Witness Name: Colin John Hilton
Statement No. WITN6913001
Exhibits: 0
Dated:

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF COLIN JOHN HILTON

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18th August 2021.

I, Colin John Hilton, will say as follows:

Section 1: Introduction

1. My name is Colin John Hilton. My date of birth is GRO-C 1945, and my address is GRO-C I do not have formal legal representation but have been supported by the Legal Services Department of my former employer, The Newcastle upon Tyne Hospitals NHS Foundation Trust in preparing this statement.
   My qualifications are M.B., B.S., FRCS(Eng)
2. My employment history is as follows.
   Aug 1968 - Jan 1969 House Officer, General Surgery, Royal Victoria Infirmary, Newcastle upon Tyne
   Feb 1969 – July 1969 House Officer, General Medicine, Newcastle General Hospital
   Aug 1969 – Jan 1970 Senior House officer, General Surgery, Newcastle General Hospital

Jan 1970 – Jan 1972 Registrar, General Surgery, Newcastle General Hospital

Jan 1972 to Jan 1973 Locum Registrar Orthopaedics and Thoracic Surgery, Royal Hospital, Wolverhampton

Locum Registrar Cardiothoracic Surgery, Queen Elizabeth Hospital, Birmingham for 1 month in early 1973

1973 to 1976 Registrar in Cardiothoracic Surgery Harefield Hospital

1976 Registrar in Cardiac surgery, National Heart Hospital 6 months

July 1976 to December 1977 Senior Registrar, Cardiothoracic Surgery Papworth Hospital, Cambridge

1978 Research Fellow, Brown University, Providence, Rhode Island, US

Jan 1979 to September 1979 Senior Registrar, Cardiothoracic Surgery St Bartholomew's Hospital, London

September 1979 to August 2005 Consultant Cardiothoracic Surgeon, Honorary Clinical lecturer, Freeman Hospital and University of Newcastle, Newcastle upon Tyne

June 1997 to May 1998 Locum Consultant Cardiothoracic Surgeon, Royal Hobart Hospital, Hobart, Tasmania

3. Member of The Society for Cardiothoracic Surgery in Great Britain and Ireland from 1975 to present.

Committee member
Post-Graduate Dean approximately 1998-2000
Responsible for the assessment of training programmes and trainees in Cardiothoracic Surgery
Vice-President 2000-2002
President 2002-2004

Member of the European Society for Heart and Lung Transplantation approximately 1986 to 2005.

Member of the European Association for Cardiothoracic Surgery approximately 1987 to 2005.

4. During my career I kept abreast of developments in Cardiothoracic Surgery by reading the relevant Journals, mainly the Journal of Cardiothoracic Surgery, The European Journal of Cardiothoracic Surgery, and the American journal of Cardiovascular and Thoracic Surgery. I also read individual articles in other journals. I attended scientific meetings in the UK, Society for Cardiothoracic Surgery and British Cardiac Society, Europe, European Association for Cardiothoracic Surgery and the European Society for Heart and Lung Transplantation and the United States, American Association for Thoracic Surgery. I also went on practical training courses in Mitral Valve surgery.
Within the Freeman Hospital we held regular Mortality and Morbidity meeting to review our performance as a department and individuals. Reviews were presented of relevant topics in Cardiothoracic surgery.

5. I have not provided evidence or been involved in any previous inquiries, investigations, criminal or civil litigation in relation to HIV, HBV, HCV or CJD.

Section 2: Your role at the Freeman Hospital

6. My primary role at the Freeman Hospital during my tenure as a Consultant Cardiothoracic surgeon was clinical. I had pre, peri and post-operative responsibility for my patients. This was shared as part of a team, with consultants in Cardiology, Thoracic Medicine and Anaesthesia/Intensive care. I also had emergency on-call duties on a regular rota. I had a minor part in the management of paediatric cardiac patients with a senior colleague for several years after my appointment until a consultant paediatric cardiac surgeon was appointed. From 1986, when the cardiac transplantation programme began, I was heavily involved with the harvesting of organs and their implantation. Again, the work was as part of an extensive team including the above specialists and Haematologists, Biochemists, Microbiologists, Pathologists, and Immunologists. All these responsibilities continued until the later stages of my career when I stopped taking part in the transplantation service. The team of Cardiothoracic consultants had regular meetings to discuss the running of the department to which I contributed. I was also the chairman of the Cardiothoracic Division in the 1980s. This involved liaising with other specialties and attending meeting with other divisional chairs. My responsibilities for other clinicians were limited to trainees. I provided career advice and practical training for those who worked directly with me.

7. The management structure at the Freeman Hospital consisted of the weekly surgeons meeting which dealt with the day-to-day running of the department. We also had input from the anaesthetic department as the cardiothoracic anaesthetists had responsibility for the running of the ICU. The next tier of management was the Cardiothoracic Division Committee which represented Cardiologists, Anaesthetists, Surgeons, Paediatric Cardiologists and had input from the nursing staff. The Chairman of this committee then attended the hospital medical committee which consisted of all the heads of department and senior management at the hospital. As far as I can remember, in the early days of my consultant career, my management was informal and mainly consisted of review by my peers. Later the more formal annual reviews, including clinical performance, were carried out by my head of department and, I think, by the senior medical officer. I also submitted my clinical results to The Society of Cardiothoracic Surgeons database.

Section 3: Knowledge of, and response to, risk of blood borne infections

8. At the start of my career as a consultant I was aware of the risks of Hepatitis associated with blood transfusion but, I suppose, assumed that all necessary steps were taken by The National Blood Transfusion Service and The Freeman Hospital Department of Haematology to minimise those risks. As time passed the risks became more defined, especially with HCV and HIV. I do not recall the mechanism of me becoming more aware of these problems developed other than by advice from my colleagues in Haematology

9. I refer to paragraph 7 above. I was aware of the risks in general terms only.

10. I do not remember any official advice and I was not part of any decision making in this regard.

11. I do not remember any enquiries or investigations taking place at the Freeman and, if there were such enquiries, I do not know what information came to light.

12. As a result of the contaminated blood problems with HIV, HBV, HCV various clinical methods were adopted to reduce the dependence on blood transfusion. These included autologous blood transfusion and several different methods of

red cell salvage and reuse. We also reduced the use of whole blood and, as time went on, used more blood products such as platelets, fresh frozen plasma (FFP) and plasma protein fraction (PPF).

13. Patients were warned that it was possible that they would require blood transfusion, but I do not recall how much detail was provided to them on the specific risks of HIV, HBV, and HCV.

14. I cannot comment on whether the steps taken by the Freeman Hospital in response to the risks of infection were adequate or appropriate as I was not fully aware of those actions which did not directly affect my surgical practice. I trusted my colleagues with expertise in the field to take the necessary actions. I do not have copies of consent forms for the relevant periods but, if the risks posed by contaminated blood were not presented to the patient, they should have been.

Section 4: Clinical practice

15. I do not have exact figures for the rates of transfusion among my patients but would estimate that a significant majority of my cardiac surgical patients undergoing major procedures on cardiopulmonary bypass would have been transfused. The figure for major thoracic surgical procedures would, I believe, be lower but still, possibly, a majority. I do not know the numbers of patients receiving blood components, but it was relatively uncommon.

16. I do not remember what guidelines were in force while I was working at the Freeman Hospital, for blood transfusion, in particular for warm blood transfusion. I am sure they changed over time as different risks became apparent and information of long-term consequences of transfusion appeared. While guidelines are very important, I believe that, in certain desperate circumstances, they do not cover the needs of the situation.

17. I do not know what specific policies were formulated at the Freeman and had no input into their production.

18. I believe that I complied with the guidelines but on one occasion I deviated as I felt the desperate situation warranted it.

19. It is correct that I used fresh warm blood on one occasion at the Freeman. It was only used when other available means to stem the bleeding had been exhausted. Blood was taken from donors who volunteered to give the blood. Previously in my career I had been involved in, but not responsible for, the use of fresh warm blood while a trainee at Harefield Hospital in Middlesex in 1973-6. I cannot remember how many times the procedure was used but I do remember that the donors were recruited from RAF Uxbridge. I have no knowledge of the screening procedures undertaken.

20. I used warm blood on one occasion in 1990 at the Freeman Hospital, in a patient who was bleeding heavily post-surgery despite all attempts to stop the haemorrhage. I cannot remember what other treatments were used and have no records available to me to cover the period. I would expect we would have administered FFP and platelets before deciding to try a transfusion of warm blood. The use of fresh, warm blood was rare but had been reported in the literature as effective in some cases.

21. As I described above, the use of FFP and platelet transfusions was the first option in the treatment of non-surgical bleeding during surgery. The development of cell savers to "clean" and recycle blood also helped. However, there were occasions when these failed and, in my mind, warm fresh blood was a last resort as a life saving measure.

22. I believe that the use of fresh warm blood was rare, but it is true that there was a view that fresh blood was beneficial in these circumstances as Dr Kesteven said. I have no knowledge of its use abroad. As I said under section 21, I had only come across this at Harefield as a trainee in the 1970s. Again, it was a last-ditch attempt to stop uncontrolled bleeding and save life.

23. I stopped using fresh warm blood after the case in 1990 following the warnings from Dr Kesteven and Dr Lloyd.

24. I was informed by Dr Kesteven and Dr Lloyd that they disapproved of the practice, and I did not use it again.

25.

a. I agree that the risk with warm blood is higher and accept that its use in this case was, in retrospect, unwise. I believed at the time that the patient was at very high risk of dying and believed that warm blood would help the situation.

b. I cannot remember what I thought of the risks at the time. The decision to use the fresh blood would have been taken in discussion with my colleagues in the operating theatre.

26. Generally, the sourcing of blood for surgery was the responsibility of the transfusion department. In this case, I cannot remember which individual was responsible.

27. The blood was obtained using standard donor bags obtained from the Haematology department. It is true that members of staff provided the blood. No other source of blood was used. As I have previously said this was a single case and was not repeated so there were no other sources of fresh, warm blood. I did not use the practice after warnings from Dr Kesteven and Dr Lloyd.

28. The Freeman was not involved in this practice. The response from Dr Kesteven suggests that they did not support the use of fresh warm blood.

29. The blood was obtained in the same way as used by the NBTS. I cannot comment on how the testing differed from the NBTS routine.

30.

a. I cannot remember how the donors were selected.

b. I cannot remember if or how they were screened.

c. I cannot remember whether the donors were asked about potential infections

d. I do not remember.

31.

a. I do not remember.
b. I do not know.

32. I do not remember such letters or any attempts to contact the DHSS etc.

33. I do not know if, when, or how surrogate testing was used

34. I do not know.

35. The patient was bleeding heavily. I cannot remember how we assessed the risks of transmitted disease.

36. I do not know.

37. I do not know.

38. I am not aware of any post-op testing.

39. I do not know.

40. No.

41. Not that I remember.

42. On the one occasion we used warm blood there was no opportunity to gain consent as it was an emergency.

43. See 42.

44. No. The patient died.

45. I do not know.

46. I do not know. There was only one patient and none following Dr Lloyd's letter.

47. I do not know.

48. I do not know what policies were in place at any hospital where I have worked.

49. I did not follow the single patient up because they died.

50. I refer to question 49.

51. I refer to question 49.

52. I refer to question 49.

53. Not to my knowledge. I refer to question 49.

54. The problem never arose. I refer to question 49.

55. I refer to questions 49 and 54.

56. I refer to questions 49 and 54.

Section 5: Look back

57. I refer to question 49.

58. No.

Section 6: Other matters

59. I have no issues to suggest.

60. I have no knowledge of the national situation regarding the supply of whole blood. I do not recall any deficit in the local supply of blood.

61. No.

Statement of Truth

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

GRO-C

Signed _____

Dated _14/10/2021_____