Witness Name: Professor Stephen Palmer
Statement No.: WITN7654001
Exhibits: N/A
Dated: 2 February 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF PROFESSOR STEPHEN PALMER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006, dated 2 February 2023.

I, Professor Stephen Palmer, will say as follows: -

Section 1: Introduction

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

1.1. I am Stephen Royston Palmer of GRO-C GRO-C My date of birth is GRO-C 1951. My professional qualifications are as follows:

- MB BChir (Cantab) 1975
- MA (Cantab) 1976
- Fellow of the Faculty of Public Health Medicine 1987
- Elected Fellow of the Royal College of Physicians 1999

2. Please provide an overview of your career in medicine and government, including details of your medical training and any particular areas of interest and expertise. Please set out the positions you have held, the dates that you held these positions and the organisations in which you held these positions.

2.1. After qualifying in Medicine I trained in Epidemiology and Public Health at St Thomas' Hospital Medical School, and then in Communicable Disease Control at PHLS CDSC Colindale. I was appointed as PHLS CDSC's first medical consultant epidemiologist for Wales, taking up post in May 1983 and continuing until 1998. Initially I was based in Cardiff Public Health Laboratory but over the next few years I was able to employ scientific and technical staff funded on Welsh Office grants to the PHLS to undertake research projects and to develop electronic surveillance systems for Wales; we became a small regional unit (CDSC Wales) managed as a cost centre within CDSC Colindale. I specialised in emerging and re-emerging zoonotic and foodborne infections, and I subsequently initiated and edited the Oxford Textbook of Zoonoses.

2.2. From 1992 to 1998 I continued as head of CDSC Wales part time because in 1992 I took up a newly created post of Director of the Welsh Combined Centres for Public Health (WCCPH) in the Welsh National School of Medicine. The purpose of the WCCPH was to develop all-Wales collaboration in injury control, chemical hazards and other non- communicable public health functions, and take on responsibility for managing the public health training programme in Wales. In 1998 I left PHLS CDSC and took up the Mansel Talbot chair of Epidemiology and Public Health in the WNSM/Cardiff University, a post I held until retirement.

2.3. Whilst an academic within the WNSM/Cardiff University I set up a UK chemical hazards service for public health, and in 2003 I was invited to set up the UK's Health Protection Agency Chemical Hazards and Poisons Division. Following that I was the Director of the HPA Local and Regional Services Division, and then the HPA's Head of Profession for Epidemiology.

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. Please provide dates of your involvement with any such committees or groups which you regularly attended or observed; provide as best you can an outline of the remit, functions and activities of each such committee or group; and describe your role in relation to each as member/attendee/observer.

3.1. My post as regional Epidemiologist for Wales was funded by new monies from the Welsh Office in anticipation of the loss of communicable disease control experience and expertise through impending retirements within the CMO's team. Therefore, a part of my role was to support the CMO's team though wholly employed by PHLS, and in this role I acted as Welsh Office Observer at many government scientific and medical committee meetings from 1983 to 1992. I cannot recall dates from memory and would need to have access to the minutes of the various committees to give more details. My role at these committees was to represent the CMO Wales and identify issues of particular relevance to Wales and to report back to the CMO. These committees included:

- The Advisory Committee on Dangerous Pathogens
- The Advisory Committee on Hepatitis

3.2. Within the Welsh Office I was a member of the AIDS steering group initially chaired by Peter Gregory. I would need to see the minutes to

recall details. The lead medical officer in the CMOs department was Dr Michael George, deputy CMO.

3.3. I was a member of the Advisory Committee on Dangerous Pathogens / Spongiform Encephalopathy Advisory Committee TSE Working Group (1997 - 1999) and contributed to "*Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection, 1998*".

3.4. I have served on numerous scientific and public health committees and working groups for the MRC, World Health Organisation, European Centre for Disease Control, Department of Health, Food Standards Agency, and Welsh Government, and was Chair of Welsh Government's Health Protection Committee, 2010-13.

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 if so.

4.1. I have not 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.

I have given evidence to the BSE Inquiry which is noted in the Phillip's Report.

Section 2: The Public Health Laboratory Service/CDSC's structure, role and relationships with others

5. *The Inquiry understands that you were the Regional Epidemiologist for Wales at the Public Health Laboratory Service ("PHLS") and the Head of the Welsh Unit of the Communicable Disease Surveillance Centre ("CDSC"). Please confirm if this is correct and describe your role and responsibilities in these positions.*

5.1. I was appointed as Regional Epidemiologist for Wales in 1982 and took up post after returning from CDC Atlanta in May 1983. Though based in Cardiff I was a member of the epidemiological team of CDSC directed by Dr Spence Galbraith (and after him by Dr Chris Bartlett). I could be deployed anywhere in England and Wales to investigate communicable disease incidents. Professionally I reported directly to Dr Galbraith, and then to Dr Barlett. In Wales my role included supporting the professional team of the CMO (Dr Gareth Crompton and then Dame Deidre Hine) and this included acting as Welsh Office Observer on Government Advisory Committees as noted above. However, the greater part of my time was devoted to supporting NHS and Local Authorities in Wales by developing epidemiological surveillance of communicable diseases, undertaking field investigation of incidents, giving advice on management and control of incidents, and supervising training in field epidemiology.

5.2. Over time I won funding from WO and PHLS to appoint scientific and technical staff and a second consultant medical epidemiologist (Dr Roland Salmon) and we became the Welsh Unit of CDSC. Dr Salmon

took over from me the observer roles for the Welsh Office, and he became head of CDSC Wales in 1998 when I stood down from PHLS.

6. Please describe:

6.a. *the role of PHLS, both in Wales and more generally and the extent to which, and the process whereby, the PHLS in England and the PHLS in Wales worked together, shared information and collaborated on decision-making and policymaking concerning the risk and spread of infectious diseases, including HIV.*

6.a.1 The PHLS was an England and Wales expert medical microbiological service funded by grants from the DH and the Welsh Office. There was an annual meeting between Welsh Office and PHLS HQ to discuss performance and funding. The PHLS was directed by the Head of the Service answerable to the Board. When I came to Wales there were PHLS Laboratories in Cardiff, Swansea, Carmarthen and Rhyl. There was no Wales regional organisation; each laboratory director reported to the Head of the PHLS in Colindale who was supported by two deputy directors. There were monthly directors' meetings in Colindale and directors took this opportunity to discuss with colleagues and with the Head of the Service informally.

6.a.2 Each laboratory was responsible for the microbiological investigation of outbreaks and incidents in their area, and undertook food and water microbiology. Most were also doing diagnostic work by contract with the NHS. Directors were usually looked upon personally as leaders in health protection, and were looked to for expert advice on infectious disease matters by health and local authorities. Each PHLS laboratory was required to report infections identified each week to Colindale, although the compliance with this surveillance function was highly

variable. (NHS laboratories were also encouraged to report to Colindale). The reports were collated each week and published in the Communicable Disease Report.

6.b In addition to the local and regional laboratories there were also PHLS reference laboratories specialising in specific organisms, mainly based in Colindale but also sometimes sited in regional laboratories. The Virus Reference Laboratory in Colindale would have been the laboratory leading on hepatitis and HIV. Cardiff PHL hosted the Mycobacterium Reference Laboratory.

6.b.1 PHLS had a number of working groups and expert committees with chairmanship and membership taken from across the whole service, recognising the different specialisms of medical consultants and PHLS scientists. These groups produced scientific and technical documents in support of the NHS and Local Authorities and other agencies involved in health protection. Committees/working groups I remember being involved in dealt with Meningococcal meningitis, zoonoses, foodborne diseases, and Norovirus.

6.b.2 PHLS was focused on scientific and technical microbiological, virological and epidemiological expertise in support of NHS and local authorities and was not responsible for public health policy which was seen as the responsibility of the Department of Health (and the Welsh Office). Advice might be given to DH and the NHS and to other organisations by experts within the PHLS in their own personal professional capacity through direct consultation or membership of expert committees, and through publication of scientific papers and reports. When CDC was set up in Colindale a senior medical officer from the DH was seconded full time to CDSC to ensure good working links with DH.

6.c. *the role of the Welsh Unit of the CDSC and the extent to which, and the process whereby, the Welsh Unit and the CDSC in London worked together, shared information and collaborated on decision-making and policy-making concerning the risk and spread of infectious diseases, including HIV.*

6.c.1. CDSC in Colindale began life as a very small enterprise with only a handful of professional staff. When I took up post in 1983 I was the only CDSC consultant epidemiologist in the regions and the first to be appointed through the CDSC training programme. There was only one other CDSC consultant field epidemiologist, who was based in Colindale. There were two other consultant epidemiologists in the PHLS based in Manchester and Oxford laboratories, and there was an Epidemiology Research laboratory in Colindale which initially was not part of the newly created CDSC. Eventually these epidemiologists were brought into the CDSC, and other regional epidemiologists were appointed. However, though these regional epidemiologists developed regional units they were always under the direction of the Head of CDSC.

6.c.2. Information sharing, formally and informally, was the *raison d'etre* of CDSC. CDSC held regular monthly scientific and management meetings attended by regional epidemiologists. CDSC was set up to undertake surveillance, support field investigation and to facilitate communication on communicable disease incidents. Discussion of risk and possible control measures was integral to all discussions though we understood that public health and NHS policy lay with the DH. CDSC's views were fed into PHLS HQ and to the DH through the Director of CDSC and through membership of advisory committees, through scientific meetings and informal discussions.

6.c.3. In Wales I shared CDSC information on surveillance and epidemiological developments and would have responded to requests for advice from the CMO and directors of public health and from directors of environmental health in Wales. The CMO Wales was

responsible for advising the Welsh Office ministers and senior civil servants on health policy, so any contribution to policy would have been through the CMOs or their deputies or via Welsh Office working groups and committees.

6.d. *the extent to which PHLS Wales had autonomy to take a different course from PHLS England.*

6.d.1 PHLS Wales was a later organisational development. When I came to Wales in 1983 each of the PHLs in Wales reported directly to PHLS HQ. I reported to CDSC Colindale.

6.e. *Your professional relationship with Dr N. S. Galbraith (**DHSC0002269_043**).*

6.e.1 My post was created by Dr Galbraith with funding from WO. Though I was initially based in the Cardiff PHL and had responsibilities within my job description to contribute to the CMO's department, Dr Galbraith was my director and I was always answerable professionally to him. For example, before I came to Wales the CMO wrote to me to ask me to give priority when I took up post to supporting the eradication of hydatid disease in Wales, which I did, with the agreement of Dr Galbraith. In ***DHSC0002269_043*** Dr Galbraith suggested to Professor Bloom that I might help with epidemiological studies. Dr Galbraith had discussed this with me and I was keen to help. I met Professor Bloom in his office to follow up this offer, but I was not invited to get involved.

7. *Please identify by name individuals who you had dealings with at the Welsh Office involved in decisions about blood and blood products, the assessment of the risks of infection (in particular HIV/AIDS) arising from blood and blood products, and the response to such risks. Please include: (i) ministers with responsibility for such matters; (ii) civil servants who played a significant role in forming and implementing policy in these areas; (iii) other advisers with whom you worked on such issues.*

7.1. I do not recall being party to decisions about blood and blood products though I would have discussed the probable sources of infection of AIDS with Dr Crompton and his colleagues such as Dr Michael George. The Welsh Office looked to the Director of the Haemophilia Centre (Prof Bloom) and the Director of the Blood Transfusion Service (Dr Napier) for specialist advice, as well as to the DH.

8. *Please describe the relationship between the PHLS in Wales, the CDSC in Wales and the Welsh Office.*

8.1. Welsh Office contributed to the funding of PHLS. PHLS Laboratories were part of a nationally (England and Wales) directed service supporting Health and Local Authorities in Wales. Individuals within the PHLS will have been asked to advise Welsh Office on microbiological and epidemiological matters. I have explained that I personally was counted as a member of the CMO's department by special arrangement and represented Welsh Office as Observer on some DH advisory committees.

9. *Did you/the PHLS/the CDSC in Wales have any role in the process by which doctors reported suspected AIDS cases to the CDSC or other bodies?*

9.1. AIDS reporting was directly from clinicians and laboratories to CDSC Colindale. I was not personally involved in reporting, but I was involved in following up the report of the first case of AIDS in a woman in Wales, at the request of CDSC Colindale. I recall interviewing a family member of that patient to ascertain possible exposures.

10. *Were there any employees within the PHLS/CDSC who had particular responsibility for liaising with the Welsh Office on issues concerning blood and blood products and/or HIV/AIDS?*

10.1. From memory I cannot recall specific discussions but Dr McEvoy at CDSC Colindale was handling day to day issues on behalf of Dr Galbraith.

11. *In your view, how effective was the relationship between the Welsh Office and the PHLS/CDSC?*

11.1. I believe the relationship worked well and I was given funding by WO to develop surveillance systems and research projects. I am not aware of any issues or problems. There was an annual meeting between PHLS HQ and Welsh Office so that any issues would have been raised there. To my knowledge there were none of a professional nature.

12. *In your view, how effective was the PHLS/CDSC in fulfilling their functions?*

12.1. I believe the PHLS laboratories in Wales and the CDSC Wales unit was effective and received strong support from WO colleagues and Health and Local Authority professional colleagues. The initiatives in developing electronic reporting of laboratory infections, initially funded by the WO, was taken up by the PHLS nationally. We were very successful in the investigation of outbreaks and contributed significantly to the understanding and control of emerging infections such as Salmonella enteritis, Campylobacter, Cryptosporidiosis, and VTEC amongst others. We also contributed strongly to the Welsh Office handling of BSE and our approach is commended in the Phillips Report.

13. *What role did you play in liaising and working with the Chief Medical Officer for Wales ("CMO")?*

13.1. I was counted as a member of the CMO's team as described above and attended the weekly Friday morning internal meeting of the professionals within the CMO's department, chaired by the CMO, where information was shared on emerging issues and reports of meetings.

14. *What was your understanding, in broad terms, of the role of the Chief Medical Officer ("CMO") for Wales during your time at PHLS? Please comment, in particular, on the following areas:*

14.a The extent to which the CMO was responsible for informing ministers about risks to public health.

14.a.1 My understanding is that the CMO was responsible for advising senior civil servants and ministers about public health risks.

14.b The extent to which the CMO was responsible for shaping policy and informing ministers of policy options.

14.b.1 My understanding is that the CMO contributed to policy development, drawing on advice from expert committees, the Department of Health, as well as his and his own team's expertise. How that was done and how ministers were informed is beyond the scope of my knowledge.

14.c The extent to which the CMO was responsible for issuing guidance, advice or instruction to clinicians and health bodies as to the risks of infection from blood or blood products.

14.c.1 CMO would issue advisory letters to the medical profession in Wales on all medical matters. My understanding is that these would be done in consultation with the other CMOs in the UK and especially CMO England so that there was a coordinated national approach.

14.d. The extent to which the CMO was responsible for issuing guidance or advice for patients and for the public.

14.d.1 In general terms I believe the CMO would have been involved in advising senior civil servants on the need for health promotion messages for the public and would be involved in advising the director of the NHS in Wales on the need for advice to patients.

15. *To the best of your knowledge and recollection, how significant a role did the CMO for Wales play in forming policies on blood, blood products and the response to the risks of HIV/AIDS during your time at PHLS/CDSC?*

15.1. I was not directly involved in this area; the question is beyond the scope of my knowledge. The focus of the meetings I attended was more to do with the sexual route of transmission, although I would have identified the growing evidence that transmission was following the model of Hepatitis B, and therefore likely to include blood-borne transmission as well.

16. *What if any role did you have in advising ministers (whether within the Welsh Office or otherwise) on any risks of viral transmission from blood and blood products and on the causes and spread of HIV/AIDS?*

16.1. In my role as regional epidemiologist I tried to keep the CMO appraised of new epidemiological findings from surveillance and research. This would have been done at Friday morning meetings and at other meetings I was invited to attend. I did not advise ministers.

17. *Please consider the contents of a note written by an unnamed Welsh Office official (**HSSG0010218**) in response to a letter from Sir Kenneth Stowe (then Permanent Secretary at the DHSS) dated 6 October 1986 (**HMTR0000008_044**). The document lists certain measures taken in response to AIDS by the Welsh Office, and refers to the work of th"HEAC(W)" (which the Inquiry understands to be the Health Education Advisory Committee for Wales).*

17.a Please comment on your role in establishing those measures.

17.a.1 I do not recall that I had any specific contribution to any of the individual measures taken. My role was to keep CMO up to date with surveillance data and to contribute to discussions generally.

17.b Please explain the role and functions of the HEAC(W) insofar as they are relevant to the Welsh Office's response to AIDS. In particular, what role, if and did they play in respect of advising on policy connected with blood and blood products?

17.b.1 This question is beyond the scope of my knowledge.

17.c. Insofar as you are able to do so, please explain why the HEAC(W) was given a prominent role by the Welsh Office in terms of its response to AIDS.

17.c.1 The Welsh Office rightly believed that public understanding of AIDS was a vital component in the control of the epidemic. Communication of risk to the public is a specialist area and was thought to be best handled by a specialist and experienced committee.

17.d What role, if any, did you play in working with the HEAC(W) on AIDS-related matters?

17.d.1 I was not a member of the AIDS subcommittee and I do not think I had any specific part to play in working with HEAC(W) except through sharing surveillance and epidemiological findings through CMO's office.

17.e. Please comment on the significance, as it appears to you, of the comment that the HEAC(W) was "separate from the Welsh Office and free to speak, is broadly based and authoritative."

17.e.1. It appears to me that the comment refers to the greater ability of the HEAC(W) to speak frankly about high risk behaviours and the modes of transmission of AIDS and recommend preventive measures such as "Safe Sex" and needle exchange programmes that might have had some negative response from the general population. The members of the HEAC(W) had specialist expertise and experience in communicating to the public.

Communication with other agencies

Please describe the working relationship if any which you/ PHLS/CDSC had with (a) the Cardiff Haemophilia Centre and (b) Professor Arthur Bloom, its Director. Please also describe (in broad terms) the nature and extent of the interactions you had with the Haemophilia Centre and Professor Bloom.

18. *Did Professor Bloom have, from the perspective of the PHLS/CDSC/Welsh Office, a specific advisory role in respect of blood products, and the treatment of, and risks to, haemophiliacs? If so, please describe the nature of that role. Please describe the working relationship if any which you/PHLS/CDSC had with the Cardiff Regional Transfusion Centre/Welsh Blood Transfusion Service. Please also describe (in broad terms) the nature and extent of the interactions (if any) you had with the Transfusion Centre and/or its director, Dr John (Tony) Napier.*

18.1. Prof Bloom was chair of the UK Haemophilia Centre director's group and the views he offered to the CMO would have been received in that light. It is beyond the scope of my knowledge to say whether Prof Bloom could be considered as advising Dr Crompton on policy or actions to be taken beyond his accepted role of reporting the views of the Haemophilia Centre directors. My own connection with Prof Bloom was limited to attendance at one or two meetings where he was present, and one visit to his office to follow up the offer from Dr Galbraith that I might help with epidemiological studies. The offer was not taken up; the meeting was cordial but brief. As to the Blood Transfusion Service, I did not have a direct working relationship. I attended one or two meetings where Dr Napier was present.

19. *The Inquiry understands that, during your time as the Regional Epidemiologist for PHLS Wales, Dr Skone was Chief Administrative Medical Officer for South Glamorgan Health Authority. Please describe your professional relationship*

with Dr Skone, and more generally any other Chief Administrative Medical Officers, and how you communicated with them.

19.1. I knew Dr Skone well professionally, and he was very supportive in establishing the new role I had in Wales. Dr Skone was very interested personally in health protection matters. There were several outbreaks and incidents in South Glamorgan that I helped investigate and control and I worked closely with him and his team, particularly with Dr Pat Jenkins who had special responsibility for communicable disease control. As regional epidemiologist I supported all the CAMOs and their colleagues in Wales. I was occasionally invited to the all-Wales meetings of the CAMOs. I communicated outside of formal meetings by telephone, letter and by personal visits, depending on the issue. The CAMOs were free to speak directly with Dr Galbraith and he with them, and I think Dr Skone would have kept in touch with Dr Galbraith.

Relationship between the Welsh Office and the Department of Health

20. *To your knowledge, how much oversight, if any, did the Department of Health (Westminster) retain over health policy decisions made in respect of Wales? Please provide any relevant examples.*

20.1. This question is beyond the scope of my knowledge.

21. *To what extent did the Welsh Office attempt to align its policies and activities with those of the Department of Health on such matters and on health policy more generally?*

21.1. This question is beyond the scope of my knowledge.

22. *Did you have regular interactions with civil servants in the Department of Health (Westminster) on matters relating to the risks of infection from blood or blood products/HIV/hepatitis and if so whom?*

22.1. No, I had no interaction with civil servants on these matters, to my recollection.

Section 3: Knowledge of and response to the risk associated with infected blood/blood products

23. *Please describe when and how you first became aware of AIDS, and when you first became aware of a possible link between AIDS and blood and blood products. Please explain the sources of your knowledge at that time, and how your understanding of AIDS and its transmission by blood and blood products developed over time.*

23.1 In 1982/3 I was seconded to the CDC Atlanta. I was in the Division of Enteric Diseases but attended weekly briefing meetings of the field services epidemiologists where the earliest reports of AIDS were shared. The risk groups became evident quickly including reports of patients with haemophilia developing AIDS. Though the cause of AIDS was not known, the most likely scenario was transmission following a Hepatitis B model.

24. *Please state which journals and publications you would regularly receive and consider in the early and mid-1980s. In particular, please comment on whether you would typically receive and consider: (i) Morbidity and Mortality*

*Weekly (please see **PRSE0000523** and **PRSE0003276**), (ii) The New England Medical Journal, (iii) The Lancet, (iv) The British Medical Journal. What other sources of information were available to you on a regular basis?*

24.1. In August 1982 I was working in Bristol within the Neonatology Unit and with the Paediatric Department of Bristol University. In December 1982 I was working on enteric disease outbreaks in USA. I do not recall seeing the MMWRs referred to above at that time, although I would probably have read them on return to the UK as AIDS emerged as a UK problem. The PHLS ran an excellent abstraction service through CPHL library. All key medical journals (including all the above) were reviewed each week and a listing of notable articles was circulated to the service each week. Articles or journals could be requested. In addition, I used the WNSM library.

25. *How did AIDS in general, and the link between AIDS and blood and blood products in particular, affect your professional role? Were you given additional or specific responsibilities as a result of the growing knowledge of AIDS?*

25.1. When I arrived back in CDSC to take up post in Wales Dr Galbraith personally was handling matters to do with AIDS. My priority in Wales had already been agreed to be hydatid disease. However, Dr Galbraith experienced some health problems and I was asked to attend some early scientific meetings on his behalf, which is why I went to the MRC and to Arrhus. I also attended the first International AIDS Conference in Washington on his behalf. However, quite quickly a large team of epidemiologists was employed in CDSC Colindale and they took on international liaison as well as surveillance and research. The major centres of AIDS were in St Mary's and Middlesex hospitals, and clinicians there were the national experts. It was natural for them to liaise with Colindale. I might have been involved in some of these studies had the offer to Professor Bloom from Dr Galbraith been taken up. However, I was not involved in any of the AIDS/HIV studies.

26. *Please consider a report on the National Institute of Health Workshop on the Epidemiology of AIDS, Maryland USA, made by you on 29 September 1983 (**HSSG0010054_010**). You conclude that "Much confusion exists about the significance of symptoms such as lymphadenopathy in AIDS risk groups. I suggest that the most useful group to study in this light is the Haemophiliacs." Please explain your thinking and why you considered "the Haemophiliacs" the "most useful group to study". What kind of studies did you envisage and to your knowledge were any undertaken?*

26.1. In the early days the clinical definition of AIDS was imprecise, partly because the major risk group had often multiple reasons for lymphadenopathy. The group that seemed most likely to have a single route of exposure with defined dates of exposure were patients receiving blood products. I thought that that group of patients would give the clearest profile of the AIDS syndrome and should be studied carefully. At the time I would have done a standardised clinical review of patients registered with Haemophilia Centres to identify patients meeting the AIDS criteria, and then retrospectively try to identify potential exposures by nested case-control studies, and prospectively follow up the patients to try to work out the natural history of the syndrome. As I have said above, I did not carry out or participate in any such studies. I see from a brief literature scan that such cohort studies were conducted from 1983 in Edinburgh and possible as early in London.

27. *On the 10 October 1983, you attended on behalf of Dr Galbraith a meeting of the Medical Research Council's Working Party on AIDS (**CBLA0001749**).*

27.a. What was your/Dr Galbraith's role in relation to this Working Party?

27.a.1 The Working Party was comprised of senior international experts in infectious diseases, virology and epidemiology. Dr Galbraith would have been invited as head of CDSC with responsibility for national surveillance of communicable disease. Because he was incapacitated, I was asked to attend.

27.b. *What was your understanding of the role of the Working Party?*

27.b.1. The purpose of the Working Party is clearly set out in the paper. The focus was on what research was needed to better understand the emerging problem of AIDS and then to advise the MRC and the DH.

28. *You attended the WHO Europe Conference, AIDS in Europe, In Aarhus, Denmark on 19-20 October 1983. You sent a minute about the meeting to Dr Crompton on 27 October 1983 (**HSSG0010056_053**). In what ways, if at all, did information from the conference influence Welsh policy on AIDS (and in particular transmission of AIDS from blood and blood products)?*

28.1. The meeting in Aarhus aimed to collate information on the emerging problem across Europe. The meeting endorsed the Hepatitis B model. I think that this was already accepted as the best working model by Dr Crompton and I do not think the Arrhus meeting and my note of it would have had any particular influence on policy in Wales.

Welsh Office meeting regarding AIDS on 19 November 1984

29. *On 19 November 1984 Professor Crompton convened a meeting of the Welsh Office on the issue of AIDS. Please consider the minutes of the meeting (**HSSG0010054_008**). In a briefing note dated 19 November 1984, AS Dredge summarised the views reached in the meeting (**HSSG0010054_005**). It may also assist to read the newspaper article referred to in the meeting, regarding the death of a haemophiliac patient in Newcastle Upon Tyne from AIDS which Mr Dredge noted "led to speculation in the press that the source of the infection was a blood transfusion" (**HSSG0010054_006**).*

30. *To the best of your recollection,*

30.a What involvement had you had in matters relating to AIDS and blood and blood products autumn 1984?

30.a.1. My recollection is that I kept Prof Crompton appraised of the latest surveillance data from Colindale but beyond that I did not have any specific involvement in AIDS and blood and blood products.

30.b What if any steps had been taken in Wales to reduce the risk of transmission of HIV through blood or blood products in that period?

30.b.1. This question is beyond the scope of my knowledge.

31. The briefing note states:

- *"There are at present a very few haemophiliac patients in South Wales, but it is likely that some may have received treatment with Factor 8 which might have been contaminated. The number at risk is estimated in single figures"* (paragraph 5)
- *"There is little that the Department can do which will immediately affect the present situation."* (paragraph 7)
- *"The risk to other types of patient from the use of whole blood is negligible: there is no evidence that any patient has contracted the disease in the United Kingdom from this source."* (paragraph 6)

31.a What sources of information did you and those attending the meeting rely on to make an assessment of the level of risk at that time?

31.a.1 I have no recollection of seeing this briefing note previously. The briefing note (**HSSG0010054_005**) makes statements about level of risk that I do not recognise from my own recollections nor from the minutes of (**HSSG0010054_008**). These may have been the views of some in the room but I do not recall that the meeting carried out any sort of formal risk assessment beyond sharing information on the current surveillance data and the state of play regarding issues noted in (**HSSG0010054_008**). I

do not recall that there was discussion on the population at risk from blood or blood products nor how risk could be assessed.

31.b Why did the meeting come to the conclusion that the numbers of those at risk of infection was in single figures? Was this view challenged? What was your view at the time?

31.b.1 I am not at all sure that the meeting did come to this conclusion. I do not believe we were in a position to make that conclusion based on evidence. At the time I do not think I would have had a view on the level of potential risk as distinct from trying to encourage good surveillance and timely analysis to get some data to inform risk assessment.

31.c. Why did the meeting come to the view that the risk of infection through whole-blood transfusion was "negligible"? Was that view challenged? What was your view at the time?

31.c.1 I do not believe the briefing note accurately represents the discussion at the meeting and reads quite differently from the minutes of the meeting. I do not agree that the meeting did come to the conclusion that risk was "negligible" although that may've been the view of some present. I repeat that at the time I do not think I would have had a view on the level of potential risk as distinct from trying to encourage good surveillance and timely analysis to get some data to inform risk assessment.

31.d. Why did those present conclude that there was little that the Welsh Office could do immediately to affect the present situation? Did those at the meeting

consider that steps could have been taken by other departments – for example the DHSS – to affect the situation? If so, what were those steps, and what efforts were made to seek to persuade others that they should be taken?

31.d.1. AIDS was a national and international problem and the lead rested with DHSS. Expert committees would be convened at this level and Welsh Office kept informed of developments. However, I do not believe the meeting was in a position to conclude that there was little the Welsh Office could do. The meeting did identify actions that should be taken up including supporting national surveillance and supporting national action to heat treat blood products and do more to exclude high risk individuals from donating blood. How and what steps were taken by Welsh Office to press these issues is beyond the scope of my knowledge.

32. In respect of "the second donor" discussed in the meeting, whose blood appeared to have contaminated 200 batches of Factor 8 including one batch used in Wales:

32.a. *Were you involved in decisions made on whether and how to inform the recipients of the batch used in Wales of the risk they had been exposed to?*

32.a.1. I was not involved with this case in any way.

32.b. Please provide any evidence that you can of what those decisions were, and how and why they were taken.

32.b.1. This question is beyond my scope of knowledge.

33. *The minutes indicate that the meeting discussed the policy of clinicians reporting suspected AIDS cases to the CDSC, and the tracing of such cases, but that the "mechanism devised had however not worked well in respect of the last South Glamorgan case". Do you know why the meeting reached that*

view? Please explain, insofar as you are now able to do so, what happened in this case.

33.1. I have no recollection of this episode. I suspect the matter was delay in reporting by clinicians so that establishing whether the patient had made blood donations was delayed.

34. *Please describe what steps were taken to make the reporting system more robust following the meeting. It may assist to consider* ***HSSG0010056_009****, a letter from the CMO to all Consultant NHS staff in Wales dated 23 November 1984 regarding the surveillance of AIDS.*

34.1. The CMO letter reinforced the need for reporting of possible cases to CDSC and to the BTS. Beyond this the need was for resources to be given to CDSC Colindale to handle the surveillance and follow up of the growing number of cases.

34.a. Please explain who had overall responsibility in Wales at this time to trace blood donors who might carry AIDS and prevent potentially contaminated donations being added to batches of blood product?

34.a.1. My understanding is that this was the responsibility of the Blood Transfusion Service in Wales.

34.b. Please explain how (i) you, and (ii) CDSC more generally, interacted with the Welsh Office, the NBTS and other relevant bodies on this matter at this point in time.

34.b.1 I do not recall interacting on this matter. Possibly Dr McEvoy at CDSC Colindale did but I cannot confirm this.

35. *On 21 December 1984 a Western Mail article was published reporting that over 50 people, including 9 from South Wales, had been exposed to blood (or blood products) from a donor infected with AIDS (****HSSG0010052_006****). Comments from Professor Bloom featured in the article. He was reported to*

have said that the "chances of them contracting the disease were almost negligible".

35.a. Did you have any involvement in this article? If so, please explain the nature of your involvement.

35.a.1 I had no involvement in this article.

35.b. Were you consulted by Professor Bloom before he made public comments on the case? Would you have expected to have been so consulted?

35.b.1 I was not consulted. I had no remit to vet such public pronouncement of NHS colleagues, and I would have been surprised if Prof Bloom had thought it useful to consult me since he was considered to be the international expert and the lead haematologist for the Haemophilia Centres in the UK.

35.c. Did you agree with Professor Bloom's analysis of the risk posed to these patients?

35.c.1 I do not believe I would have been able to endorse the risk statements on the basis of evidence. The rate at which exposed people became infected and the natural history of infection was not yet known.

36. *In a meeting on 4 May 1983 (not attended by you but by Dr McEvoy of CDSC) [**HSSG0010055_001** and **HSSG0010055_002**] the Welsh Office had considered whether to ban imported American Factor VII.*

36.a. When and how did you first become aware of the case of a haemophilia patient under Professor Bloom's care in Cardiff who was thought to have AIDS?

36.a.1 I do not think I had taken up post by the 4th May 1983. I do not recall how soon after I was appraised of the data on cases in Wales when I did take up post.

*36.b. The precise date and mechanism by which the report was made are unclear: in particular, whether Professor Bloom reported the case directly to CDSC as well as to UKHCDO, or whether his AIDS/3 form was passed to CDSC by Dr Craske. What if any discussions took place, to your knowledge, about that patient, or the implications of his infection, other than at the meeting on 4 May? (**WITN3408009**)*

36.b.1 This question is beyond my scope of knowledge.

36.c. What if any discussions took place, to your knowledge, about the possibility of banning (or limiting) the importation of US factor concentrates, other than at the meeting on 4 May?

36.c.1. This question is beyond my scope of knowledge.

37. *Also in May 1983, Dr Galbraith proposed to the DHSS that "all blood products donated made from blood donated in the USA after 1978 should be withdrawn from use until the risk of AIDS transmission by these products has been clarified" (**CBLA0000043_040**).*

37.a. Did you have any discussions with Dr Galbraith on this issue? If so please provide details.

37.a.1. I do not have any recollection of discussions with Dr Galbraith on this issue. Unfortunately Dr Galbraith GRO-C GRO-C was not able to be present at CDSC over the period, although the subject would most likely have been aired at CDSC internal meetings.

37.b. Were you aware of Dr Galbraith's views at this time? If so, to what extent did you agree with him?

37.b.1 I was just arriving back in the UK and I was not party to discussion before Dr Galbraith wrote his letter. The case that Dr Galbraith makes for the significant risk from imported blood and blood products is strong and I believe I would have agreed with

his assessment. However, the issue was generally understood to be the balancing of an as yet unquantified potential risk to those with haemophilia versus their known risks if Factor VIII was unavailable. Until there was an alternative safe supply of Factor VIII the quandary was extreme.

Hepatitis

38. *Please describe how you received information about the risks associated with hepatitis, in particular Non A Non B hepatitis, and how your understanding of the extent of the risks or severity of Non A Non B hepatitis developed over time. From what sources did you gather or receive information on the issue of hepatitis?*

38.1. My knowledge and understanding on NANB hepatitis would have come through general reading of the literature and information shared at scientific meetings.

39. T*he Inquiry understands that you attended meetings of the Advisory Group on Hepatitis (see* ***CBLA0001904 and DHSC0003826_106****).*

39.a. *Please explain, as far as you are able, the decision-making remit of this Group.*

39.a.1. The role of the Advisory Group was to inform and provide expert advice to Government health departments.

39.b. What was your role in relation to this Group?

39.b.1. I attended the Group as Welsh Office observer. My remit was to identify aspects of specific relevance to Wales and report to the CMO Welsh Office. There were PHLS experts from Colindale on the group.

40. *What role, if any, did you play in disseminating information about the risks associated with hepatitis, in particular Non A Non B hepatitis, to other organisations, clinicians or the wider public.*

40.1. I did not play any role.

Section 4: Work of Welsh Office post-1985 and other issues

41. *There was a high-profile public education campaign about the risk of AIDS from the mid 1980s. Please describe, in broad terms, the role you and the Welsh Office played in contributing to the content or development of the campaign, and to educational resources for the public and clinicians about AIDS more widely. It may assist to again review the note written by the Welsh Office on its AIDS campaign policy dated 6 October 1986 (**HSSG0010218**).*

41.1 I was not a member of the AIDS Sub Group and played no part in the campaign. I was a member of the Welsh Office AIDS steering group and would have kept the group informed of epidemiological developments and surveillance data. The question of the Welsh Office's contribution to the campaign is beyond the scope of my knowledge.

42. *Please again consider the note written by the Welsh Office on its AIDS campaign policy in response to the letter of Sir Kenneth Stowe dated 6 October 1986 (**HSSG0010218**), at paragraph 5: "From beginning [sic] Welsh Office has pressed the view that AIDS is primarily a social/ educational/ behavioural/ community problem, rather than a medical/ clinical one."*

42.a. What do you understand this comment to mean?

42.a.1 I do not understand the comment since AIDS was both a problem for society in terms of prevention, and for the medical service in terms of diagnosis and treatment including safety of clinical therapies. The note criticises DHSS for being slow on issues of real importance and gives the example of guidance to

surgeons etc which is a clinical issue and therefore does not support the statement quoted above.

42.b. How did this view shape the way in which the Welsh Office approached AIDS policy? In particular, what effect (if any) did it have on the approach taken to the risk of transmission of AIDS through the use of blood and blood products?

42.b.1. I do not recognise this view as representative of discussions within the CMOs team. I have no knowledge of how widely this view was held nor whether it had an influence on policy.

42.c. Is it a view that you shared at the time? Please explain your reasons for agreeing or disagreeing with it.

42.c.1 As a statement of the AIDS problem I disagree with it, as explained above. I know that the CMO's team worked hard with the dental profession, for example, to prevent blood borne infections, and also there was concern to prevent needle stick injuries in health care.

Statement of Truth

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

Signed GRO-C

Dated 2 February 2023