Witness Name: Professor Anthony John Pinching
Statement No.: WITN7652001
Exhibits: 0
Dated: 2nd May 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR ANTHONY JOHN PINCHING

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 30 January 2023.

I, PROFESSOR ANTHONY JOHN PINCHING, will say as follows: -

Section 1: Introduction

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

1.1. Professor Anthony John Pinching
GRO-C Middlesex, GRO-C UK.
GRO-C 1947

BA (Oxon) First Class Honours	1968
DPhil (Oxon)	1972
BM, BCh (Oxon)	1973
MA (Oxon)	1973
MRCP (UK)	1976
FRCP	1986-2021

2.0 ***Please outline your employment history.***

2.1. **1973-1982**

Medical Training posts:

House Physician (Oxford), **House Surgeon** (Swindon),

Senior House Officer (Hammersmith Hospital & Royal Postgraduate Medical School; National Hospital for Nervous Diseases)

Registrar to Prof DK Peters (Hammersmith Hospital & Royal Postgraduate Medical School)

Senior Registrar to Prof DK Peters (Hammersmith Hospital & Royal Postgraduate Medical School)

Research Fellow to Prof JH Humphrey (Royal Postgraduate Medical School)

1982 – 92

Senior Lecturer, later (1989) Reader, in Clinical Immunology

St Mary's Hospital Medical School, Imperial College

Honorary Consultant in Clinical Immunology

St Mary's Hospital, London

1992 – 2003

Louis Freedman Professor of Immunology,

(and from 1998) Head of Division, Molecular Pathology

St Bartholomew's & The Royal London School of Medicine & Dentistry, Queen Mary & Westfield College, London,

Honorary Consultant in Clinical Immunology (and Clinical Director – 1992-1999)

Infection & Immunity, Royal (Barts & the London) Hospitals NHS Trust

2003 – 2011

Associate Dean for Cornwall, Professor of Clinical Immunology,

Peninsula Medical School (later PCMD), University of Plymouth

Honorary Consultant in Clinical Immunology, Royal Cornwall Hospitals NHS Trust

2011

Retired from all clinical and academic activities.

2.2. I do not hold any documents which might be relevant to the questions posed below. Any files that I had retained were destroyed when I left Barts & The London in 2003.

3.0 ***Please describe, in broad terms: a. your role and responsibilities in 1983 when you were a senior lecturer and consultant immunologist at St Mary's Hospital Medical School;***

3.1. **Undergraduate and Postgraduate Teaching in Clinical Immunology**

Research in Clinical Immunology (acquired immunodeficiency – especially AIDS, autoimmune disease): basic science and clinical studies

Clinical responsibility for the Immunopathology Service and associated clinical consultations.

Clinical responsibility for patients with (suspected) immunological diseases: acquired immunodeficiency – especially AIDS; autoimmune diseases; chronic fatigue syndrome (CFS/ME). Head of the specialist multi-disciplinary team for care of patients with AIDS and related diseases.

3.2. During the early years of AIDS, there was a need for informed comment/advice for policy makers, professional bodies, and the public – especially through the media; I saw the provision of such information and guidance as a responsibility for someone in my position

b. how and when you first became aware of AIDS.

3.3. In the first half of 1981, I was a Research Fellow, investigating mechanisms of acquired immunodeficiency resulting from therapy for autoimmune disease. A clinical colleague, with whom I had worked and with whom I published a report on infections in therapeutically immunosuppressed patients, returned from a period of clinical and research attachment in the USA and told me about the earliest accounts exchanged among clinicians in infectious diseases of a 'new immunodeficiency disease'. These were published in June of that year, in Morbidity & Mortality Weekly Reports.

3.4. Later that year, on various requests from colleagues, I studied the immunological profiles of blood from London patients with suspected AIDS or AIDS-related illnesses using the laboratory tests on white blood cells that I was using for my research studies on acquired immunodeficiency.

3.5. On news of (and prior to starting) my appointment to the Senior Lecturer/Hon. Consultant post at St Mary's, I was approached by colleagues there in the Sexually Transmitted Disease Clinic and Microbiology Departments to help set up research studies on sexually active homosexual men, as their previous studies on Hepatitis B in that population suggested strong similarities to those affected by the new disease in the earliest USA reports. This began a major collaborative research and clinical effort at St Mary's, including what became known as the Wellcome Natural History Cohort Study on homosexual men.

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

4.1. **Medical Research Council Working Party on AIDS 1983 – c.1987/8 Scientific Secretary; Clinical Immunologist.**

I was in the role on the MRC AIDS Working Party for the duration of its work. I do not recall nor have a record of when the Working Party was disbanded, but it was a year or so after the Department of Health's EAGA had been set up – it was felt that EAGA was the appropriate body for many areas, while research would go through usual MRC channels.

4.2. **Department of Health (Expert Advisory Group on AIDS – EAGA) 1984 – 1991/2 Member; Clinical Immunologist.**

I was an active member, for the first several years, on EAGA, but do not recall nor have a record of when I ceased to be a member. I provided advice and input on clinical issues, but also – from the first meeting – strongly urged the government to take a lead in public information campaigns. A very early and appropriate focus of EAGA was on protecting the blood supply; EAGA subgroups looked into different aspects of this, some of which I was a member. I had no special expertise in blood transfusion, but was able to advise on matters relating to my clinical and academic knowledge of AIDS and HIV, including issues around introduction of HIV testing and the need for pre- and post-test counselling.

4.3. **Parliamentary Social Services Committee Inquiry on AIDS 1986-7**

I was one of two specialist advisors to this pivotal inquiry, whose deliberations and report had a substantial impact in many areas of public policy.

5.0 ***Please confirm whether you have provided evidence to, or have been involved in, any other inquiries, investigations or criminal or civil litigation in relation to 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 and copies of any statements or reports which you provided.***

5.1. I have not.

Section 2: Events in 1983

6.0 ***On 1 May 1983 an article appeared in The Mail on Sunday entitled "Hospitals using killer blood" [PRSE0000199]. The article quoted you as follows: "It seems madness that our blood supplies are coming from a country suffering from an incurable killer disease that nobody can even test for." a. Is this a statement which you made at the time?***

6.1. Not as such. I think that this 'quote' was a paraphrase of views which I expressed during a much wider, long (c. 1-2 hours) interview about AIDS. This took place in person (in my office at St Mary's Hospital Medical School) with Ms Douglas, during which it was not apparent to me, nor made clear to me, that the issue of blood products was the main topic of her journalistic enquiry.

6.2. The wording is not wording that I would have used (e.g. *"seems madness"*; *"incurable killer disease"*). This is confirmed by my statements soon after to Mr Julian Meldrum (see **HSOC0016078_003**). Also, I knew that most of our blood supplies did not come from the USA, but that some blood products (Factor VIII concentrates) had to be sourced thence.

6.3. It is possible that Ms Douglas posed questions in the terms quoted, to which I might have replied – probably at some length, and with caveats

– in broad agreement to the expression of concern, but not using those words.

6.4. It was only on publication that I realised the focus of her enquiries. I definitely do not recall her checking the wording in advance of publication, which was always my preference at the time. It is possible that she was unable to reach me in time. I do remember my surprise and upset at the article – the awful headline and misleading 'quote' – when it appeared; and also because it related to a very small part of our long discussions about AIDS.

b. Did this accurately reflect your views at the time?

6.5. Although I was not, nor did I claim to be, expert in blood/blood product transfusion, my knowledge and expertise in the rapidly emerging field of AIDS meant that I would, at that time, have been concerned about sourcing blood products from the USA, for two main reasons: a) the much greater number of AIDS cases, and hence of likely carriers of the as-yet-unidentified causative agent, in the USA; and b) my awareness of the recruitment of paid blood donors in the USA, meaning that some might be – e.g. through injecting drug use – at greater risk of blood-borne infectious agents, although I knew (qv The Bulletin of the Haemophilia Society) that US producers of concentrates had acted to reduce risk.

7.0 ***On 8 May 1983 a further article appeared in The Mail on Sunday entitled "Action to ban danger blood" [PJON0000001_101] which quoted you as saying "I wouldn't dream of giving a patient American blood products. We have to find an alternative immediately."***
a. Is this a statement which you made at the time?

7.1. I presume that this 'quote' was derived from the original interview. It is plausible that I would have answered a hypothetical question (e.g. "Would you yourself give patients American blood products?") in the terms of the first sentence, but I would also have emphasised: "unless

there is no alternative in a clinical situation of definite clinical need." (or a similar phrase.) That caveat could have been removed by a sub-editor.

7.2. My views at the time were correctly stated on 30th June 1983 by Julian Meldrum in **[HSOC0016078_003]** in relation to the 1st May article: *"His view was, and remains, that it would not be wise to use American Factor VIII or other blood products, unless there were no practical alternative."* In relation to the 8th May article, he states: *"He in fact stated repeatedly that he 'wouldn't dream of giving a patient American blood products' unless there were no alternative. … When challenged on this point, Susan Douglas maintained that the qualification had been present in her copy as submitted but was cut, completely changing the sense, by the sub editor responsible for the story."*

7.3. My article in the Haemophilia Society Bulletin, probably written around the same time, makes similar points about the balancing risks and benefits.

7.4. The second sentence: *"We have to find an alternative immediately."* could be a direct quote, although I probably said: "as soon as practicable".

7.5. I should emphasise that I was, at the time, relatively inexperienced (and untrained) in dealing with journalists. I saw it as my duty – in the light of my specialist knowledge in such a rapidly emerging area of medical science – to be very open to press enquiries about factual aspects of AIDS, and immediately related matters, and to offer information and explanation to the best of my knowledge and understanding at the time.

7.6. With time and experience (these articles included), I learnt better how to answer journalists in shorter, focused terms, and without multiple

modifying clauses (which could be edited out, changing meaning), to minimise misunderstanding and reduce the risks from later sub-editing.

b. Did this accurately reflect your views at the time?

7.7. As above, in my reply to 6b), broadly yes, with the caveats set out above in my reply to 7a).

8.0 ***When answering the above questions, the Inquiry invites you to consider the written statement of Susan Douglas [WITN4120001], the journalist who wrote the above articles, in particular at paragraphs 59-60, 68-69 and 71, and her oral evidence to the Inquiry on 15 September 2022, in particular at internal pages 32-34 [INQY1000242]. Please set out your recollection (if any) of your interactions with Ms Douglas.***

8.1. As outlined in my reply to 6a), the long interview with Ms Douglas, held at her request, was wide-ranging, discussing AIDS and what we knew about it at the time. It reflected my 'open-door' policy: I felt that experts in such a rapidly developing field had a responsibility to raise public knowledge and understanding, and that the media had a key role in that.

8.2. I do not agree that she checked the 'quote' in the 1st May 1983 article, as I would have corrected it had she done so (see also my reply to 9). I appreciate that this was her normal practice, but I do not know why it didn't happen on this occasion. Perhaps she was unable to reach me because of my extensive clinical and academic activities.

9.0 ***Please consider the document sent by Julian Meldrum to the Press Council, complaining about press coverage of AIDS [HSOC0016078_003]. This document states:***

At p. 2 that *"Dr Tony Pinching is willing to submit evidence in support of the points made".*

At p.8, referring to the article on 1 May 1983, that *"The text of the report, as printed, misquotes and misrepresents the views of Dr Tony Pinching, one of the doctors quoted, and the only one quoted in support of the principal angle, who insists that he did not use the word "madness" at any time while speaking to Susan Douglas. His view was, and remains, that it would not be wise to use American Factor VIII or other blood products, unless there were no practical alternative. The alternative suppliers of Factor VIII mentioned would not be able to meet the needs of haemophiliacs dependent on this product in Britain. The balance of risks and benefits should depend on the circumstances of individual patients and the clinical judgement of their medical advisers."*

Also at p. 8, referring to the article on 8 May 1983, that *"This report again, and more seriously, misrepresented Dr Pinching's views. He in fact stated repeatedly that he "wouldn't dream of giving a patient American blood products" unless there were no alternative, and that he did not support the call for an immediate ban on imports of American blood products."*

a. Did you see this document at the time it was produced?

9.1. Yes, I remember that I did. I do recall one or more conversations with Julian Meldrum about this. I recall him as being very meticulous and thorough in his approach.

b. Please comment on the accuracy or otherwise of what is set out in this document insofar as it refers to your position and your views.

9.2. His statements relating to me and my views are accurate, and sound very much what I would have said to him at the time. The key phrase *"unless there were no alternative"* sounds correct, and is apparently admitted by Ms Douglas, within his article, as having been removed by a sub editor. See my reply to 7 a).

c. What was your understanding at this time (in May 1983) of the alternatives to treatment with American Factor VIII products that might be available? In particular, was it your understanding that there were no alternatives? If so, what was the basis for that understanding?

9.3. The availability of Factor VIII products from different sources was not an area of my expertise, although I understood at the time (mainly from Haemophilia Centre Directors) that USA was the only country capable of providing the quantity of Factor VIII then needed by UK haemophiliacs, and that alternative suppliers would not be able to meet the needs of UK haemophiliacs. My view on American blood products in the context of AIDS at the time is set out in my reply to 6 a) above.

d. Was it, as recorded by Mr Meldrum, your position at the time (and if so why) that you did not support the call for an immediate ban on imports of American blood products?

9.4. Mr Meldrum would seem to be quoting views that I held at the time. While I was not an expert in blood products and their usage, I derived my understanding from the scientific literature, and from wide discussions with expert colleagues, including several haemophilia specialists. Based on this at that time, I would have felt that an outright ban without an alternative source could have removed a product that had had a major impact on the quality of life of haemophiliacs.

9.5. As with any other medical intervention, the impact of new or emerging risks from treatments used should be balanced with the relative benefits in clinical judgement, and discussed appropriately with patients.

e. Having regard to the sentence "The balance of risks and benefits should depend on the circumstances of individual patients and the clinical judgement of their medical advisers", was it your expectation that the

balance of risks and benefits would be fully discussed **with individual patients by their medical advisers before treatment was given?**

9.6. Yes, see above in reply to 9 d). This is usual clinical practice.

10.0 ***An article by you, entitled "The Acquired Immune Deficiency Syndrome (AIDS)" [PRSE0000411], appeared in the Haemophilia Society's Bulletin No 2 of 1983.***

a. How did you come to write this article?

10.1. I was asked, as I recall, by David Watters of the Haemophilia Society, to write a brief background article about AIDS. I do not have a record of the date of publication, nor the date of submission of my article, but the likely submission would have been between February and April 1983.

10.2. I was writing several such articles, on request, for diverse professional groups and others (e.g. an early article in *The Magistrate*), to help raise awareness of the emerging facts about AIDS.

b. Please consider the paragraph beginning "How does this affect haemophiliacs?".

i. You stated that AIDS had affected roughly 1 in 1000 haemophiliacs in the UK and two patients in the UK. What was the purpose of including these figures in the article? Why was no reference made to cases which were being reported in other European countries [PRSE0002321 (Spain), DHSC0000717 p4 (Germany)]?

10.3. Correction: The relevant article stated: *"AIDS has affected roughly 1 in 1000 haemophiliacs in the USA, and two patients in the UK."*

10.4. My article was a short account of the basic factual knowledge about AIDS at the time of writing, but it was appropriate to make brief specific

reference to the specific area of haemophilia for the *Haemophilia Bulletin*.

10.5. The figures from the USA were used because the epidemic was most advanced there, and thus it had the most extensive epidemiological data. The figures for the UK were most relevant to a UK readership.

10.6. I would have been aware of the published Lancet letter about cases from Spain but, for this brief report, a full review of the European epidemiological data was beyond its scope.

10.7. I would not have seen the paper from the Lisbon Meeting in May of the 'Committee of Experts on Blood Transfusion and Immuno-haematology', as this was not widely published, to my knowledge; I may have been aware of German cases, but my point about wider European data applies.

ii. Why did you characterise the risk to haemophiliacs as being "to some extent theoretical" and "probably small"?

10.8. The statement was my honest belief, based on the data available to me at the time. We were reliant on AIDS case ascertainment, with no marker for the causative agent, which was not yet known. Very few cases of AIDS had been identified in the UK by early 1983, the likely time of writing, and there was still considerable uncertainty about the extent to which the UK would be affected.

iii. Was your reference to the "enormous benefits of such concentrates in haemophiliacs, especially for home therapy" intended to encourage haemophiliacs to continue to accept treatment with US factor concentrates and if so why?

10.9. No. This was definitely not my intent, nor would I have had any motive to do so. This extracted phrase – and therefore the associated question

– is very unhelpfully removed from the context of the whole paragraph, which can and should be read as a whole:

"How does this affect haemophiliacs? AIDS has affected roughly 1 in 1,000 haemophiliacs in the USA, and two patients in the UK. The immediate source of infection in such patients is thought to have been Factor VIII concentrate, derived as it is from thousands of donors. On the other hand, this new and to some extent theoretical hazard of using concentrates has to be set against the enormous benefits of such concentrates in haemophiliacs, especially for home therapy. As in any other medical setting, the risk of treatment has to be balanced against the dangers of the disease itself. Factor VIII concentrate from the USA may be the most likely to contain the AIDS agent: however the risk is probably small and no source can be regarded as completely free from risk. Furthermore the USA is the only country capable of providing the quantity of Factor VIII currently needed by UK haemophiliacs. US producers of Factor VIII concentrate have already acted to reduce the risk of transmitting such an agent. The present balance of opinion among haemophilia centre directors in the UK therefore is that imported Factor VIII concentrate should continue to be used for those selected patients already receiving it: i.e. severely affected haemophiliacs with frequent bleeds, and excluding children and those with mild disease. The source of Factor VIII concentrates will need to be kept under constant review, as will blood donor policy, both by the medical profession and the relevant industrial concerns, to minimise or eliminate the risks."

10.10. The paragraph was an honest attempt to put the new and, at that stage, uncertain risk, in a balanced way into the context of current treatment for haemophilia in the UK.

iv. Bearing in mind that you were not a haematologist and not involved in the treatment of people with haemophilia, was it, in your view, appropriate for you to be setting out perceived advantages of treatment with factor concentrates in this article and if so why?

10.11. See my reply to 10 b) iii. I was setting out the need to balance risks and benefits, in the light of the new information available about AIDS at the time. The article inevitably predominantly addressed the issue of risk,

with its focus on AIDS. It was appropriate to put such new and, at the time, uncertain risk into the context of the rationale for the use of Factor VIII concentrates.

10.12. The benefits of Factor VIII concentrates in the treatment of Haemophilia, and to quality of life of patients were widely known and discussed at the time, as seen in the same issue of the *Haemophilia Bulletin*, for example. My knowledge of their benefits was derived from discussions with several Haemophilia Centre Directors as well as the literature.

v. You refer in the article to the "present balance of opinion among haemophilia centre directors in the UK". What was the source of your understanding as to that balance of opinion? Did you agree with that opinion and if so on what basis?

10.13. The comment derived from discussions with several Haemophilia Centre Directors, both as individuals, and also from their reports to me of the views expressed by colleagues at their meetings.

10.14. I didn't have any expertise or experience to agree or disagree, but I was hearing a consistent message from more than one individual.

vi. The last sentence of this paragraph states that "The source of Factor VIII concentrates will need to be kept under constant review, as will blood donor policy, both by the medical profession and the relevant industrial concerns, to minimise or eliminate the risks". What did you mean by this? What did you anticipate would and should be done to keep "under constant review" the "source" of Factor VIII concentrates?

10.15. This sentence means exactly what it says.

10.16. It emphasised that, as new data emerged, it would be important continually to review the selection of blood donors, and the sourcing (i.e. country/countries and donors) and the production methods for Factor VIII concentrates, so that such risks related to AIDS which became apparent could be minimised or eliminated.

10.17. I was keenly aware of how rapidly new information was becoming available, even month to month, in the two years since the first case reports of AIDS. It was less than a year from first publication (July '82) of epidemiological data indicating risk in recipients of blood/blood products.

10.18. It seemed very likely that the suspected infectious agent (at that stage only known by how it seemed to spread, as shown by the epidemiological data on the groups affected) would be identified, and that in due course tests for it could be developed.

10.19. By these means, I envisaged that it would be possible to select donors, screen them and products derived from them, as had been done for Hepatitis B, and possibly further to reduce risk further during the manufacturing process.

10.20. I saw this as a role for all those bodies responsible for obtaining, preparing and utilising blood and blood products.

vii. The last sentence of the article refers to the need to keep the continuing implications for many members of the population "in a proper perspective". What did you mean by that?

10.21. This final general summary paragraph needs to be read as a whole; the concluding sentence can thus be understood as a general final comment about the implications of AIDS for members of the wider population:

"AIDS is an epidemic new form of cellular immune deficiency; it appears to be caused by a viral agent transmitted by intimate contact or blood product inoculation. Currently the disease is resistant to treatment; no specific tests for it or the causative agent exist. It has continuing implications for many members of the population, but these need to be kept in a proper perspective."

10.22. In early 1983, there was much public confusion and misunderstanding about AIDS, notably about its scale and routes of transmission of the causative agent, especially in the light of some alarmist coverage in the popular press. It was important that everyone knew the facts as they emerged, kept up to date, were able to assess their own risk, but had it in perspective with the many other risks that we all encounter in our lives.

11.0 ***On 9 May 1983 Dr Nicol Spence Galbraith, of the Communicable Disease Surveillance Centre, wrote to the DHSS advocating the temporary withdrawal of all imported US blood products [CBLA0000043_040].***
a. Did you see this letter at the time or otherwise become aware of its contents?

11.1. I do not recall seeing it. I feel sure that I would remember if I had, given that the matter related to the *Mail on Sunday* articles discussed above.

b. Did you have any discussions at the time with Dr Galbraith about these issues? If so please provide details.

11.2. No, I do not recall doing so; again, I think it likely that I would remember if I had.

11.3. I cannot exclude the possibility that he or a colleague might have contacted me by telephone in the wake of the *Mail on Sunday* articles – in view of the fact that I was quoted therein, but I have no record of that.

11.4. I do not remember any contact with Dr Galbraith – for whom I had a high regard – at that time on this topic.

11.5. As emphasised above, this was not an area of my special expertise nor of any formal responsibilities at the time. Therefore, I would not expect to have been in receipt of a copy of such a letter, nor involved in policy discussions about it.

Section 3: Other matters

12.0 ***You were the Scientific Secretary to the MRC Working Party on AIDS [CBLA0001749]. At or following its meeting on 20 December 1983 [DHSC0002239_115], a report was produced about the possibilities for research on AIDS in the UK.***

a. The second page of the report stated that cases of AIDS had occurred already in haemophiliacs and "more are likely". What if anything can you recall about the discussions that took place regarding the risks to haemophiliacs and the likelihood that there would be more infections?

12.1. I must emphasise that the MRC Working Party was focused on UK Medical Research, as set out in the Terms of Reference.

12.2. Department of Health Observers were present and their role in relation to the Working Party is set out in item 7 of the first meeting (10.x.83)

12.3. The Report was a collation of expert advice gathered at the time, as explained. I was substantively involved in the drafting of the Report. I cannot add anything to what is in the Report, and in the minutes from the meetings, but would regard these documents as a careful, full and thorough assimilation of the information available and advice received at the time.

12.4. I have retained no records from those meetings and deliberations. They were destroyed in 2003, when I left my post at Barts & The London.

b. Professor Arthur Bloom was a member of the Working Party. What if anything can you recall about any discussions with, or contributions from, Professor Bloom regarding the risks to haemophiliacs?

12.5. The Minutes are a proper record of the meetings and attributed comments can be seen therein, e.g. item 7 of the 2nd meeting (20.xii.83.).

12.6. Item 7 refers to Minutes of CBLA Working Group on AIDS that was presented at the meeting and spoken to by Professor Bloom. I do not have a copy of the CBLA Working Group Minutes, but I am sure that the Inquiry could obtain one, if it has not already done so.

12.7. I do not have any specific additional recollections about Prof Bloom's contributions, nor do I retain any records of them. I recall that he was a clear and open contributor to the discussions regarding haemophilia and blood products. The article in the *Haemophilia Bulletin*, based on his AGM talk a few months before, but suitably updated, gives a fair sense of what would have been some of his thoughts.

c. The report referred to a study underway by Haemophilia Centre Directors, observing that "It offers a special opportunity to study attack rates, incubation periods and other important factors". What if any involvement did you have in the study?

12.8. I had no involvement in this study.

13.0 ***At the Working Party's meeting on 25 October 1984 [MRCO0000541_047] it was recorded (p.2) that "Some members thought that it might be unethical to inform patients who were seropositive for HTLV-3, since no treatment could be offered if AIDS developed subsequently. However, haemophiliacs may wish to know so that they can use barrier methods of contraception to try to avoid infecting their wives and any children born subsequently". What if anything can you recall about this discussion? Which members thought it might be unethical to inform patients who were seropositive? Was that a view you shared at the time?***

13.1. I recall the discussion, one of several along similar lines in different fora at the time. My recollection is that the point of view that it might not be ethical for HTLV-3 seropositive individuals to be told their status was put forward by a few members who had less or no direct involvement in patient care, but I do not remember whom. This issue was only starting to be addressed at that time, and many were only just starting to appreciate the complex issues involved.

13.2. My strong opinion was that:
a) individuals *must* be informed and counselled prior to testing for HTLV-3/ HIV, for whatever purpose such testing was proposed; *and*
b) that they *must* give informed consent to such tests; *and*
c) that they *must* be told the result with full post-test counselling:
to enable them, if positive, to minimise any risk of transmission to others (and, if negative, to reduce their risk of contracting HTLV-3/HIV);
to ensure that they were aware of, and being monitored for, any signs of ill-health, so that appropriate interventions could be offered; and to advise on how to maximise their health and wellbeing.

13.3. I articulated these views in other fora, including at Department of Health's EAGA and its subgroups.

13.4. I should note that, during my years of work on AIDS, I developed a keen interest in Ethics as applied to Medicine, and how it was being reshaped by the challenges of AIDS and HIV. In October 1984, my interest and awareness in Medical Ethics was already present, and this issue, together with those of clinical confidentiality and resource allocation, were major topics on which I strongly articulated and acted upon such ethical imperatives.

13.5. It is also clear that issues raised by AIDS/HIV necessitated the reshaping of many areas of clinical practice and medical ethics.

14.0 ***An article in the Guardian on 15 October 1985 [NHBT0000024_018], concerning the transmission of HIV through blood transfusion, records you as stating "We are only talking about a handful of cases in the pipeline, it is unlikely to be in double figures."***
a. Is this a statement which you made at the time?

14.1. Yes. I believe so. This article specifically relates to transfusions of blood, not of pooled blood products such as Factor VIII concentrate.

14.2. Andrew Veitch was at this time a notably accurate and thoughtful journalist when reporting on AIDS/HIV.

14.3. This was my honest opinion and estimate, based on my knowledge at the time. It was expressed to a journalist, who was reporting on the Department of Health statement, when he telephoned me to ask for my views.

14.4. My estimates reflected the fact that measures had already been taken to protect the UK supply of blood for transfusion, and that these would have reduced the risk, which was already small. HIV testing had not yet been introduced for blood donors, but this was about to be started around that date.

14.5. We did not yet have results from wider HIV sero-prevalence studies in different populations in the UK, nor was there a full understanding of the natural history of HIV infection and rates of progression to AIDS.

b. If so, what was the basis for your view that there would only be a handful of cases, unlikely to be in double figures?

14.6. See my reply to 14 a).

15.0 ***An article in the Daily Mail on 13 February 1986 [HSOC0019518_020] reported concerns expressed by Dr Peter Jones about the effectiveness of heat treatment in inactivating HIV. It reports that you challenged Dr Jones' claim that heat treatment might not always work and sets out your belief that patients may have been infected before they started to receive heat-treated product.***

a. Does this accurately report your views at the time?

15.1. No, not as stated. The article is presented in such a way as to suggest a polar opposition between Dr Peter Jones's views and my own, and to imply a certainty that I did not have, nor expressed. As so often happened, the reporting has created a falsely polarised impression of our views about a complex and nuanced issue.

15.2. The evidence of which I was aware at the time suggested that heat treatment could substantially reduce risk, but prospective data were not yet available on whether this was fully effective (compare: *"absolute guarantee").*

15.3. The concerns that heat treatment might not be fully effective – relayed to me by the journalist in a telephone enquiry – seemed to be based on presumptions about blood products previously used in the case(s) described; prior use of non-heat-treated blood products could have been the source of their HIV infection.

15.4. I was simply trying to caution against premature, or over-, extrapolation, from what seemed to be limited, anecdotal data. I was not *"… challenging Dr Jones's claims …"*, but expressing caution about how to interpret the available data.

15.5. I emphasise this was not my principal field of activity, but I was informed from the scientific literature and specialist AIDS/HIV meetings as well as from discussions in EAGA subgroups at the Department of Health about issues pertaining to blood product processing.

b. If so, what was the basis for your confidence in heat treatment?

15.6. See above, in my reply to 15 a).

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

16.1. HIV & affected haemophiliac children in Schools: I note my involvement (late September 1985) in speaking to parents in person and to the public (via news media) about the first known case of a HIV-positive haemophiliac attending a school (in GRO-A). This was a pivotal time, and the careful handling of the issue by the child and his parents, the school, local education and health bodies was impressive and important in achieving constructive, balanced discussions, and ultimately a good outcome.

16.2. I was asked by the local health and education bodies to speak at a meeting with parents of the other children at the school; this was a few days after the announcement to the other parents about the situation of this boy, whom they had stated would remain in the school. I spent some three hours one evening, speaking and answering all their questions, in the public session and privately afterwards. I also spoke to journalists, and on an early evening local television news show prior

to the meeting. All but one family allowed their children back to the school in the days after. Other schools and parents were able to follow their examples.

16.3. I did write an article about this episode; if it is not available to the Inquiry but of interest to it, I may be able, given some time, to find a copy.

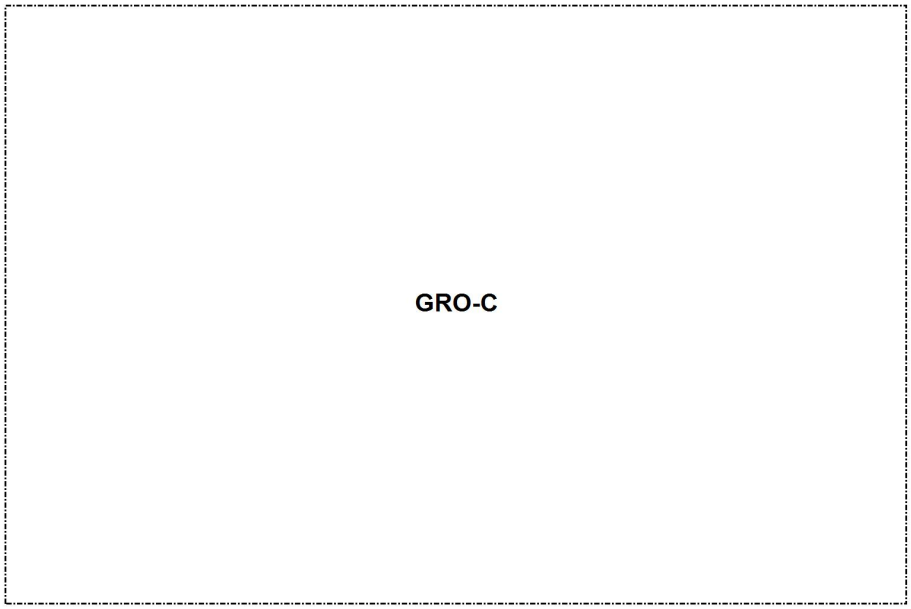
16.4. General Comments: Specialists working in the field of AIDS/HIV were frequently, and understandably, asked – by politicians, civil servants, colleagues, professional bodies, journalists, etc., and the public – to explain the scientific facts for the public and to project likely futures, especially in the first decade of the epidemic. We did the best that we could in a complex and rapidly moving field, where many key data were still lacking. As more data emerged, so our predictions and projections, and opinions, were refined or changed, as is normal in any scientific field.

16.5. Looking back forty years, it may hard for others now to appreciate the problems of balancing the desperate need for more information about AIDS, among many people and groups, at a time when those data were not yet available, and – for those working in the field – the need to make reasonable judgements and predictions, from the fragmentary, changing picture – over the first 5-10 years especially.

16.6. Personally, I was open and honest in giving comments – stating the facts known to me, and giving my personal professional opinion.

Statement of Truth

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



Signed

Dated 2nd May 2023