Witness Name: Sir Liam Joseph Donaldson
Statement No.: WITN7557001
Exhibits: WITN7557002 - WITN7557007
Dated: 14/12/2022

**INFECTED BLOOD INQUIRY**

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**WRITTEN STATEMENT OF SIR LIAM JOSEPH DONALDSON**

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I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 18 October 2022.

I, Sir Liam Joseph Donaldson, will say as follows:

## Section 1: Introduction

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

   1.1 Liam Joseph Donaldson MB ChB, MSc (Anatomy), MD, FRCS (Ed), FFPH, FRCP, FMedSci. My address is GRO-C GRO-C I was born on GRO-C 1949.

2. **Please set out your employment history with dates if possible, including the various roles and responsibilities that you have held throughout your career.**

***Current main appointments***

| Date Span | Professional Body/Association | Position |
|---|---|---|
| | | |
| 2021 - date | North East and North Cumbria Integrated Care Board | Chairman |
| 2016 - date | London School of Hygiene and Tropical Medicine | Professor of Public Health |
| 2015 - date | Chatham House | Associate Fellow |
| 2011 - date | World Health Organisation | Patient Safety Envoy to the Director General |
| 2010 - date | Independent Monitoring Boards: Global Polio Eradication and Polio Transition Programmes | Chairman |

***Past appointments***

| Date Span | Professional Body/Association | Position |
|---|---|---|
| | | |
| 2009 - 2019 | Newcastle University | Chancellor |
| 2015 - 2020 | Cardiff University | Honorary Distinguished Professor |

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|---|---|---|
| 2010 - 2015 | Imperial College London | Chair in Health Policy |
| 2010 - 2012 | National Patient Safety Agency | Chair |
| 1998 - 2010 | Department of Health, United Kingdom Government | Chief Medical Officer, England; UK Government Chief Medical Adviser |
| 1994 - 1998 | NHS Executive: Northern and Yorkshire | Regional Director and Regional Director of Public Health |
| 1994 -1996 | Northern and Yorkshire Regional Health Authority | Regional General Manager and Regional Director of Public Health |
| 1986 - 1994<br><br>1992 - 1994<br><br><br><br><br>1986 - 1992 | Northern Regional Health Authority<br>Northern Regional Health Authority | See positions below<br><br>Regional General Manager and Regional Director of Public Health<br><br>Regional Medical Officer and Head of Public Policy |
| 1972 - 1986 | Health Authorities and Universities in Bristol, Birmingham and Leicester | Posts in Hospital Medicine and Surgery, General Practice, Public Health and Academic Medicine |

3. **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.**

3.1 Apart from my past and present employment roles, I am a Fellow or Honorary Fellow of nine medical royal colleges, I am a Fellow of the Academy of Medical Sciences, I am an honorary graduate of 17 universities. Any of those organisations may have had research or commercial activities that relate to the Inquiry's Terms of Reference. My positioning in relation to all of them is such that I would have had no personal knowledge or involvement in such matters.

4. **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.**

4.1 I do not think anything I have done fits into these categories.

## Section 2: Your role at the Northern Regional Health Authority

5. **Please describe the roles, functions and responsibilities you had at the Northern Regional Health Authority ("NRHA") during your period as:**
    a. **Regional Medical Officer;**
    b. **Head of Clinical Policy Division;**
    c. **Director of Public Health;**

5.1 This section addresses questions 5a-c.

5.2 The Regional Medical Officer and Head of Clinical Policy roles were combined in the job that I was appointed into in 1986. The title of the Regional Medical Officer element of the job was changed to Regional Director of Public Health across the country after a review of the public health function in 1988, carried out by the then Chief Medical Officer, Sir Donald Acheson.

5.3 It is important to emphasise that the Regional Medical Officer/Regional Director of Public Health was not a "mini-CMO." The responsibilities of the post were compartmentalised and no more or less important than the roles of the other officers who, like me, reported to the Northern Regional Health Authority Chairman and Board through the Regional General Manager.

5.4 In the role, I did not have oversight of everything medical. As its medical members, the Northern Regional Health Authority had three knowledgeable and influential individuals. Each was quite long-serving, which was a great advantage for continuity of policymaking, particularly in medical and scientific areas.

5.5 Our board chairman was Professor (later Sir) Bernard Tomlinson. He was a distinguished professor of pathology (at a time before full sub-specialisation, when pathology often included histopathology, chemical pathology and haematology).

5.6 I do not recall the precise date, but Professor (later Sir) Michael Rawlins joined the board in or about 1989/1990 and later became Vice-Chairman. He was a professor of clinical pharmacology in Newcastle University and a physician in the Newcastle hospitals. He held a number of local and national committee roles over the years and was well-connected internationally.

5.7 Dr Alex Dellipiani was a Consultant Physician at North Tees hospital and brought great experience from the perspective of a frontline clinician in one of the most socially and economically deprived parts of the region.

5.8 My input to board discussions was in the form of opinions and not “advice” in the way I operated as CMO later. My medical view went into the “melting pot” if a medical issue was discussed at a board meeting, I was often outranked by the statutory, and sapiential, authority of the medical board members (including the Chairman). I was in my thirties, the youngest Regional Medical Officer in the country. At the time of appointment, I had never attended a board meeting of any kind, I had never met a minister, I had never received or written an official letter. I had never spoken to a journalist. I was given guidance notes (Exhibit WITN7557002, Exhibit WITN7557003, Exhibit WITN7557004 and Exhibit WITN7557005) on how to behave in a board meeting as well as other useful aides memoirs.

5.9 Looking back on those years, I feel very grateful for the kind and wise mentorship of Professor Tomlinson.

5.10 Within the management team, I was initially the junior member and not always invited to key meetings, not out of malice but because I think it was felt that I would not have much to offer at the time. My predecessor’s role had not been valued by the Regional General Manager, J Douglas Hague. There was an inner group who came up with the important policy and resource allocation proposals to put to the board. That inner group comprised the Regional General Manager, the Director of Planning and the Director of Finance.

5.11 Gradually, over the years, as I demonstrated my abilities and personal qualities, my credibility and influence both with the board and the management team increased.

5.12 A major responsibility of the Regional Medical Officer at the time of my arrival in 1986 was a personnel one. The Northern Regional Health Authority held the contracts of all the consultants in the region except for those in Newcastle. There was a similar arrangement across the country in which regional health authorities held most of the consultant contracts and “teaching districts” held their own consultants’ contracts. I was supported by a very able medical staffing department.

5.13 All dimensions of this bureaucratic system pitched me into a heavy workload from day one, including dealing with unreasonable behaviour on the part of a small number of doctors, many of whom were much older than I. For example, in the first few weeks of the new job I had to coordinate the holiday absences of a two-man consultant team who had not spoken to each other for a decade. The composition of consultant appointment committees (Advisory Appointments Committees) was laid down in statute. A Regional Health Authority member had to be in the chair. It was expected that I should also attend to provide administrative support to the process. This became so time consuming that, in due course, I had to reduce the number that I attended. Eventually, this seemed to be accepted by the members, and freed up more time to deal with the many challenges of service development in this large region.

5.14 During 1987, just over a year after taking up my post as Regional Medical Officer, the Cleveland child sexual abuse crisis blew up. The Northern Regional Health Authority was the holder of the contracts of the two consultant paediatricians whose actions had led to the crisis. This was the focus of national and international attention and generated media coverage that ran for a very extended period of time. I was involved in all aspects of the crisis, managing a hugely complex and rapidly developing situation on behalf of the Authority. My role involved investigating the doctors, organising professional panels to review cases, handling huge media interest, listening to the views of many doctors, preparing evidence for the Butler-Sloss public Inquiry, attending the Inquiry's hearings, dealing with the two doctors' contractual situation including disciplinary hearings and High Court proceedings.

5.15 This Cleveland-related work dominated my time for 18 months. Other regional officers took over substantial tranches of my other work during this time. One of the public health doctors in Newcastle University dealt with medical issues at times when I was unavailable.

5.16 After this period, I led work across a wide range of domains to address longstanding poor population health and to improve the quality of services in the Northern Region.

**d. Executive Director**

**and explain how these changed over time.**

5.17 This section addresses question 5(d).

5.18 I was not an Executive Member of the Northern Regional Health Authority until 1 April 1991 when changes brought in by the National Health Service and Community Care Act, 1990 created boards with executive and non-executive members. Between 1986 and the end of March 1991, my post and that of the Regional General Manager and other members of the management team was an "officer," not a member, of the Authority. I attended Board meetings, I participated in discussions but was not a party to decisions made by the Board and I was not entitled to vote.

5.19 In 1992, I was appointed, through open competition, to the post of Regional General Manager of the Northern Regional Health Authority. Less than two years later, the Authority was merged with the Yorkshire Regional Health Authority and I was appointed through competition to the same role in this. Apart from the important work of maintaining continuity of services in this huge geographical area, most management activity was directed to a further reorganisation that abolished Regional Health Authorities. As a result of this, in 1996, I then became a Regional Director in the NHS Executive (within the Department of Health) and thus a civil servant rather than a NHS employee.

**6. Please describe the organisation of the NRHA during the time you worked there, including:**

**a. its structure and (in broad terms) its staffing and in particular to whom you were accountable;**

6.1 A core group of officers of equal status, including myself comprised the senior management team, was accountable to the Regional General Manager and, through him, to the Northern Regional Health Authority Chairman and members. I refer again to my answer to Q5 at paragraph 5.3 above.

6.2 Apart from myself, the regional officer roles covered Planning, Finance, Nursing, Estates, Management Services, Personnel. Over the years, there were some small changes to the titles and content of these posts, but the major change came in 1991 when officers of Regional Health Authorities became Executive Directors. See also my answer to Q5 a-d.

**b. how the NRHA was funded and how this changed over time;**

6.3 This replicates Q10. Please see my answer to that.

**c. its remit, including the geographical area it covered and the hospitals and haemophilia centres within its area;**

6.4 The origin of the organisation dates back to when the NHS was established in 1948. At that time, it was the Newcastle Regional Hospital Board. In 1974, it was reorganised unifying the then tripartite structure of hospitals, family practitioner services and public health (and some other former local authority services) and this replaced the Newcastle Regional Hospital Board with the Northern Regional Health Authority. The geographical jurisdiction remained unchanged apart from some parts of Cumbria and North Yorkshire that were affected by boundary changes.

6.5 The Northern Regional Health Authority's function was to ensure the effective provision of health care throughout the region, and to co-ordinate the local NHS activities of Area Health Authorities (later District Health Authorities), Community Health Councils, Family Practitioner Committees and individual hospitals. There were several reorganisations of this local NHS

organisational layer during the time I was in the region. Local NHS organisational structures and titles changed.

6.6 Reorganisations of the NHS were achieved through primary or secondary legislation and applied to all health regions of England. They are well set out in publicly available documents, proceedings of Parliament and numerous books about NHS history. I have set out the broad position here, but if the Inquiry wishes chapter and verse on NHS reorganisations from 1970 to 2000, I recommend commissioning a report from one of several living experts. The Northern Regional Health Authority served a population of nearly three million people and covered Cumbria, Northumberland, Tyne and Wear, Durham, Cleveland and part of North Yorkshire. The headquarters of the Authority was in Newcastle-upon-Tyne.

6.7 It is not possible to give a fixed number of hospitals because there were frequent service reconfigurations, mergers of hospital administrations, closure of hospitals, and opening of new ones. Cottage hospitals were especially prone to closure and change of use. I estimate 16-18 general hospitals and 5-6 mental health hospitals during the first five years that I was in post and smaller numbers later. As an illustration the current Integrated Care Board for the North-East and North Cumbria (established on 1st July 2022) covers mostly the same boundary as the Northern Regional Health Authority did and contains 13 NHS Foundation Trusts; two are mental health services, the remainder are acute hospitals. If the Inquiry wishes to see a year-by-year tally, this could be pieced together from Tyne and Wear archives and any similar archive for Teesside, County Durham, Northumberland and Cumbria. There was one Haemophilia Centre located in the Royal Victoria Infirmary, Newcastle-upon-Tyne.

**d. whether the NRHA was subject to any form of regulation and if so, what;**

6.8 This is a rather broad question on which there is a wide range of public information available. If the Inquiry's interest is in all aspects of regulation of

the Authority, then I would direct it to public archives covering the period 1986-1992, for example on health and safety at work legislation (the headquarters building in the grounds of Walkergate Hospital in Benfield Road), the radiation hazard and protection legislation (the Regional Medical Physics Service), legislation covering the safety of vehicles, including ambulances. Food was also prepared and served by the Northern Regional Health Authority and information on food hygiene legislation and regulations is freely available in public sources.

6.9 If the Inquiry wishes alternatively or additionally to know whether the performance of the Northern Regional Health Authority as a health organisation was regulated the answer is “no.” Regulation of health bodies in that way only came in during 2004 with the creation of the Commission for Healthcare Audit and Inspection (also known as the Healthcare Commission). This body became responsible for inspecting standards of NHS care and investigating serious failures of quality and safety. After several reorganisations, the successor body is currently known as the Care Quality Commission (CQC).

**e. the role of the Regional Scientific Officer within the NRHA;**

6.10 In my time, the Regional Scientific Officer was Mr G.E. Whittaker, now deceased. He was originally appointed by the Newcastle Regional Hospital Board as the Regional Administrative Scientific Officer.

6.11 Thus, Mr Whittaker had unrivalled length of service in a regional role dating back to the time when the organisation of the NHS was still “tripartite”: hospitals, family practitioners, public health. He had an intimate knowledge of people and services throughout the region.

6.12 He had a roving commission within the Authority on scientific and technical matters. He was involved in this capacity with the Regional Blood Transfusion Service and the Regional Medical Physics service. Good examples of his involvement with the former are shown in his idea to set up a

plasmapheresis station in Eldon Square Newcastle (NHBT0101335_016) and the wide-ranging and detailed technical areas set out in a five-page letter on policy (NHBT0101335_052).

**f. the nature and extent of any relationship between the NRHA and the Blood Products Laboratory ("BPL").**

6.13 The primary relationship of the Northern Regional Health Authority with the BPL was through Dr Lloyd, the then Director of the Blood Transfusion Service (see further at my answer to Q12, paragraph 12.2). It is likely that the Regional Scientific Officer had some professional links there or had visited the facility, but I was unaware of that. It is unlikely that the Northern Regional Health Authority Chairman or board members had any independent relationship with BPL because they would have viewed it as a technical agency.

**7. Please describe, as far as you are able, the extent to which the NRHA had regular dealings with the Department of Health and Social Security (later Department of Health) and the nature of such dealings.**

7.1 Firstly, each of the 14 Regional Health Authorities related to the Department of Health and Social Security (later Department of Health) through an annual review meeting of the Region's plans and performance and this process was led by a senior official of the Department. There were also regular meetings of regional officers with similar portfolios at which senior Departmental civil servants would discuss their policy areas to receive feedback on their proposals, and to review and agree how actions should be implemented through the regions down to operational level. On top of this, there was a free flow of contact between Regional Health Authority staff and civil servants on particular topics as well as about problems that were arising. In a complex area of health care, this could involve regular interactions about a particular programme of work. For example, I recall that the policy of moving people with mental handicap (now called learning disability) from large

hospitals to community units was a complex and multi-faceted programme of change. The relationship between the centre and the regions was not strictly hierarchical but key decisions would often need to be checked out or signed off by the Department. In the example given, the Secretary of State might be being lobbied by an MP colleague about the location of such a community facility and the civil servant in the Department with the policy lead would be mindful to ensure that regional officers did not ignore such a Ministerial interest in a programme of this sort.

7.2 Secondly, some Regional Health Authorities had more influence and were listened to more closely by the Department than others. It was always said that the Thames regions had more access to Whitehall; after all they were on the spot geographically. Beyond that, there were some regional officers who seemed to be in the know and others that had a lot more clout. As in other walks of life, much of this came down to personal relationships: people who had worked together in the past, or had been at the same school or university were able to remain close when their counterparts were left more at the periphery of power structures. My perception was that the Northern Regional Health Authority, whilst it had perfectly effective working relationships, was never part of the inner circle.

7.3 Thirdly, the growing importance of the NHS element of the Department was highly significant. In the early 1980s, there was really no NHS headquarters. Through the mid- to late-1980s, the NHS had moved to its third chief executive working with a large team of managers and a board. This NHS Management Executive (it has had various names, currently called NHS England) was still located within the Department of Health but was afforded much more autonomy and power over NHS decisions. Inevitably, because of the high public profile of the NHS, it was to the NHS Chief Executive that the Secretary of State and other Ministers were turning on a daily basis. Increasingly the NHS Chief Executive's name was appearing in the Prime Minister's diary. There was also, for a time, a Policy Board chaired by the Secretary of State. As the NHS Executive grew and evolved, the Northern Regional Health Authority fell into lockstep with it and had more uneven

contact with the pure civil service parts of the Department of Health. The annual regional review meetings were the business of the NHS Executive, no longer led by the Department of Health's senior civil servants.

7.4 Fourthly, the relationship of the Northern Regional Health Authority with the Department of Health on public health and scientific matters was completely different to that on the NHS. In its work on the government's NHS agenda, there was much more joint working with the centre and considerable flexibility for Regional Health Authorities on how results were achieved. This encouraged a degree of innovation in how services were designed and delivered. For example, it enabled me to establish a fast-track cataract treatment centre in Sunderland rather than waiting for the NHS Executive to establish such an approach for the whole country.

7.5 In the area of public health and science, especially where public protection was concerned, the centre was firmly in control of the way in which problems were dealt with and interventions made. To a large extent this is the same today, as is evident in the way that vaccine policies were formulated for combatting COVID-19. It reflects the need for risks and risk mitigation strategies to be clearly identified and to be examined by the range of scientific committees and expert scientific advisers that are part of the machinery of government. It also enables international expertise, policies and experience to be part of deliberations and decision-making. It allows a consistent approach to be taken to public risk communication.

7.6 Thus, whilst the Northern Regional Health Authority could set up a cataract centre, it could not have taken steps to clear beef and beef products from supermarket shelves throughout the north-east of England when there was speculation and public concern that Bovine Spongiform Encephalopathy (BSE) might transmit to people. This was because, at the time, the national scientific advice was that the infective agent would not cross the species barrier. National policy in that matter was clear. Nor could the Northern Regional Health Authority have set up a population screening programme for prostate cancer because the National Screening Committee had ruled against

it. I am not disagreeing on this example, simply seeking to show that in such areas of health policy there was a tight central grip.

7.7 A good example of the centre's expectation of national consistency and policy compliance on public health and science matters is Deputy CMO Harris's admonishment of the Director of the Public Health Laboratory in his letter of 19th March 1985 (DHSC0002263_027). Screening blood for HIV ahead of other parts of the country was said to be at risk that it "*could severely embarrass other transfusion centres who are unable to screen donations until commercial tests now becoming available have been properly evaluated."* Dr Codd, the benighted Director of the Newcastle Public Health Laboratory was thus condemned as perpetrating "*entrepreneurial exercises*" when it could be argued that he thought that he was acting as quickly as possible to protect patients when a new intervention became available. As I explain in my answer to Q28, I was a Senior Lecturer in Epidemiology at Leicester University in 1985 and had no involvement in the screening.

7.8 The concept of the "precautionary principle" dates back a long time in history, without necessarily being labelled as such, covering inaction in areas like asbestos. Debate on it in UK public policymaking did not properly emerge until after publication of the BSE Inquiry. It remains a difficult area for elected politicians and the civil servants supporting them to deal with, COVID-19 lockdowns being just the latest example.

**8. Did the Secretary of State for Health hold regular meetings with the Chairs of the Regional Health Authorities and what if any involvement did you have? Please set out your understanding as to the purpose of these meetings.**

8.1 Although I was never at these meetings between the Secretary of State and the Chairs of the Regional Health Authorities, the Northern Regional Health Authority Chairman, Professor Bernard Tomlinson, used to chat to me about the meetings when he returned from them. He also gave regular insights into the background and personalities of the other Regional Chairs.

He had a raconteur style that meant that things that he said come to mind even after all the years that have passed. On this basis, I feel able to assist the Inquiry with what I believe to be a reasonably accurate account of the *modus operandi.*

8.2 It is my understanding that the Secretary of State (usually with other health ministers in attendance) did meet regularly with Regional Health Authority Chairs. I did not attend those meetings, nor did my regional officer colleagues, nor to my knowledge did those from any of the other 13 regional officer teams. I am not certain but think it is likely that the chief executive of the NHS and some of his executive team did so. I am not sure if the Chief Medical Officer attended regularly. By the time I became Chief Medical Officer, Regional Health Authorities had been abolished.

8.3 I cannot be sure which matters featured on the agendas for these meetings, but it would almost certainly have involved a mixture of strategic items (e.g., planned or forthcoming white papers), performance reviews (e.g., covering targets for waiting list reduction), the financial position of the NHS and any expected policy announcements. In addition, in my (subsequent) experience of the way the Department of Health operated, it would always have been possible for senior civil servants to ask the Secretary of State's office for particularly important items to be included for discussion with the Regional Health Authority Chairs.

8.4 Aside from such formal committee-style meetings, it is my understanding that there was regular contact between the Secretary of State, other Health Ministers and the Regional Chairs. The group elected a "chair of chairs" and I understood from Professor Tomlinson that this individual (in my time Sir Donald Wilson from the Mersey Region) would have contact with ministers on an *ad hoc* basis on at least a weekly frequency. It is important to remember that the appointment of Regional Health Authority Chairs was directly by the Secretary of State rather than by an independent process. As such, they were widely regarded as political appointees. That is not to suggest that all were "card carrying" members of the party of government nor that they were

unprincipled in any way. However, they were generally expected to be supportive of, and help to implement, government policies. I understood from Professor Tomlinson that many of the formal meetings (referred to above) ended with a dinner that, over time, enabled a positive chemistry to develop between the Ministers and the Chairs.

**9. What degree of oversight or influence did the DHSS/DH have over the NRHA and its decision-making?**

9.1 In areas of risk and public safety that were operating across the country, the decisions were largely nationally determined with little room for regional autonomy. On the NHS, there was more room for regional interpretation and local adaptation of national policy and for innovation. See also my answer to Q7.

**10. Please set out your understanding of how funding was allocated to the NRHA.**

10.1 For most of my time in the Northern Regional Health Authority, I was not in a position in which I was involved in resource allocation matters. This fell to other regional officers. However, as a member of the team, I did have a general understanding of how it operated.

10.2 My understanding was that Regional Health Authorities were allocated money by the Department of Health and Social Security/Department of Health on a weighted population basis (taking account of size and age structure). Once the NHS Executive became established within the Department of Health, in practice, dealings between the Regional Health Authorities and the centre on money were led by officers of the NHS Executive. It is similar in 2022, whereby NHS England (technically sitting within the Department of Health and Social Care) deals with NHS resources entirely.

10.3 I recollect that it was a constant and bitter bone of contention for Northern Regional Health Authority members that the national allocation

formula did not contain a proper adjustment for deprivation and rurality. Thus, they considered the allocation process unfair, biassed to the south and politically motivated.

**11. If the NHRA wanted to seek additional funding from the DHSS/DH, what process would be followed?**

11.1 My understanding and experience is that the "centre" would rarely if ever make additional in-year financial allocations to help regional health authorities meet management cost pressures. It would have been regarded as bad management to have complained about such cost pressures. They would certainly never make allocations to shore up an Authority's "running costs" (the directly managed regional services were part of such management costs). Additional "hypothecated" funding allocations were regularly made by the Department of Health or NHS Executive to deliver particular outcomes or for a clearly defined purpose (e.g., waiting list reduction). Such money could not be used for other purposes.

## Section 3: Relationship between the NRHA and the Newcastle Regional Transfusion Centre

**12. Please describe the relationship between the NRHA and the Newcastle Regional Transfusion Centre. Please set out, as far as you are able, the extent to which you, and/or the NRHA, had regular dealings with the Newcastle Regional Transfusion Centre ("Newcastle RTC") and please describe the nature of those dealings.**

12.1 The Regional Blood Transfusion Service (including the Transfusion Centre) was one of three regional services directly managed by the Northern Regional Health Authority. The other two were the Northumbria Ambulance Service and the Regional Medical Physics Service. All other so-called "regional services" were managed by the local health authority where they were located, though they served all three million people wherever they lived.

Most were based in Newcastle-upon-Tyne; for example, heart surgery was based at the Freeman Hospital.

12.2 Each of the three services was headed by a person of considerable professional "weight": Dr Huw Lloyd (Blood Transfusion), Mr Laurie Caple (Ambulance Service) and Professor Keith Boddy (Medical Physics). Thus, the Regional Health Authority managed them with a "light touch" in respect of oversight and second guessing, trusting their judgement and not seeking to micromanage. However, they were each accountable to a regional officer who was supported by the Regional Scientific Officer; the latter had broad oversight of each service and any big decisions that it took in respect of technical, scientific and clinical matters. The regional officer accountable for the Blood Transfusion Service was the Director of the Management Services Division (NHBT0001580, page 29, paragraph 3.4.2). That accountability was limited because until April 1991, the Northern Regional Health Authority Chairman and Board were ultimately accountable because regional officers were officers who attended board meetings and not executive members sharing in decisions that carried public accountability. I refer again to my answer to Q5 (a)-(d).

12.3 Thus, the Northern Regional Health Authority's "dealings" with the Regional Transfusion Centre were through the Northern Regional Blood Transfusion Service on aspects of performance, service needs, funding and national policy requirements. Straightforward matters would be dealt with by the Director of Regional Blood Transfusion, and he would update the Director of Management Services and the Regional Scientific Officer at their routine regular meetings. The Director of Regional Blood Transfusion would bring bigger, more complex or contentious issues to the attention of these latter officers as they arose. Resource matters would draw in the Director of Planning (who dealt with prioritisation across the board) and the Director of Finance. Major decisions on the service would be considered by the Chairman and members of the Northern Regional Health Authority at their board meeting on the basis of papers prepared by officers.

**13. Please explain, as far as you are able, the extent to which you, and/or the NRHA, had any oversight or influence over decisions taken by the Newcastle RTC.**

13.1 I feel that my answer to Q12 also provides a response to this question, bearing in mind that I was not in charge of the Northern Regional Health Authority at that time. I refer again to my answer to Q5 (a)-(d).

**14. Please explain how, in broad terms, funding decisions were taken by the NHRA in relation to the Newcastle RTC (you may find Appendix 2 of TYWE0000064 of assistance). What process would be followed in the event of the RTC seeking further funding?**

14.1I was not in charge of, or party to, funding decisions made by the Northern Regional Health Authority at that time. I will do my best to answer as a former Northern Regional Health Authority team member.

14.2 As I mention above in paragraph 12.3, the Regional Transfusion Centre was part of the Regional Blood Transfusion Service and, as such, was one of three directly managed regional services (the others were Regional Medical Physics and Northumbria Ambulance). It sat in a management services budgetary category that also paid for salaries and infrastructure of Regional headquarters staff, the costs of running the board, the cost consultants' salaries (other than those in Newcastle) and the costs of other functions that I cannot remember in detail.

14.3 The important point is that, like every other NHS service, the Regional Blood Transfusion Service had to be seen as in competition for scarce resources. All three services had strong cases when their needs and demands were reviewed. Redistribution from one to another had consequences. To take money from the ambulance service might have slowed response times in a region already struggling with the distance to reach rural communities quickly in cases of life and death emergency. To take money from medical physics might have reduced capacity to check, calibrate

and quality assure radiation treatments and affect the speed of onset of treatment of 70 types of cancer and a huge array of diagnostic tests.

14.4 When the Regional Transfusion Centre requested more money this would come through the Director of the Regional Blood Transfusion Service and be evaluated by the team of officers described in my answer to Q12 at paragraph 12.3 above, and then go to the Northern Regional Health Authority Board for decision, usually as part of an overall consideration of headquarters budgets, as I have stated. The Board paper NHBT0001580 gives a good insight into the context of this process of decision-making.

**15. Dr Huw Lloyd stated in his statement (WITN6935001) that the NRHA was generally opposed to funding new staff positions – was this correct and if so what was the reason for this?**

15.1 Dr Lloyd was an excellent and committed Director and always wanted the best for his service. I was not aware that he held this view. I do not recall this policy ever being espoused within the Northern Regional Health Authority. It would be unusual for a pre-emptive policy view like that to be held and certainly not at board level. Situations changed, available resources changed and business cases coming to the board would be considered by members on their merits in the prevailing circumstances. It may be that an officer within the regional management team had expressed an opinion to Dr Lloyd and it became writ large.

15.2 I think it helpful to provide the context of Dr Lloyd's quote by the Inquiry given above. He states at paragraph 10 (b) of his statement (WITN6935001)

> *"For most of the time funding, both operational expenditure and capital, was provided directly from the RHA, based on a yearly submission from the Centre. There was usually considerable discussion over capital requirements.*
> *The RHA was generally opposed to funding new staff positions. I later was told that this arose from my predecessor's decisions to not reduce*

*laboratory staffing levels following the introduction of automated blood grouping.*

*During my time as Medical Director and later Chief Executive, this was not an issue as the implementation of computerization and various reorganizations resulted in a reduction in total staffing."*

**16. In December 1989, the Sunday Times reported that the Newcastle RTC applied to opt out of regional control to become a self-managing trust as part of the government's NHS reforms, but that the Department of Health refused permission. In the article, Dr Lloyd was reported to have stated that self-management would have allowed the Newcastle RTC to "rebuild its staffing and image" (NHBT0005471; see also the reference to the Newcastle expression of interest in opting out having been "put on ice" on page 2 of SBTS0000096_076). What if any knowledge or involvement did you/the NRHA have in this matter?**

16.1 It appears that the focus of the *Sunday Times* article is given by its headline "*Crisis of dwindling blood donors"* speculating that the cause was "as a result of fear of AIDS and the spartan image of blood donor clinics." That seems to be the context and thus Dr Lloyd, and others from transfusion centres, were approached primarily to comment on reasons behind reduction in donor numbers. The Inquiry asks about my involvement and that of the Northern Regional Health Authority with the "bid" for Dr Lloyd's service to become self-governing. This is mentioned in the article.

16.2 I remember these events reasonably well. This was a tightly controlled central government process and a flagship policy of Mrs Thatcher's administration. The Regional General Manager, Mr Hague, appointed a small review team to oversee all aspects of implementation of the reforms (of which NHS Trust status was one part). Management consultants were engaged to provide further support to what was a complex programme of change. I sat on some of the panels judging the management consultants' pitches for the contract. Through this involvement, I was privy to some of the inside information. The review team received and evaluated "expressions of interest"

to become self-governing (under the reforms brought in by the National Health Service and Community Care Act, 1990) from health organisations within the Northern Regional Health Authority's boundaries

16.3 The review team recommended to the Regional General Manager which candidates should be submitted to the Department of Health/NHS Executive. These recommendations went to the Northern Regional Health Authority Board and my memory is that they were endorsed after discussion but without modification. Bids submitted by Regional Health Authorities were judged centrally and approved or rejected on nationally determined criteria.

16.4 I recall that the Department of Health/NHS Executive civil servants gave the Northern Regional Health Authority review team an off-the-record steer that they wanted to see expressions of interest from "hospitals only." This was a national approach and not a special message for the Northern Region. It was, though, the basis on which the review team did not put the Blood Transfusion Service on its final list of recommendations. The eventual list submitted for national consideration contained hospitals (I cannot remember which). It also contained the Ambulance Service. Proposing the latter was clearly in defiance of the private steer. It is my recollection and understanding that it came about because of the skilful lobbying of the head of that organisation and was only allowed because of the promise of it being a "pilot." The Freeman Hospital and the mental health hospital, both in Newcastle-upon-Tyne and the Northumbria Ambulance Service were the only first wave organisations approved in the Northern Region.

**17. In the late 1970s, it appears that the NHRA decided to purchase commercially-produced Factor VIII to meet increased demand, instead of investing in plasma procurement at the Newcastle RTC (see paragraph 6 of NHBT0001580). Please explain the extent to which you were involved in this decision and outline the factors informing the decision as far as you are able.**

17.1 During the 1970s, I was a medical student (at Bristol University) who had only recently left school, a surgical trainee (in Birmingham hospitals) and a lecturer in epidemiology (at Leicester University). Therefore, at the time, I had no knowledge of the matters to which you refer in this question.

18. **In response to a request to increase plasma procurement in 1984, the NRHA stated that it could only give a qualified assurance due to the capital and revenue resources required and the need to build up the number of plasma donors in the region (DHSC0002247_077). What if any steps had, to your knowledge, been taken by the NHRA prior to this to increase plasma procurement? What steps were taken in response to this request?**

18.1 In 1984, I was a Senior Lecturer in Epidemiology at Leicester University. Therefore, at the time, I had no knowledge of the matters to which you refer in this question.

19. **Dr Lloyd in a document produced in September 1989 set out three possibilities to explain why the production of plasma at the Newcastle RTC remained static until the late 1980s: (1) the preference of the Newcastle Haemophilia Centre for commercial Factor VIII may have resulted in an increased Factor VIII budget for the Newcastle Haemophilia Centre and no additional funding for the Newcastle RTC; (2) the NRHA may have been unhappy with the way the Newcastle RTC was run and considered that NHS money was better spent on commercial products; (3) Dr Anne Collins may have advised the NRHA that BPL had insufficient capacity to process the plasma (it could not "deliver the goods") (TYWE0000064). Please set out your understanding/that of the NHRA as to the factors which may have impacted on the Newcastle RTC's production of plasma.**

19.1 I was not aware of Dr Lloyd's option appraisal in September 1989. These three options were described by Dr Lloyd in his evidence in terms of they "occur to me." The document to which the Inquiry refers is an attachment to a

letter of 1st September 1989 from Dr Lloyd to Crutes, solicitors (this was the firm that handled all the Northern Regional Health Authority's legal work), with whom he was corresponding at the time in relation to HIV litigation. As Dr Lloyd states at the outset of the letter, he only became Director/General Manager of the Regional Blood Transfusion Centre in late 1988. Thus, he would have no actual knowledge of earlier events surrounding plasma production. I have no basis for knowing if any of the information conveyed by Dr Lloyd in his Appendix 1 relative to plasma production is accurate or not.

19.2 In the time that Dr Lloyd is referring to (late 1970s to late 1988), I was either not employed by the Northern Regional Health Authority or not the leader of the regional management team. I was not a member of the Northern Regional Health Authority. I refer again to my answer to Q2 above regarding the dates of my employment at the Northern Regional Health Authority and my positions then held. I refer also to my answer to Q5 (a) – (d). I speak here as a regional officer with other responsibilities at the time. I have difficulty accepting Dr Lloyd's Option 2 as anything more than the conjecture he stated it was. The members of the Northern Regional Health Authority held the view that Dr Lloyd ran a good service. If they did not, he would have been moved on.

**20. In 1987/1988, Dr Lloyd sought the NRHA's views on a proposal to have part of the Newcastle RTC's plasma fractionated either commercially or by the Scottish Plasma Fractionation Centre, until such time as it could be processed by BPL (NHBT0103462_024; NHBT0103462_016). The NRHA did not support this proposal (TYWE0000067). Please set out your involvement if any in that decision and the reasons for it.**

20.1 I was not involved in this decision.

**21. In a proposal prepared in 1988, the NRHA concluded that there was an "inescapable requirement" for the Newcastle RTC to increase plasma procurement towards the target of 28,000kg p/a, as it was "too risky and too costly" to continue to rely on the supply of commercially-produced**

**blood products (NHBT0001580 (paragraphs 1 and 24)). Please explain the extent to which you were involved in this decision and outline the factors informing the decision to invest in plasma procurement at that stage. You may find NHBT0072037 of assistance.**

21.1 It appears that NHBT0001580 is a paper that went to the Northern Regional Health Authority Board for a decision. Although it does not say so on the paper, the date of the meeting would have been on or around 26 July 1988 (which Google tells me was a Tuesday) because press releases (NHBT0072037) were either on the same day as the Authority's meeting or the next morning. With the passage of 34 years, I cannot remember the discussion at the board meeting. I can be pretty confident in saying that, at that point in the evolution of the management team's way of working (1988), I would not have been involved in drawing up a paper like this.

21.2 It would have involved the Regional General Manager, the Director of Planning, the Director of Finance, the Director of Management Services, the Regional Scientific Officer, and (probably) Dr Lloyd for the sections relating to his service.

21.3 In 1988, officers were in attendance at board meetings (see my response to Q 5d) but not part of the decision-making persons. Thus, I could not have been party to the actual decision, nor could the regional officers that presented the paper to the Board.

21.4.I should note that at this point that the NHS was facing the most severe financial constraints. It was just prior to the meltdown at Birmingham Children's Hospital that led to Mrs Thatcher making an unscripted announcement on BBC Panorama that she would establish a fundamental review of the NHS. The Northern Regional Health Authority's decision to regard the requirements of the Regional Blood Transfusion Service as an "inescapable commitment" was giving it priority above many other important areas of service.

**22. In 1989, cross-charging was introduced in England and Wales to act as an incentive for RTCs to increase the amount of plasma being sent to BPL (see NHBT0057426_002). As far as you are aware, what effect (if any) did cross-charging have on the plasma supply in the NHRA?**

22.1 I do not know the effect and do not know whether any statistical modelling or impact assessment was done at the time. I refer also to my answers to Qs 19, 20 and 21 above.

**23. In February 1988, Dr Peter Jones (Director, Newcastle Haemophilia Centre) provided the NRHA with a historical record of the Northern Region's use of Factor VIII since 1969 in order to "allay any worries" that this was "in any way untoward" (BPLL0002848_001). What if any concerns did you and/or the NHRA have about the extent of the use of Factor VIII in the Northern region?**

23.1 I have no recollection of any concerns on the part of the Northern Regional Health Authority or myself over the extent of the use of Factor VIII in the Northern region. The correspondence with Dr Jones appears to have been triggered by a letter to me, in my capacity as Regional Medical Officer, by Jim Cousins, Labour MP for Newcastle Central dated 3 December 1987 (PJON0000023_065). Mr Cousins sought detailed information on AIDS figures for haemophiliacs and asked specific information on blood products administered to haemophiliacs in the north-east over an extended period.

23.2 I received the February 1988 letter from Dr Jones (BPLL0002848_001) in my capacity as Regional Medical Officer in response to a letter to him that was sent under my name on the 22nd December 1987. He states that the letter was drafted by the Regional AIDS Coordinator. I do not remember how the letter came to be drafted, but Dr Jones regarded it as a challenge to his clinical practice and it appears that he did not think the Regional AIDS Coordinator was the person to enquire of him in this way.

23.3 The Regional AIDS Coordinator was a new post that we created and the first appointee, Mrs Muriel Robinson, had been a hospital nursing sister from one of the Newcastle hospitals who had cared for the first waves of AIDS patients in the region. Looking at the timing of the letters, she would have been in post for a few months at most.

23.4 I was not aware of concerns about Dr Jones's practice and would not have initiated such correspondence. I would not have mistrusted or sought to second-guess a senior clinician such as Doctor Peter Jones. I never heard the Northern Regional Health Authority Chairman, Professor Bernard Tomlinson (who had practised pathology in Newcastle since the time that the NHS was founded) expressing concern or making critical comments about Dr Peter Jones. Moreover, the Northern Regional Health Authority and its officers, also would have borne in mind that it had a respected and trusted Drug and Therapeutics Committee in situ in Newcastle where the Haemophilia Centre was based.

23.5 In this period of NHS history, consultants were autonomous practitioners whose professional judgement was the sole determinant of what treatment would be offered to a patient or group of patients in a service. It was virtually unheard of to challenge such a senior doctor's judgement on the appropriateness of a particular therapeutic approach, unless they were acting illegally. So far as addressing any "outliers" in a community of practice, in say a teaching centre such as Newcastle, the local Drug and Therapeutics committee might engage, but even then, would tread extremely carefully in challenging a doctor's clinical judgement.

**24. In your reply of 14 August 1987 to a letter regarding the discrepancy between Northern Region haemophilia figures and the rest of the country, you stated that this "stems from the fact that there has always been an aggressive policy towards prophylactic treatment resulting in more factor 8 being prescribed in this area." [PJON0000023_065] [PJON0000024_003] When did you become aware of this "aggressive**

**policy" and what if any steps were taken by the NHRA in response to the policy?**

24.1 The letter of 14 August 1987 (PJON0000023_065) was a letter to me from the same Jim Cousins MP referred to in paragraph 23.1 above. This letter seems to have been part of an initiative by him to obtain information.

24.2 In the Northern Regional Health Authority at that time, the reply to a letter received by a senior officer with generalist knowledge (my then self) would be drafted by those with the requisite technical or scientific knowledge and with full understanding of the service concerned. I became aware of the policy when I received the draft reply to Mr Cousins for signature.

23.3 My use of the term "policy," which the Inquiry is interested in, should not be interpreted as a policy in the wider management sense but as a clinical expression relating to treatment. I recognised the words "treated aggressively" to denote an approach to care based on giving the best chance of survival or positive outcomes to patients. Another usage of that term, for example, might be in the field of cancer care. Thus, I did not interpret these words as alarming.

25. **Did the NRHA contract directly with any pharmaceutical company for the purchase of imported blood products?**

25.1 I do not know. I was not involved in contractual matters of this kind.

26. **At a national meeting between the BTS, haemophilia centre directors (HDCs) and DHSS in September 1981, Dr Hamilton (Newcastle Haemophilia Centre) reported that in the Northern region Factor VIII was purchased for all Haemophilia Centres through the Pharmaceutical Officer (CBLA0001448). What was the role of the Pharmaceutical Officer at the RHA? Do you remember who occupied the role during your**

**tenure? Would the Pharmaceutical Officer have had the authority to take their own decisions as to what to purchase, or would they have been expected to purchase concentrates in accordance with the Haemophilia Centre's requests/demands?**

26.1 The national meeting to which you refer was nearly five years before I took up post. Whilst in my post from 1986 onwards, I had always understood that the purchasing and ordering of products for the patients was done by the Chief Pharmacist at the Royal Victoria Infirmary in Newcastle-upon-Tyne, with the detailed specification of what was required being made by the Haemophilia Centre. If Dr Hamilton was correct, and his explanation of the situation still prevailed five years after he said it, I do not recall this additional dimension to purchasing.

26.2 I remember that the role of Regional Pharmaceutical Officer was held by Professor Jim Smith. There was another individual in that post in the early period. His name may have been Faraday. I cannot recall their respective dates of service.

27. **Was the NRHA in any way responsible for decisions about the choice of product used to treat patients in haemophilia centres and/or hospitals, for example the choice between one imported factor concentrate over another?**

27.1 I do not ever remember the Board discussing and agreeing purchasing options at this level of granularity.

*Screening*

28. **In March 1985 Dr Harris (Deputy CMO) wrote to Dr Whitehead (Director at PHLS), stating that it had become apparent that PHLS and Dr Codd in Newcastle were already undertaking HTLV-III/HIV screening, in advance of the anticipated introduction of screening in 1985/6 (DHSC0002263_027). What if any knowledge did you have in relation to**

**this? What steps had been taken by the NHRA to introduce the test? What money had been allocated by the NHRA? Did you/the NHRA share Dr Harris' concerns and if so why?**

28.1 In 1985, I was a Senior Lecturer in Epidemiology at Leicester University. Therefore, I had no knowledge of the matters to which you refer in this question.

29. **The Newcastle RTC commenced testing blood donations for HCV in April 1991 using the second-generation Abbott test and ahead of other RTCs. This decision was criticised by Dr Gunson, other RTC directors and DH officials. What was the NRHA's opinion regarding Dr Lloyd's actions at the time? Did the NHRA take any steps to support Dr Lloyd's decision?**

29.1 I do not have any recollection of this controversy, nor have I been provided with any papers that would assist. I refer also to my answer to Q30 below. I can only say how I think the Northern Regional Health Authority would have reacted. Whilst they had a positive view of Dr Lloyd, I think that they would have been wary of defying government policy when they would have known that ultimately the approach would have been consistent with national scientific advice and the Chief Medical Officer's view. Otherwise, I cannot remember whether this came to the Board agenda.

30. **Dr Lloyd defended his decision in letters to Dr Gunson, RTC directors, the Northern RHA, and Dr Lane at BPL in May and June 1991. In relation to the delay, he wrote: "If during that period anyone becomes infected and subsequently takes action, in my opinion, I would have had no defence. We had the wherewithal to test, including kits, equipment, and staff and we had agreed to start previously. The delay is thus administrative and that not only forms no basis for a defence or a mitigation but also I think aggravates the situation." He further stated that "...not to test now that we have the ability to test would be indefensible under the current Product Liability Legislation." These**

**letters are provided for your reference: NHBT0000074_010;NHBT0000074_014;NHBT0000192_011; NHBT0000191_162; WITN6935044; WITN6935043; NHBT0000192_044; NHBT0000192_031; NHBT0000192_043; WITN6935039. What was the reaction from the NRHA?**

30.1 I cannot recall a board discussion of this matter. It would be necessary to search the agenda and minutes of the Northern Regional Health Authority in archival form to see if there was such a discussion. I note that the only letters to the Northern Regional Health Authority provided to me by the Inquiry NHBT0000191_162 and (WITN6935044) are addressed by Dr Lloyd to Ian Vickerman, the Executive Director of Human Resources at the time, and seemingly the person to whom Dr Lloyd reported.

**31. What funding and operational support was provided to Newcastle RTC to aid in the implementation of testing for HCV in 1991?**

31.1 I was not responsible for assessing comparative bids for financial investment and prioritising them for consideration by the Northern Regional Health Authority Board. Within the regional management team this was done by the Director of Planning and the Director of Finance with input (in this case) from the Director of Management Services and the Regional Scientific Officer. I have covered this subject more generally in my answers to Qs 11 and 12.

*The National Blood Authority*

**32. In a letter to Mr Canavan on 8 November 1991 you expressed reservations about the proposed creation of the NBA (DHSC0004584_029). Please explain why there were, within the Northern Region, "considerable reservations about the concept of a National Blood Authority".**

32.1 There was a fear that the Northern Region would lose out to the south in resource allocation decisions by such as centralised body. The Northern Regional Health Authority members and officers had a grievance that it was being unfairly treated by the centre in broader funding allocation policy.

**33. In August 1994 the NHS Executive wrote to you to seek your views on the NBA's proposals with regard to the transfusion medicine consultants employed in the Transfusion Service (DHSC0046980_022):**

**a. What were your views about the NBA's rationale as set out in the letter?**
**b. To what extent was under or over transfusion a problem within the Northern Region?**
**c. What steps had been taken within the Northern Region to promote best clinical practice within transfusion medicine?**

33.1 I do not remember this letter. There is a possibility that I never saw it. It would have been sent to someone within the organisation to prepare a background briefing before it came to my office. However, by this time we were the Northern and Yorkshire Regional Health Authority, four months into the merger of two large regional health organisations that had existed in one shape or form since the origin of the NHS. So, I think it highly likely that the person dealing with it would have been trying to gather information on the blood transfusion situation in both former regions and was taking time to synthesise the information.

33.2 My attention was on stabilising the post-merger situation in the large combined Authority. It was a hugely complex and contentious process. My primary duty was to provide continuity of healthcare to seven million people, to ensure that the new body was compliant with all legislation and regulations, and to safeguard the integrity of resource allocation decisions.

33.3 The letter could have been responded to by one of the other medical staff in the new organisation who did not want to bother me. Or a reply could

have awaited the background briefing and/or my personal availability given the huge pressures on my time during that period. I would not have been close enough to the two regional services' performance and wider policy to have had enough prior knowledge to express an opinion without a background briefing.

33.4 Situations like this, when the NHS headquarters was canvassing opinion (this does not appear to be a formal consultation) from all its senior staff were multiple. Timely responses were seldom received from everyone, so, once the majority had replied, a summary of opinions would be made and forwarded to the person who needed to know the views.

## Section 4: HCV Look back

**34. Were you involved in setting up any HCV look back programmes during your time at the NRHA/Northern and Yorkshire Region? If so, please provide details.**

34.1 I am almost certain that there were occasions when look-backs were required during my 12-year period in the regions. I do not recall many specifics as it was a routine public health investigative methodology. At that time around the country, it was not uncommon to discover health care workers (e.g., surgeons or dentists) carrying infections like Hepatitis B, Hepatitis C, and HIV which posed a risk to their patients. Hundreds of people might need to be traced. There was often concern that such infections might be harboured for a long time because of the stigma and loss of employment consequences of openness.

34.2 Other types of incidents (e.g., severe salmonella outbreaks) might also require extensive interviews with people on their retrospective involvement. There was a great deal of attention on the risks of Legionnaire's Disease at that time (including hospital buildings and incinerators). Look back was an important part of those investigations too. I have fragmentary memories of some such occurrences. My most vivid memory is of an incident at Northern

Regional Health Authority building at the Walkergate Hospital site. The incident was presented in dramatic circumstances when a cleaner ran down the corridor screaming: “AIDS, AIDS, we are all going to die.” She had found intravenous drug using equipment in a toilet with extensive spillage of blood. It was very alarming for a non-medical person who did not fully understand the mode of HIV transmission. This required look back tracing of any staff or visitors who had used the toilet in the previous few days.

34.3 Whilst the Regional Health Authority public health team often coordinated investigations, the lead was usually with the local Director of Public Health supported by the Public Health Laboratory Service, sometimes with back-up from experts at the Communicable Disease Surveillance Centre at Colindale.

**35. In a letter dated 29 May 1996 you made some comments on a Hepatitis C draft paper [DHSC0042289_074]. You stated that “It might be wise to conduct a full cost-benefit analysis on the look-back exercise, taking into account negative as well as positive benefits, before further decisions are made regarding whether wider publicity should take place.” What was the reasoning behind this?**

35.1 This was not my communication. At this point in 1996, the Northern and Yorkshire Regional Health Authority had been abolished. I was a Regional Director of the NHS Executive (part of the Department of Health) covering the same geographical area. If it was drafted for me, then I would not have cleared it to go for a number of reasons. I would never have signed off as “Northern and Yorkshire.” It would have been “Regional Director, Northern and Yorkshire.” I am quite pedantic about things that are part of an official record. I would not mix different syntaxes in headings. The first heading is a question, the others are not. I would never use the word “rationed” (para 6b) in relation to clinical care. There are other grammatical errors that I would not have allowed through in a draft. Finally, if I was sending this prior to discussion at a board, I would have named the board in question. Also, it is not coherently argued for speaking to at a meeting. It would have left me looking foolish. The

regional structure was still quite new, and I had temporary staff and no substantive private office.

35.2 Although I accept that the communication ends with my name, given the anomalies I have identified, it cannot have been drafted by me nor could I even have reviewed it. If I did I would have noticed the errors I have identified. In all the circumstances I do not consider that I had any involvement in this document. It is likely that this was something drafted by a technical member of staff and forwarded by a civil servant endeavouring to be helpful in meeting a deadline.

**36. You referred in the same document to patients suffering unnecessary life-long anxiety and that this raised "ethical issues of whether we should screen them in the first place". Why was this your view?**

36.1 I do not know what "in the first place" means. I did not write it. Therefore, it was not my view.

**37. You also noted that it was important to raise awareness of the professions to HCV and available treatments; what if any steps to achieve this were taken within the regions for which you were then responsible?**

37.1 I refer to my answer to Q36 above. Notwithstanding that I did not "also note," as I have explained I was now part of the Department of Health. We would not have mounted such a campaign independently. Such advice to professionals would come via central guidance or a CMO letter. We would then disseminate through our networks.

**Section 5: Your role as Chief Medical Officer**

**38. The Inquiry understands that you were the Chief Medical Officer ("CMO") for England between January 1998 and May 2010. Please describe your**

**role and responsibilities and whether they changed during the course of your time as CMO.**

38.1 The start date was 21st September 1998, not January.

38.2 The Chief Medical Officer post has existed since 1855, when it was established in response to the great cholera epidemics that swept Victorian England. At the time I was appointed, only 14 people had held the post over this entire period.

38.3 I was the first (and only so far) to be accredited in public health on the General Medical Council specialist register. I was the first to have had management, as well as public health, experience.

38.4 In my time, the role was not purely advisory but also carried management responsibilities in the Department of Health. The role was changed for my two successors (Sally Davies and Chris Whitty) and narrowed down to be purely advisory in relation to medicine, medical science and public health. They also held part-time management roles as Directors of Research and Development. My sole post was as Chief Medical Officer.

38.5 In my case, the role was a mixture of reactive, proactive and oversight work. Teams of civil servants, usually organised into "policy branches" covering subject areas (e.g., immunisation and vaccination) fed into me through a senior civil servant who headed a management function made up of numbers of such teams. At a certain point during the time I was in office, the senior civil servants heading these functions were designated "Director General." They reported to me but also to the Permanent Secretary who was the administrative head of the Department of Health. At different times, two and three of these roles were filled by Deputy Chief Medical Officers.

38.6 The management functions headed by the Directors General (or their predecessor equivalents)/ Deputy Chief Medical Officers varied over time. There were numerous reviews, reorganisations and budgetary pressures that affected

my management portfolio. At various times, it included mental health, health protection, health promotion, social care, research and development, health care quality and other functions. The scope of this was huge so the day-to-day management, oversight and quality assurance of these areas of work was in the hands of the Directors General. I tended to be hands-on in relation to bigger policies and programmes of work. The seniority of their roles in civil service terms meant that Directors General/Deputy Chief Medical Officers would see ministers directly, usually, but not always, keeping me in the loop so that I was aware of what was going on. To note that I was not always *au fait* with what was happening in my management portfolios is not a criticism of my senior colleagues but simply a reflection on the volume, depth and complexity of the work. Their jobs were “24/7” as was mine.

38.7 What I have described so far about the CMO role is merely the baseline responsibilities.

38.8 I was given a brief by the New Labour government to help them modernise many areas of health and health care. I did much of this by producing 28 special reports that scoped a subject and made recommendations. I selected areas where I felt there were major population health challenges, weaknesses in the NHS or potential threats to the public health.

38.9 I have given a simplified explanation of the structure of the Department of Health. This is because it is clear from the documents on the Inquiry’s website that it has already received a great deal of evidence on the complex civil service infrastructure in the Department of Health.

**39. What was your understanding of the role and responsibilities of the CMO during a public health emergency?**

39.1 Although the Inquiry asks me what I "understand" to be the role and responsibility of the CMO during a public health emergency, as I was the CMO, I can answer this question directly by setting out some examples of emergencies that I managed during my time in office.

39.2 It depends on what is meant by a public health emergency. Some would say that if the circumstances are serious enough to generate COBRA meetings then that amounts to a public health emergency.

39.3 I dealt with a number of matters that I consider to be a public health emergency. These included the global SARS outbreak, the foot and mouth crisis (which carried a potential enhanced BSE risk), the polonium radioactive poisoning, the collapse of confidence in the MMR vaccine, and the "swine 'flu" pandemic (the first pandemic for 40 years).

39.4 I organised and led the public health response after agreeing the overall approach with Ministers (and sometimes the Prime Minister). I then reported on progress to Ministers, and usually also COBRA, on a regular basis (mostly this was every few days) and sought their agreement on handling and policy decisions. To do this job, I worked closely with senior civil service colleagues, the Health Protection Agency, the NHS Chief Executive, and experts and scientific committees. According to Ministerial preferences, I held media briefings and gave extensive media interviews and appeared on "sofa" television programmes where I was sometimes questioned by members of the public. I organised reports and briefings. I briefed MPs. I was not purely an adviser (see my answer to Q 38), I was leading and managing the response, working with the politicians as the democratically elected government. I also liaised with the WHO and with my counterparts in other European countries, though few of their CMO jobs had the scope of responsibilities of the UK CMOs.

**40. Did you understand it to be part of your role to provide information, advice and/or guidance to clinicians? If so, how (broadly) did you seek to discharge that role?**

40.1 Generally speaking, the CMO does not set out to provide systematic guidance for clinical practice. There are approved curricula in 65 specialties and 31 sub-specialties of medicine. There are many different diseases and clinical conditions. All these areas are covered by good practice guidance produced by

professional and scientific bodies and committees both nationally and internationally.

40.2 Since around 1999, NICE (the National Institute for Health and Care Excellence) has issued a whole range of guidance for the NHS classified in different ways. Most of it is for clinicians to follow or to assist in the design of services. Like my predecessors, I produced guidance regularly on immunisation and in emergency situations. From time to time, there was value in issuing guidance on emerging diseases or clinical situations. I also produced guidance and recommended action on important public health topics (e.g., tuberculosis or health care infection) or guidance that clinicians could use to advise their patients or that the public could use directly (e.g., on alcohol levels or physical activity).

**41. Did you understand it to be part of your role to provide information, advice and/or guidance to the public? If so, how (broadly) did you seek to discharge that role?**

41.1 Of course, it has always been part of the CMO role to do this. I communicated through the print and broadcast media, sometimes where there was a studio audience. Some of this was built around my 28 special reports, my Annual Reports, or the 14 CMO-commissioned reports. Often it was in response to health stories in which health ministers or Number 10 asked me to respond to media bids. There were periodic evaluations of my public communication. For example, between November 2007 and April 2008, I was mentioned in 228 items of coverage generating 288 million WOTS (Weighted Opportunities To See). This means that every adult in the UK had six opportunities to see or hear about me as CMO. The publicity had an 81% positive net effect. I have the detailed statistics because I kept a copy of the evaluation report (Exhibit WITN-05) thinking that it would be valuable in teaching public health students. I would regard this as one of my quieter years, so across the 12 years, there can be little doubt that my level of public communication was high. It should be noted that the government had a communications planning grid that tended to discourage any one department or individual getting too much exposure. So, there were some constraints on getting airtime.

**42. What was your understanding of the purpose of the CMO's Annual Reports "On the State of the Public Health"? (DHSC0007020, DHSC0007021, NHBT0062180_001, DHSC0007023, DHSC0007024, DHSC0007025, DHSC0007026, DHSC0007027, DHSC0007028).**

42.1 The purpose was ultimately to highlight matters that needed to be better understood and to call for action in specific areas that I felt would improve the population's health or the quality of care in the NHS. I determined the content of each report, I decided how it would be presented and I wrote quite a lot of it personally, drawing on content experts for fact checking and to ensure that I had explained the topic properly. The reports also aimed to update on the progress of issues previously highlighted. I used charts and diagrams to aid understanding and used a style of presentation to be accessible to both professionals and lay members of the public alike. Thus, they were public facing reports, they were not cleared in advance with ministers or the civil service, and they were popular with journalists which was helpful in getting the key content and messages across.

**43. What steps were taken by you during your time as CMO to raise awareness amongst clinicians and/or the public about (a) HCV generally and (b) the link between blood transfusion and HCV? (You may wish to consider DHSC0041221_044).**

43.1 After publication of my report *Getting Ahead Of The Curve,* follow-up work was undertaken in relation to certain communicable diseases that had been highlighted in the report. The most prominent of these was pandemic influenza planning. Until then, the government had little specifically in place to deal with such an eventuality.

43.2 As part of this follow through on *Getting Ahead Of The Curve,* a Hepatitis C Action Plan for England was released in 2004 with professional and public awareness campaigns (DHSC0041221_044 refers to the latter). In particular, in 2004, the Health Protection Agency supported the Department of Health to

provide an externally commissioned campaign aimed at healthcare professionals and the public called *FaCe It,* which sought to raise awareness of hepatitis C Infection to underpin the government's Hepatitis C Action Plan for England. This included a website, poster campaigns and displays as well as advertorials and commissioned pieces for print and radio targeting groups at risk of HCV infections.

43.3 Guidance was issued to the NHS in July 2004 (Hepatitis C: *Essential information for professionals and guidance on testing* (Exhibit WITN7557007 that stated *inter alia:* "*There was a risk to recipients of blood transfusions (before September 1991) or blood products (before 1986) in the UK. For example, there is a high prevalence of HCV in people with haemophilia who received clotting factors before 1986."*

**44. Please describe in broad terms the nature and frequency of your interactions with Ministers. Did Ministers generally accept the advice that you and your medical colleagues within the Department provided, or was that advice often challenged?**

44.1 I met the Secretary of State or other Ministers regularly. At times this could be daily or several times a week. I would estimate that the number of subjects "in play" with ministers at any one time might be 30 to 40. Discussions would cover policy matters, plans, ideas, problems, forthcoming parliamentary business and a range of other themes.

44.2 The term "advice" does not really do justice to my relationship with ministers. Yes, sometimes I would give straight advice. More often, I would set out the scope of a subject, give insight into the different viewpoints on it, outline the range of available action and talk through the pros and cons of each. In other words, from an independent perspective, I would help ministers to gain a full understanding of a subject and to reach the best decision.

44.3 I liked to be challenged. The problem with a bureaucracy is that there is too much hierarchy and deference towards those at the top. At times, I was quite alarmed that some civil servants with whom I worked did not challenge me. I do not know what happened in private meetings between other colleagues and ministers. A few were frightened of ministers. Above anything else, in these roles, you have to be prepared to “speak truth to power.”

44.4 On a specific example of my advice not being taken, the government rejected my independent advice to introduce smoke-free workplaces and public places. I continued to argue and advocate for it. It came about through a Parliamentary free vote, granted because the Government was going to lose a whipped vote if it tried to get its MPs to throw the idea out.

**45. To what extent did you have regular interactions with the Chief Medical Officers for Northern Ireland, Scotland and Wales?**

45.1 I met them as a group periodically and on an individual basis as the need arose.

**46. What, in broad terms, was the role of the Chief Medical Officer’s Advisory Group on Hepatitis during your time as CMO? Please find the following summaries for your assistance in answering the question: DHSC0004294_015,DHSC0020785_038,DHSC0032277_003, DHSC0032369_019, DHSC0042287_042, SCGV0000283_016.**

46.1 The Advisory Group on Hepatitis was established almost 20 years before I was appointed as CMO. It operated similarly to most of the other scientific committees associated with health, in reporting to all four UK government health departments and putting key papers in the public domain and in the Parliamentary library. This point on openness is very important because it provides a way for scientists, the public health community as well as patients and the public to disagree with a committee's findings or express concerns or point to areas that may be being overlooked.

46.2 The committee maintained an overview of all aspects of the risk posed by hepatitis viruses to patients in the NHS and to the public. It was encouraged to do this without fear or favour and free of political interference. It reviewed many areas of public health policy and management including immunisation, protocols to respond to situations where there were infected healthcare workers, providing guidance on new and emerging areas of risk, updating guidance on existing areas of risk, and commenting or advising on the work of other bodies and committees that were issuing guidance, policy statements or otherwise considering hepatitis infection.

**47. During your time as CMO, the policy and "line to take" of the Department of Health, in relation to the position of those who had been infected with HIV and HCV from blood and blood products was to maintain that there had been no fault or wrongdoing on the part of the Government or NHS and that patients had received the "best available treatment" at the time. Calls for a public inquiry were rejected on this basis. Were you ever asked to advise the Department in relation to this policy and line to take? If so, what advice did you provide?**

47.1 I do not ever recall being asked to give advice on the "line to take" which had codified the policy on infected blood and blood products consistently adopted by successive governments.

47.2 Such a request to a CMO would have been highly unusual because it is not within the scope of their normal functioning in an area of public health protection. A CMO would usually be asked about the level of risk, who was at risk or potential risk, what the adverse health outcomes were and how they might be mitigated or removed entirely. In the case of infected blood and blood products, these matters were largely established.

47.3 Thus, in being asked to give advice on the "line to take," I as the CMO would have been placed in a position of being required to rule on the Blair or Brown Governments' current stance on the three components of "the line to

take" accepting blame, agreeing to a public inquiry, and providing compensation.

47.4 Given that a CMO must always provide advice independently, to formulate such advice would have involved a wide range of preparatory work and evidence gathering.

47.5 It would have meant establishing the root causes of the harm that the patients had experienced; that process would have involved reviewing past documents and conducting extensive interviews of individuals historically in key positions in roles inside and outside the governments of the day. Only then would it have been possible to give the Government independent advice on whether it was right to absolve itself (and its predecessors) from blame, and to continue to maintain the line that "patients had received the 'best available treatment' at the time."

47.6 The CMO would then have needed to take a view as to whether the causation was sufficiently clear that it was unnecessary to dissect it further in a public Inquiry (since not holding such an Inquiry was another policy strand in the "line to take").

47.7 Finally, the CMO would have needed to have independent legal advisers, since I understood that the "line to take" was supported by government legal advice, received over the years. This last step alone, required to equip the CMO to give truly independent advice, would have been unprecedented and seismic in its implications.

## Section 6: Better Blood Transfusion/Appropriate Use of Blood

**48. The Health Service Circular 1998/999 on Better Blood Transfusion was issued on 11 December 1998 [NHBT0083701_002]. What involvement, if any, did you have in the drafting of the circular? Please set out what you understood to be the main priorities required of Trusts and clinicians as a result of the Circular.**

48.1 I started as CMO on 21st September 1998, a comparatively short time before the Circular was issued. For this reason, I was not involved in drafting it. Please note that it was authored by the NHS Medical Director, not the CMO. It was based on a seminar that my predecessor and the other three UK CMOs had held that summer. I feel that the priorities equate to the required action set out in the Circular itself.

**49. Please consider DHSC0038500_007 and DHSC0038500_049. Please explain why it was considered necessary to hold a further seminar on better blood transfusion. What were the primary concerns for you as Chief Medical Officer?**

49.1 An initiative like this needs to have its momentum sustained. Without the continuing profile given by CMO interest and attendance, it would slip below the radar.

**50. A further circular was issued in 2002 [NHBT0062177_001] and the CMO's National Blood Transfusion Committee was established. With reference to DHSC0006783_002 and RLIT0000848 please explain the purpose of establishing the Committee and what its aims and objectives were.**

50.1 One of the most difficult aspects of any national health system is to secure implementation of policies at operational level. There are multiple demands on hospitals from within their areas and they will constantly complain about being bombarded with national demands and imperatives. Implementation of almost everything is variable and inconsistent across the country. Like it or not, blood transfusion would not have been recognised by NHS management as a traditional priority area or even something that would have been seen as a new priority that should jump ahead of others. As long as the supply of blood was available, the appropriateness of blood use would have been seen as "hope to do" rather than "must do."

50.2 The primary purpose of the National Committee was to ensure that blood is used safely and appropriately: please see the National Blood Transfusion Committee minutes of its meeting on 25th September 2006, 17/06 (RLIT0000858).

**51. How successful do you consider the National Blood Transfusion Committee to have been in addressing issues relating to the appropriate use of blood? Please set out what if anything acted as a barrier to achieving more efficient use of blood and blood components. RLIT0000852 and RLIT0000854 may be of assistance.**

51.1 I felt that it was reasonably successful, not least the increase in the proportion of hospitals that had their own Transfusion Committees. It is vital to have commitment and critical mass at operational level. In a complex system like health care, it is not a simple matter of identifying a "barrier" and removing it. The NHS does not operate in a command-and-control mode like the military. There is a whole field of scholarship on so-called adaptive change in complex, multi-stakeholder systems, which is what the NHS is. Making better blood transfusion an integral part of NHS care is just the sort of cultural challenge that change management theory and practice grapples with.

**52. In 2006 a review of the Better Blood Transfusion Initiative was undertaken. What were the reasons for the review? Did you have specific concerns about the progress that was being achieved? If so please set out what those concerns were and what if anything would have enabled further progress to have been made. DHSC0004205_021 may be of assistance.**

52.1 The progress review was part of the process of health service circulars at that time. The review date of 4 July 2005 was stated in HSC 2002/009 (line three at the top of the document). (NHBT0083701_002, page 1). Thus, the review was not triggered by concerns but was an administrative requirement. The civil servants in this policy area reviewed progress and set out their assessment in an undated document (DHSC0004205_021) that I believe to

be written some time in 2006. They concluded that*: "excellent progress has been made in many areas."* However, they list four reasons that made progress "*slower than ideal*." These four reasons can be found in DHSC0004205_021 as bullet points on page 3.

52.2 One of them states*: "The CMO's NBTC has no effective means of enforcement (can only influence, cannot implement)".* This was and is still quite true. The Better Blood Transfusion initiative was a developmental programme in a "Cinderella" area of health care. It had a very low profile within the NHS management community and no prominence in the clinical community. Ironically, although blood is lifesaving, it is more seen as part of the "infrastructure" of care, little reflected upon unless supply is threatened. The efficiency of management of blood supplies (especially in planned surgery), the dangers of overuse of blood transfusion, and errors during the use of blood are all areas that did, and still do, need attention and improvement. So, a review of progress is a good way of maintaining the focus of the NHS on a topic like this and reminding managers that there is still work for them to do.

52.3 Outwith the blood transfusion practitioners and experts involved in the initiative and the seminars, I cannot recall these issues ever being mentioned to me by any NHS manager nor any non-haematology doctor in my 12 years as CMO. This contrasts with the heavy lobbying and advocacy approaches I had in dozens of other fields asking me to prioritise an area of service, a disease or a health problem.

**53. Following the review, what actions did you take, or require the Committee to take? Please answer with reference to DHSC0004109_030, RLIT0000858 and RLIT0000860.**

53.1 By issuing a further circular HSC 2007/001 with a toolkit to assist implementation for action by chief executives and directors of public health of strategic health authorities, chief executives of NHS Trusts and Primary Care Trusts, and the Chief Executive of the Blood and Transplant Authority.

DHSCOO4109_030 page 2 appears to be an earlier draft of this circular. The National Blood Transfusion Committee then had a basis for advocating for action and assessing implementation.

**54. Reflecting over your time as CMO, do you consider that enough was done to improve the efficient use of blood and blood components? What if anything prevented further progress being made?**

54.1 More than had been done before my time. Something that was a professional backwater was given a high profile through the four-CMO seminars and my CMO Annual Report. I chose the topic of Better Blood Transfusion for one of my CMO Annual Reports. Had I taken a poll of NHS leaders on what to put in my Annual Report, I am quite sure blood transfusion would not have featured in their list of priorities.

54.2 The significance of this should not be taken lightly given the many other priorities crying out for this level of attention. The lack of even more progress is due to competing priorities for management and leadership time and resources. Is it an important part of undergraduate and postgraduate medical curricula? I do not know but this would help greatly to help to make it a core part of clinical practice.

## Section 7: Infectious Diseases Strategy

**55. In 2002 you published "Getting ahead of the curve – a strategy for combating infectious diseases" [RLIT0001745]. What led to your decision to produce this strategy? Why, to the best of your knowledge, had no strategy been published at any earlier stage?**

55.1 Throughout my time as CMO, I tried to identify important areas of health and health care where there was no strategic framework or direction to drive improvement. Communicable diseases was one such area. I also introduced the world's first health system level patient safety programme. I invented the

concept of clinical governance and put forward proposals to reform the General Medical Council (implemented through legislation) to make it easier to deal with poor or unsafe practice and to create a larger lay membership of the council itself.

**56. The strategy notes, at p.12, that the present surveillance system fell short of what was necessary fully to protect the public health. Why was this the case? What was your understanding as to why corrective action had not been taken earlier?**

56.1 The UK system of communicable disease surveillance is very strong compared to most other parts of the world. Thus, the "falling short" is a qualified remark. This comment, made in the strategy, relates to the ideal. Whilst the UK surveillance system is one of the best, across most of the world, surveillance quality falls short of what is really required for strong prevention and control of communicable diseases. Latterly, I have been involved in work with the World Health Organisation to try to strengthen communicable disease surveillance systems globally (especially given the importance of tracking pandemics and other new threats).

56.2 The establishment of the Communicable Disease Surveillance Centre in January 1977 was a pivotal development. It became part of the Public Health Laboratory Service. Its founding Director, Dr Spence Galbraith, was a pioneer. He emphasised assembling robust information, drawn from surveillance, research, and outbreak investigations, to inform the development and implementation of national policy and best practice. The surveillance systems he instituted were absorbed into the Health Protection Agency at its formation.

**57. The strategy refers to under-reporting/under-notification of infection (p.12). What if any steps had been taken (to your knowledge) prior to 2002 to address this?**

57.1 My answer to this is covered in my response to Q 56.

**58. The "Getting ahead of the curve" report led to the establishment of the Health Protection Agency. Why, to your knowledge, had steps not been taken earlier to establish a centralised public body with a statutory function to control the spread of infectious diseases?**

58.1 There was such a centralised statutory body. It was called the Public Health Laboratory Service. It was founded as part of the NHS in 1946.
The Health Protection Agency replaced the Public Health Laboratory Service and bodies dealing with radiation and chemical protection. The Health Protection Agency was first created as a Special Health Authority in April 2003. In April 2005, it became a non-departmental public body, following implementation of the Health Protection Act 2004. The Health Protection Agency then provided a unified source of specialist support and expertise for Health Protection and health emergency planning across the United Kingdom.

58.2 Key functions of the Health Protection Agency were:

- To advise government and each of the devolved administrations on public health protection policies and programmes;
- To deliver services and to support the NHS and other agencies to protect people from infections, poisons, chemical and radiation hazards;
- To provide an impartial and authoritative source of information and advice to professionals and the public;
- To respond to new threats to public health and provide a rapid response to health protection emergencies;
- To improve the knowledge base for health protection through research and development as well as education and training.

58.3 During its 10 years of operation, the Health Protection Agency combined expertise in communicable disease, environmental hazards and biological medicines to create an organisation that was recognised worldwide for the

quality of its scientific advice, its rapid response capabilities and the leading-edge research that underpinned its work.

58.4 It was replaced in 2013 by another body, Public Health England, and this became directly politically accountable to the then Secretary of State for Health, Andrew Lansley, rather than being independent as the Health Protection Agency was.

## Section 8: Other matters

**59. Please provide any further comment that you wish to provide about matters of relevance to the Inquiry's Terms of Reference.**

59.1 I have spent a large part of my professional career striving to raise awareness of the level and sources of avoidable harm suffered by patients in the NHS and, through my work with the World Health Organisation (WHO) and other national and international bodies. The purpose of these endeavours has been to address the vital question of how to make health care safer. I have produced a number of major reports. I have spoken on this subject to dozens of conferences and meetings in countries around the world, including to health ministers. I have met and listened to many patients and families who have experienced such harm in this and other countries. Many have become involved in working with us in the WHO Patients for Patient Safety Programme, which I established in 2005. Over and over again, I have been moved by the quiet courage and dignity of these patients and families in the aftermath of harrowing and incalculable loss. I have been struck how consistently victims of avoidable harm express three priorities for what they hope will result from their experiences: an apology for what happened, a clear and honest explanation of why it happened and a commitment that it should not happen to anyone else (the need for learning is deeply felt). Financial redress is essential and important but, in my experience, does not supersede these priorities in the eyes of patients and their families.

59.2 I have followed the proceedings of the Inquiry with this background of emotional, as well as medical, experience of learning about how and why such avoidable events occur and the impact they have in human suffering. In so doing, I have been powerfully moved by the tragic experiences of the victims of infected blood and blood products. I hope that the Government, the NHS together with the medical and scientific world will show, by implementing the Inquiry's recommendations, that they are honouring the memories of all those who have died and suffered.

**Statement of Truth**

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

Signed GRO-C

Dated 14th December 2022

**Table of exhibits:**

| Date | Notes/ Description | Exhibit number |
|---|---|---|
| 16 November 1967 | Document entitled "Officer Handling of Committees", | WITN7557002 |
| September 1972 | Document entitled "Modes of Address of Medical Practitioners | WITN7557003 |

| | | |
|---|---|---|
| 1 February 1974 | Document entitled “Reference List for Spelling and Allied Subjects | WITN7557004 |
| September 1972 | Document entitled “List of Examples” of principal letters in common use. | WITN7557005 |
| 20 June 2008 | A Panarc International Media Analysis Report on CMO Coverage November 2007-April 2008 | WITN7557006 |
| July 2004 | Guidance by the NHS on Hepatitis C - Essential Information for Professionals and Guidance on Testing | WITN7557007 |