales) on all of the correspondence that they sent their RTCs as previously detailed. Some aspects of this related to specific English matters such as payment, but in these cases NBTS (Wales) worked in parallel with the Welsh Office to address those issues. NBTS (Wales) submitted data on progress to

the NBA and reports were drafted for England and Wales as previously outlined (MODE0004454).

Please explain the following:

a. Who was responsible for the implementation and overall responsibility of the programme?

87. NBTS (Wales) was responsible for the implementation of the programme in south Wales in line with the guidance issued by the government (NHBT0002796_002) and reported its progress to both the Welsh Office and through the Wales representative on the working group and also via NBA.

88. Overall responsibility for the programme in South Wales rested with the Welsh Office.

b. Did WBS provide guidance to the Regional Transfusion Centres and Haematology Department in Wales and were they accountable to WBS?

89. NBTS (Wales) consisted of a single Regional Transfusion Centre.

90. Our records show active engagement with the hospitals in South Wales to enable access to the patient records and to facilitate communication with the patients' General Practitioners and hospital clinicians.

91. Initial information on the exercise was provided to hospitals by the NBTS (Wales) Medical Director in January 1995 (WITN6876082) and this was followed with a series of communications requesting access and updating on progress (WITN6876069).

92. The haematology departments in South Wales were accountable through their host organisation to the Welsh Office and have never been accountable to NBTS (Wales) or WBS.

c. After 1994 is there a uniformity of approach in the lookback exercise of WBS and NHSBT? If there were differences please highlight them.

93. Uniformity of approach was an objective of the Ad Hoc Working Party on Hepatitis C Look-back and correspondence shows that provision of a standard protocol and letter templates (WITN6876067, NHBT0010810) aimed to support that approach. It is clear that NBTS (Wales) was in receipt of these and we have not been able to identify information to suggest that this guidance was not followed.

94. Correspondence from the NBTS (Wales) to the Welsh Office and hospital haematologists indicates that NBTS (Wales) may have provided more direct support to hospitals to undertake the review and the provision of counselling than was required in the NBA protocol (WITN6876068, , WITN6876069 and WITN6876080).

95. Without access to the details of the exercise delivery in English centres we are not able to make a direct comparison.

96. The line of accountability for NBTS (Wales) was to the Welsh Office as previously outlined.

d. Are there any other features which distinguish the WBS lookback exercise from England?

97. From the documents identified in the archive, a summary of the NBTS (Wales) approach was provided to the Head, Health Services Division, Welsh Office on 19th December 1995 which suggested that the approach in Wales differs in so far as the centres in England did not follow the process from beginning to end, but identified donations to the receiving hospitals (WITN6876084), however we have not been able to make a direct comparison.

Q20. Please provide an account of the results and findings of the 1995 look-back exercise for Wales, including but not limited to:

98. Our records include a single digitised (spreadsheet) record of patients identified by the HCV lookback exercise. We believe that this is the complete version but have been unable to conclusively verify this. We have answered Question 20 from statistical information dated 1 February 2003 contained within this record. The data is not easily interrogated and these figures have been collated based on the analysis that we have been able to undertake. There remain a small number of anomalies.

a. The total number of people who were identified as being at risk of HCV infection through blood transfusions;

99. 690

b. The total number of people notified of the risk of HCV infection through blood transfusion;

100. We are not able to provide this information as it is not specifically recorded on the WBS database. However the record shows that of the 690 people identified as at risk, 185 people were known to have been tested with results recorded.

101. Of the remaining 505 people identified at risk of infection, 469 had died by the time of look-back, with the cause of non-testing of the remaining 36 people being noted as being unsuitability for testing, error in identification, unknown, or outside of region.

c. The number of people who were tested for HCV as a result of being notified that they were at risk;

102. 185 people were tested for HCV.

d. The number of people who tested positive for HCV following notification;

103. 64 people tested positive.

e. The number of people who tested negative for HCV following notification;

104. 110 tested negative.

f. The number of people whose tests results were indeterminate;

105. 11 had an indeterminate result.

g. The number of people who failed to respond to a notification that they were at risk of HCV infection;

106. We have not been able to identify this information, however the Lookback report dated 15th April 1996 states that there was one person that did not reply (WITN6876087).

h. An account of attempts made to establish contact with people who did not respond to notifications;

107. We have not been able to identify this information in much detail, however the Lookback report dated 15th April 1996 states that there was one person that did not reply (WITN6876087).

i. How many people in total were counselled as part of the 1995 look-back exercise?

108. We have not been able to identify this information.

Q21. Please provide copies of any interim and final reports for the 1995 Look-back exercise.

109. The NBTS (Wales) provided monthly reports internally to the senior staff, to the Welsh Office and onwards to the Working Group as well as through NBA (WITN6876085 and WITN6876086). Progress reports were given to the Working Party through both NBA and the Wales representative (WITN6876087). A number of these monthly reports made by the NBTS (Wales) Consultant Haematologist leading the exercise have been identified and are provided (WITN6876085). In a letter to Dr Hall in the Welsh Office on 3rd March 1997 (WITN6876086), a copy of such a report to the NBA is included.

110. The only summary report that we have been able to identify to date in the archive is included in a letter from the NBA Medical Director of June 2nd 1995 which provides a Progress Report from the NBA on the HCV Lookback Programme as of May 1995 (MODE0004454).

Q22. Has there been any attempt to use the data obtained from the 1995 look-back exercise to determine the total number of infections of HCV from blood transfusions up to September 1991? If so, please provide an account.

111. We have not been able to identify any such calculations for NBTS (Wales) within our records.

Q23. Accepting that the recommendation of the Penrose Inquiry, that everyone who had a blood transfusion before September 1991 be tested for HCV, was directed to the Scottish Government, please provide an account of any steps taken by WBS in response to this recommendation.

112. As noted the report was directed to the Scottish Government. We have no record of being asked to engage in a formal discussion with Welsh Government or Public Health Wales on this but are aware of an informal conversation that

the report had been published and that we would await such engagement should it be required.

Q24. In a letter (NHBT0036358) of Dr Angela Robinson (National Blood Authority) dated 1998, to Dr Mortimer, Public Health Laboratory Service, discussing the US Public Health Service's recommendation that all recipients of blood prior to 1992 should be tested for HCV, Dr Robinson suggests that there is no requirement for such a recommendation in the UK. Is this view consistent with WBS's position today?

113. To date, we have not found a copy of this letter from the NBA in our archives. It is possible, given the distinct reporting arrangements of NBTS (Wales) and the NBA that we were not copied into this correspondence. We have found no record of discussions within NBTS (Wales), or between NBS (Wales) and another organisation, on this matter.

114. The WBS is not able to form a view on this as it does not have access to sufficient information on which to base an opinion, or the current breadth of professional expertise to make such an assessment. Consideration of such issues is generally made by the appropriately constituted professional advisory committees: we understand that historically this would have been the Advisory Committee on Microbiological Safety of Blood and Tissue (MSBT) or the Advisory Committee for Virological Safety of Blood (ACVSB); currently the relevant committee would be the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO).

Q25. Please provide the number of blood donors for each month (highlighting any repeat donors within the specified period) who tested positive for HCV, from the introduction of routine screening for HCV in September 1991 to date or from the earliest date that you have records.

115. From September 1991 to May 2021 there were 308 donors who tested positive for HCV, and 116 repeat donors. Monthly figures are provided in the document attached as (WITN6876088).

Q26. Please provide the number of blood donors for each month (highlighting any repeat donors within the specified period) who tested positive for HIV, from the introduction of routine screening for HIV in October 1985 to date or from the earliest date that you have records.

116. From March 1984 to May 2021 there were 146 donors who tested positive for HIV and 105 repeat donors. Monthly figures are provided in the document attached as (WITN6876088).

Q27. Please provide the number of blood donations and the number of separate donors, for each permanent blood donor centre, area and region, for each month from earliest records to date.

117. The Blood service has a number of different definitions relating to 'blood donation.' For the purposes of our response we will use 'number of donations commenced' for whole blood and platelets. There will be a small percentage of attrition with not all commenced donations going on to be viable, however these numbers will be low and consistent throughout the years.

118. Our current system (ePROGESA) has been running from May 2015, so there will be a short period of time in the system transfer when some figures were duplicated across systems as a result of change over process to the new system creating a small margin of error. Prior to 2016 the number will only relate to South Wales, and from 2016 the number of donations and donors will relate to the whole of Wales.

119. Prior to the current system, we operated a computerised system called TRACE, with donor records being uploaded to this in 1984, and again there will be a short period when records were being transferred and uploaded where the digital record of figures may not be complete creating a small margin of error.

120. Before 1984 all records were paper based and are archived and we are not able to provide information requested prior to this date.

121. With regard to the information relating to blood donors per month, this figure would generally match up with the number of donations being made as there is a 12 to 16 week period before donors are able to donate again (the only exception is in relation to platelet donations which can be donated every 3 weeks). We have therefore provided an annual figure rather than a monthly one for the number of separate donors commencing a donation.

122. For details on the number of donations and donors, please see the document attached as (WITN6876089).

Q28. Please provide the number of blood transfusions provided by the WBS for each year from earliest records available to date.

123. The WBS (and its predecessor organisations) is a provider of blood components to Welsh hospitals. The selection, use and ultimate fate of these blood components is recorded by the hospital laboratories and medical departments.

124. This data is not currently available from the WBS. However as part of the Blood Safety & Quality Regulations (BSQR) (2005 as amended) there is now a requirement for each hospital to complete a Blood Compliance Report to submit their blood component issue data to the Medicines Healthcare and products Regulatory Agency (MHRA) on an annual basis.

Q29. In the document titled 'Protocol for clinical investigation of the significance of isolated anti-HBc or anti-HBc/anti-HBs <0.1 IU/L' (NHBT0007906_001), reference is made to a proposed Hepatitis B look-back study being conducted, following the same procedure as the HCV look-back. Assuming that the proposal and protocol was agreed, please provide an account of this HBV look-back study, and exhibit any interim and final reports.

125. The provenance of this document is not indicated but indicates it was sent to the NBA in April 1995. No reference to this proposal, or evidence of such an HBV study, has been found to date in the archives of the Welsh Blood Service.

Q30. Are you aware of instances of undetected HCV infected donations, post September 1991? How many?

126. To date, we have not been able to identify any instances in the search of our records.

Statement of Truth

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

Signed GRO-C

Dated 28th October 2021

Table of exhibits:

Date	Notes/ Description	Exhibit number
31/01/1995	Letter Brydon to WBS re WP meeting	WITN6876067
18/01/1995	Letter from MD at NBA re Lookback action for RTCs	NHBT0011115
22/02/1995	Letter from Dr Trenchard to CMO Wales on HepC Lookback update	WINT6876068
24/02/1995	Letter from Dr Trenchard to Haematologists re Lookback	WINT6876069
17/01/1995	Letter from CMO to MD at NBTS(Wales) re Lookback	WITN6876070
06/02/1995	Letter from MD at NBA to Dr Napier Re revised Lookback guidelines	NHBT0012007_006
	WBS Hep C Information booklet	WITN6876076
12/07/1996	Infected Donor Surveillance Folder.	WITN6876074
30/12/1999	Checklist for completing tasks	WITN6876075
01/04/2021	SOP MOI-104	WITN6876073
11/01/1994	Briefing for Media and Press Correspondents	WITN6876071
12/05/1995	NBA letter Lab protocol	MODE0004465
12/09/1995	Example of notification by NBTS (Wales) of an indeterminate HCV result	WITN6876090
01/06/1995	Examples of engagement with HBs on Lookback	WITN6876081

13/01/1995	Letter to CMO from Gail Williams re Start of Lookback	WITN6876080
16/01/1995	Parliamentary Question re Lookback from Rhodri Morgan to John Redwoodd.pdf	WITN6876079
11/01/1995	Letter from J S Metters, Deputy Chief Medical Officer to Doctor, re Hepatitis C and Blood Transfusion	NHBT0002768_001
30/06/1995	Memo to Dr Williams from Dr Hutton re Lookback	WITN6876087
23/05/1995	Letter from Dr Hutton confirming no problems with hospitals	NHBT0036922
15/09/1995	Letter from NBS AR to TN re letter to consultants re Lookback	NHBT0010810
01/03/1996	Letter re Indeterminate HCV Lookback Results	NHBT0036529
03/03/1997	Letter to Dr Hall WO re Lookback stats	WITN6876086
22/06/1995	Letter form WO advising of funding for lookback	WITN6876077
12/01/1995	Memo to haematologists and blood bank mgs re Lookback	WITN6876082
06/11/1995	PHLS re Lookback stats	WITN6876091
30/06/1995	Memo to Dr Williams from Dr Hutton re Lookback report example to Welsh Office	WITN6876085
31/05/1995	Progress report on Lookback with stats from NBA	MODE0004454
11/01/1995	Questions and answers for calls to	DHSC0002502_007

	helpline from public, regarding Hepatitis C and Blood Transfusion	
19/12/1995	Report to WO on Lookback	WITN6876084
31/03/1985	Letter re Lookback costs	WITN6876078
26/10/1995	WHCSA Meeting Cardiff	WITN6876072
	Penrose Inquiry - Dr John Gillon - Witness Statement	PRSE0000623
10/07/1985	RTD meeting	CBLA0002212
09/10/1985	Regional Transfusion Directors_ Meeting Minutes	DHSC0002365_002
21/11/1984	SGHA Minutes	CVHB0000001_040
19/12/1984	SGHA Minutes	CVHB0000001_042
20/03/1985	SGHA Minutes	CVHB0000001_050
16/10/1985	SGHA Minutes	CVHB0000001_052
31/01/1995	Letter to MD from WO updating on Lookback Working Group	WITN6876083
11/01/1995	Nominees for the ad hoc working party on Hep C	DHSC0003555_013
	Q25 and Q26 breakdown_ 1984-2021	WITN6876088
	Q28_ Donations from 1984-2021	WITN6876089
03/04/1995	CMO guidance programme to identify recipients of blood infected with Hep C	NHBT0002796_002
15/10/1986	SGHA Minutes	GLAR0000073