INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR GORDON LOWE

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 26 July 2021 to Ms Jane Grant, Chief Executive Officer, NHS Greater Glasgow and Clyde Health Board.

On 17 November 2021, the NHS Scotland Central Legal Office asked me to assist the Board by providing a response, on behalf of the Haemophilia Centre at Glasgow Royal Infirmary, to criticisms in a statement by Mr GRO-B on his management at the Glasgow Royal Infirmary between 1991 and 1994.

In preparing previous IBI request responses, I have requested viewing of complete case records from Glasgow Royal Infirmary. The Central Legal Office has informed me that this was not allowed by the Inquiry in the case of Mr GRO-B, and instead photocopied case records were sent to me. I am not confident that the copied records I have been sent are a full set.

1.1.At paragraph 12 of Mr GRO-B 's statement, the witness states that he has recently found out he had been tested for hepatitis C (HCV) in 1991 and 1993 without his knowledge and therefore without consent.

I do not see this wording in paragraph 12 of Mr GRO-B 's statement.

I also note paragraph 14 of Mr GRO-B 's statement: " I believe that the testing for HIV was without consent. Apart from that I feel that consent has been obtained appropriately." This presumably includes testing for hepatitis C.

The photocopied case records include my clinic notes and letter to Mr GRO-B 's general practitioner from his first attendance at the Haemophilia Clinic on 12 April 1990, following referral from the Edinburgh Haemophilia Centre. He had been diagnosed as HIV positive in Manchester in June 1985. We agreed a comprehensive care plan, including: a new Haemophilia Card; continued home treatment with SNBTS factor VIII concentrate; 3-monthly clinic review with monitoring of his HIV status by tests for HIV activity and antigen, T cell lymphocyte subsets; testing for hepatitis B and non A,non B (liver function tests); availability of Centre counselling; and physiotherapy and dental reviews (WITN7116011).

I note Mr GRO-B 's statement (para10) that HCV testing was discussed with him by myself when it became available and whether he would wish to be tested. I recommended testing, in accordance with UKHCDO guidance, and this was performed. From the case records this can be dated as 12 March 1991. This test was reported as negative, and I informed Mr GRO-B and his general practitioner of this at his next clinic review on 27 June 1991 (WITN7116012).

The case records indicate that Mr GRO-B agreed at clinic review on 2 December 1991 to participate in the clinical surveillance study of SNBTS high-purity factor VIII concentrate (produced initially in collaboration with the Blood Product laboratory in Lille, France). This study involved reporting clinical efficacy in treating or preventing bleeding; and also monitoring of transfusion transmitted infections including HIV, hepatitis A, hepatitis B, and hepatitis C (WITN7116013).

As noted by Professor Tait in his letter to Mr GRO-B of 6 August 2018 (WITN 2117005), two further hepatitis C antibody tests were reported as positive on 18 June 1993 and 13 August 1993. I agree with Professor Tait's view that the negative result of the hepatitis antibody test of 21 March 1991 was due to the fact that in some patients with HIV coinfection, the associated immune suppression meant that some patients did not produce the hepatitis antibody in the early hepatitis antibody tests. It is therefore likely that Mr GRO-B 's hepatitis C infection was acquired before the viral inactivation of factor VIII concentrates in the mid-

1980s, from his treatment at the Manchester Royal Infirmary Haemophilia Centre. The safety of SNBTS factor VIII concentrates from hepatitis C and other transfusion transmitted infections in a study of previously untreated patients was reported by Scottish Haemophilia Centre Directors in 1993 (Bennett, B., Dawson, A.A., Gibson, B S., Hepplestone, A., Lowe, G D.O., Ludlam, C.A., Mayne, E.E., Taylor, T. Study of viral safety of Scottish National Blood Transfusion Service factor VIII/IX concentrate. Transfusion Medicine, 1993, 3, 295-298.)

The case records confirm that I informed Mr GRO-B at clinic review on 18 March 1994 that two consecutive HCV antibody tests were positive, and discussed the implications, including risk of progressive chronic liver disease, and risk of transmission by blood or sexual practices. While his liver function tests had been normal, we agreed that he be referred to Dr J. Mackenzie's gastroenterology clinic for monitoring and management of hepatitis C; in accordance with UKHCDO guidance. (WITN7116014). A liver ultrasound scan reported on 29 July 1994 that the liver appeared normal. From 1995, Haemophilia Centre policy was that in patients co-infected with HIV and HCV, management of both infections, including antiviral treatments, would be co-ordinated by the Infectious Diseases Department: initially Dr A Pithie at Ruchill Hospital; then from 2000 by Dr A. Seaton at the Brownlee Centre, Gartnavel General Hospital, as described by Mr GRO-B

1.2.At paragraph 14 of Mr GRO-B 's statement, the witness states that he believes he was tested for HIV without his knowledge and therefore, without consent.

I presume that Mr GRO-B refers to his first testing for HIV in 1985 at Manchester Royal Infirmary.

As noted in 1.1 above, when Mr GRO-B first attended Glasgow Royal Infirmary on 12 April, 1990 we agreed a comprehensive care plan, including 3-monthly clinic review with monitoring of his HIV status by tests for HIV activity and antigen.

1.3. At paragraph 17 of Mr GRO-B 's statement, the witness states that when he required a GRO-B in 1994 as a result of thrombocytopenia, he was not told that this was attributed to having HIV.

Mr GRO-B 's third Exhibit (WITN2217006; letter of 13 July 1994) summarises the treatment of Mr GRO-B 's thrombocytopenia: a low platelet count causing bruising and nose bleeds. This was treated with initially with intravenous immunoglobulins; then alternative treatment of thrombocytopenia was discussed with Mr GRO-B by myself, Dr Pithie from the Infectious Diseases Department, and my Co-Director Dr Walker who as a Consultant Haematologist specialising in haemostasis and thrombosis had much experience of treating immune thrombocytopenia. GRO-B rather than steroids which may promote opportunistic infections in patients with HIV infection, was fully discussed as a treatment with Mr GRO-B for thrombocytopaenia, who agreed that this be performed by Mr J. Anderson on 21 July1994, with success in normalising Mr GRO-B 's platelet count.

Thrombocytopenia has many causes. It occurs in about 20% of symptomatic HIV patients, in whom it is called HIV related thrombocytopenia: the mechanism is not clear. Whether or not HIV was the cause of Mr GRO-B 's thrombocytopenia, its management and cure by GRO-B was appropriate and successful.

1.4. At paragraph 42 of Mr GRO-B 's statement, he states that his Glasgow Royal infirmary records appear to be incomplete.

I agree with Mr GRO-B that the photocopied Glasgow records provided to me are very jumbled, difficult to follow, and may be incomplete. This is why I have requested viewing of complete, original case records from Glasgow Royal Infirmary; both in this and in other requests for responses by the Inquiry. I repeat this request.

Statement of Truth

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

Signed GRO-C

Dated 25 March 2022

Table of exhibits:

Date	Notes/ Description	Exhibit number
12 April 1990	Clinic notes and letter	WITN7116011
12 March 1991 & 3 July 1991	Clinic notes and letter	WITN7116012
2 December 1991	Clinic notes	WITN7116013
9 May 1994	Clinic notes and letter	WITN7116014