Witness Name: Mr Peter Alan Millner
Statement No.: WITN7721001
Exhibits: N/A
Dated: 20 June 2023

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MR PETER ALAN MILLNER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 15 September 2022

I, Mr Peter Alan Millner, will say as follows: -

Section 1: Introduction

1. My name is Peter Alan Millner D.O.B GRO-C 1959. I am a retired Consultant in Orthopaedic and Spinal Surgery.

2. I graduated with Honours in Medicine and Surgery from the University of Leeds School of Medicine in 1984. After Basic Surgical Training, I obtained the Fellowship of the Royal College of Surgeons of England in 1988 and then commenced Higher Surgical Training in Orthopaedic and Trauma Surgery, obtaining the Intercollegiate Specialty Fellowship in Orthopaedic Surgery in 1994. I did further sub-specialty training in Spinal Surgery throughout 1994 and 1995, in the inaugural post of the National Spinal Surgery Fellowship (based in the departments of Neurosurgery and Academic Orthopaedic Surgery in Leeds and Wakefield); I also did fellowships in trauma and spinal surgery at the University Hospital of

Geneva, Switzerland and at the Klinikum Karlsbad-Langensteinbach, Germany.

3. I gained my Certificate of Completion of Specialty Training in early 1995 and was then appointed as Senior Lecturer, University of Leeds and Honorary Consultant in Spinal Surgery at the Academic Unit of Orthopaedic Surgery based at St James's University Hospital, Leeds. In 2001, I left my academic post and became a full-time NHS Consultant Trauma and Orthopaedic Surgeon, specialising in Complex Paediatric and Adult Spinal Surgery, based at St James's University Hospital. In 2006, because of reconfiguration of Trauma and Related Services, I moved with my entire department to join my Neurosurgical Spinal Surgery consultants in a new integrated Spinal Surgery Unit based at Leeds General Infirmary.

4. I became the senior orthopaedic spinal surgeon in the department in 2007 and was the Lead Clinician for Spinal Surgery until 2011. From 2011 onwards, I ceased general orthopaedic trauma surgery and focused entirely on Spinal Surgery. Throughout my consultant career I held a variety of executive roles in the UK Spine Societies' Board, the British Scoliosis Society and the British Scoliosis Research Foundation. In addition to my clinical workload, from 1995 I ran an expert witness medicolegal practice until I retired from my NHS consultant post in April 2021. I remain registered with the General Medical Council but do not hold a licence to practice.

Section 2: Responses to criticism of the witness with Inquiry reference number W2640

5. This statement is made at the request under Rule 9 of the Inquiry Rules 2006, by the Infected Blood Inquiry, for the purposes of responding to professional criticisms made in paragraphs 16 and 17 of Witness Statement WITN2640, related to her mother's treatment at Leeds General Infirmary ("Leeds") while under my care from 2017 onwards; and professional criticisms made by the patient in Witness Statements

WITN2641001 and WITN2641015, respectively. This witness statement has been delayed pending receipt of copies of the patient's hospital records, which were received on 14 June 2023.

6. It is my understanding that unfortunately W2641 became infected with Hepatitis B virus in April 1979 because of a blood transfusion; at that time, I was a first-year medical student at the University of Leeds.

7. The criticism that has been made in WITN2640001 is that:

    7.1 "Mr Milner told us that the tested Mum for HBV by accident, when conducting other tests necessary for her operation. However, I do not actually believe that the test was requested by accident. He said it was a special blood test that had to be sent out of the hospital to a lab. If he had accidentally asked for it, it would have been flagged up. I work in public services, and if you request a test like that that costs more and requires more work, someone at the hospital would have double checked and asked why he was having it done and he would have had to justify it. I believe that Mr Milner knew my mum might have been at risk of hepatitis, because he knew the consultant who had performed her heart operation personally and was aware of the operation she had had. I don't think he would ever admit he knew she was at risk, but I think he might have suspected and wanted to test her to make sure. The fact that he felt it was necessary to say he had accidentally requested the test, to me, seems as though he would not have been expected to perform an HBV test on someone who he knew had previously had a blood transfusion, and wanted to avoid scrutiny of this decision by his seniors.

    7.2 The way Mum was first informed she might have hepatitis was in a letter from Mr Milner, telling her to have a test at the GP. I feel it's inappropriate to receive a diagnosis like that in a letter, particularly as my mum had no inkling that he had tested her for

HBV in the first place. I remember feeling shocked when she showed me the letter and reassuring her that it was probably a false positive - saying that tests can be wrong all the time. It was the first we had heard of hepatitis, and it shocked us both to think that she could have it and not known"

8. In addition, statement WITN2641001 made by the patient includes the following:

    8.1. "I do not know why Dr Gracie believed that I had been tested for hepatitis in error, given that my records note that Mr Milner had performed a liver function test as part of my post-operative assessment and this had come back abnormal, leading him to request a hepatitis screening."

9. Supplementary statement WITN2641015 made by the patient includes the following:

    9.1. "At paragraph 8 of my original statement, it states that during a post-operative assessment after a spinal surgery, a consultant orthopaedic surgeon called Mr Milner told me that I would need a special blood test. It also states that he said the blood test was not one of the routine tests he usually conducted.

    9.2. This information is incorrect. It should state that I was under post-operative care for spinal surgery and after a follow up appointment I was sent for what I thought were routine blood tests. At no point was it explained to me what the blood tests were for.

    9.3. I was never told that I would be having a special type of blood test. As far as I was aware they were carrying out routine tests as a follow up from my spinal surgery.

9.4. There was no mention of what type of test I was going to have or what the blood test was looking for. Dr Milner just stated that he was sending me for further tests and he completed the test request form which I then took to the hospital phlebotomist."

10. My first contact with the patient was in my outpatient clinic on 18 November 2015, following a referral from her GP with spinal problems causing low back and bilateral leg symptoms. I diagnosed spinal stenosis and advised surgical decompression and fusion, but in view of her history of cardiac surgery for mitral valve disease I thought she should be reviewed by a cardiologist, for advice on her fitness for surgery and any necessary perioperative precautions. I noted that she had undergone a variety of surgical procedures for other, non-spinal conditions, with no ill effect. I did not suspect that she had contracted Hepatitis B or any other blood-borne infection.

11. In due course, the patient was seen and investigated by my cardiology colleagues and declared fit for spinal surgery. I planned for up-to-date spinal imaging studies and for the usual pre-operative blood tests, which included full blood count, urea and electrolytes, liver function tests, bone chemistry, coagulation studies and inflammatory markers.

12. The patient was admitted to Leeds General Infirmary under my care on 16 August 2016 and underwent an uncomplicated posterior decompression and instrumented (pedicle screw) fusion of L3 to L5 vertebral levels on the same day; she made an uncomplicated and satisfactory recovery and was discharged home on 23 August 2016.

13. The patient was seen for follow-up in my clinic on 21 September 2016, 12 October 2016, and 18 January 2017, by which stage her pre-operative symptoms were much improved and she had recovered from her spinal surgery to the point where I told her that I felt she was fit enough to proceed with an operation on her left forefoot, which had been delayed

pending her spinal operation. I arranged a further review appointment for September 2017.

14. When I saw the patient in clinic on 11 September 2017, she told me that in March 2017 she had slipped and fallen down a grassy bank, causing pain in her upper thoracic spine. She told me she had attended the A & E department and had undergone x-ray examination, which revealed a fracture. She stated that she had also seen her GP, who had arranged blood tests and a DEXA (bone mineral density) scan, following which she was placed on medication for osteoporosis (risedronic acid).

15. I took new x-rays and confirmed the presence of a fracture in the T4 vertebra and noted a suspicion of loosening of the L3 vertebral pedicle screws that were used to hold her lumbar fusion in place; although she had no low back symptoms to indicate a fusion problem. I organised a new MRI scan of her spine, to assess the healing of her T4 fracture and look for other signs of bone disease that may have led to the fracture and screw loosening.

16. In addition, I arranged several blood and urine tests to look for causes of "weak bones"; these included routine tests for evidence of infection and special tests for osteomalacia and a type of bone marrow malignancy called myeloma. These special tests are sent to a regional laboratory and therefore the results can take several days or even weeks before they are available.

17. It is my usual practice to send the patient a copy of my clinic letter for their reference, as I am aware that it can be difficult to remember all the information and everything that is said in a consultation, and I note from the hospital records that indeed a copy of my clinic letter from 18 September 2017 was sent out to the patient.

18. I had no reason to consider that the patient had any form of blood-borne infection and therefore no reason and certainly no ulterior motive to order

tests for such infections. Had I had any suspicion that the patient was harbouring a blood-borne infection, from whatever source, I would have commissioned such tests pre-operatively so that I could take adequate precautions to protect me and my staff. This would have included counselling and a full explanation of the implications of a positive test. I didn't explain that an HBV test was being performed as I didn't intend for that to happen.

19. Subsequently, I recall being very surprised to receive the lab result stating that the patient had tested positive for Hepatitis B infection, as I did not know why or how this test had been booked; I even considered that the result might be a lab error and that the test result was for a different patient due to a mix-up; clearly, this was not the case.

20. My clinic practice was for my registrar or spinal fellow to sit in with me during consultations, for teaching purposes, and for the registrar or fellow to order various tests electronically on my behalf, while I continued to speak to the patient. I believe that this is probably how the HBV tests were mistakenly ordered, when ordering routine post-op liver function tests.

21. In September 2017 the electronic ordering system was new and was still under development, consisting of drop-down menus and options which then had to be selected, and it was quite easy to navigate to and select an incorrect option. I note that several other unusual and clinically irrelevant blood tests were ordered that same day, such as complicated immunology tests, which adds to my suspicion that an accidental selection error was made. I stress that I would have had no ulterior motive for doing this test - if I had suspected that the patient had HBV infection, I would have done the test before I operated on her, not after.

22. Contrary to the assertion in WITN2640, these special tests are not "flagged up", even if ordered accidentally and no-one would double check or ask me to justify it; and there are no "seniors" to scrutinise any such decision by a consultant. The witness is incorrect in the statement "to

avoid scrutiny ...by his seniors"; the HBV test was ordered accidentally and, in any event, as the consultant, I was the person in charge, or the “senior” and not liable to such scrutiny.

23. I cannot recall if I said that I knew the consultant who carried out the patient's cardiac surgery although I knew most of the several hundred consultants in Leeds, at least by name; however, my knowledge of the cardiac surgeon was not a close friendship, given our different specialties and very large age difference between us, but based on his fame as an inventor of a prosthetic heart valve and renown as a surgical pioneer. When the cardiac surgery was performed in 1979, I would have been a student of about 19 years of age at that time. There is no reason why I would think that a patient was at particular risk of hepatitis because, as suggested, I "knew the consultant who had performed her heart operation personally". To my knowledge I have never personally met the cardiac surgeon in question, who I understand retired from clinical practice in 1987.

24. I note that the witness felt that it was inappropriate to receive the notification of possible HBV infection in a letter and I have sympathy with this viewpoint. Such news is never welcome and is always a shock, whether received through a letter or face to face; at the time, I felt that the most important thing was to act quickly and get the patient into the appropriate service as soon as possible to confirm or refute the diagnosis of possible active HBV infection as quickly as possible.

25. I am a spinal surgeon, not a liver specialist, and not qualified to deal with the results of a positive test in terms of onwards medical management. I would have had to refer the patient onwards anyway, to an appropriate liver specialist at her local hospital (she did not live in the Leeds area).

26. Such an onward referral is the responsibility of her local GP and Clinical Commissioning Group and as such, I also contacted the GP with the same information and a request to arrange appropriate follow-up locally,

including a repeat HBV test to confirm or refute the diagnosis. It would have been inappropriate to introduce a further delay by bringing the patient back to my clinic, only for me to have to explain that I did not have the expertise to deal with the condition, nor knowledge of the correct inwards referral pathway.

27. I am sorry if any of my actions have caused the patient any additional distress over and above the knowledge of her condition. I have not seen the patient since she was discharged from my clinic on 1 August 2018, but as I have had access to her hospital records, I note that GRO-C GRO-C my understanding is that she has not developed any complications from chronic HBV infection. I hope sincerely that she continues to remain well, and that the outcome of this inquiry brings her some closure.

Statement of Truth

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

Signed: GRO-C

Dated: 20 June 2023