Witness Name: Royal Free Hospital (Dr Paul Trembling)
Statement No.WITN7738001
Exhibits: WITN7738002-003
Dated:
12-1-24

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR PAUL TREMBLING

I provide this statement on behalf of the Royal Free London NHS Foundation Trust (the "Trust") in response to the notification under Rule 13 of the Inquiry Rules 2006 dated 2 June 2021 and the request under Rule 9 of the Inquiry Rules 2006 dated 10 May 2023.

I, Paul Trembling of the Royal Free London NHS Foundation Trust, Pond Street, London, NW3 2QG, will say as follows:

Section 1: Introduction

1. I am employed by the Royal Free London NHS Foundation Trust ("the Trust") as honorary consultant hepatologist. I also hold a substantive post as consultant hepatologist at East and North Hertfordshire NHS Trust. I have held these posts since 1 June 2015. I am also an honorary associate professor at University College London.

2. As honorary consultant hepatologist at the Trust, my responsibilities include providing a weekly viral hepatitis clinic and attending the weekly regional viral hepatitis multidisciplinary meeting, where I manage patients with chronic hepatitis B, chronic hepatitis C and other liver conditions. I am the clinical lead of the North Central London Viral Hepatitis Network (part of the NHS England Hepatitis C Operational Delivery Network).

3. I have been asked to write this witness statement on behalf of the Trust to respond to certain criticisms raised in the witness statements of W2012 dated 16 March 2020 and her son, W2035, dated 19 December 2019 in which they raise criticisms regarding the care W2012 received by the Trust.

4. For the purpose of preparing this witness statement I have reviewed the records held by the Trust in relation to W2012 and provide this statement on the basis of those records. I have also considered comments made by Professor Geoffrey Dusheiko in response to W2012 and W2035's statements, who was involved in the patient's care in the past. Where matters within this statement are not directly within my own knowledge, I believe them to be true.

5. The inquiry has requested that the Trust respond to the following comments made by W2012 and W2035 in their statements as follows:

    a. (W2012)
        i. Paragraphs 17 – 20
        ii. Paragraphs 43 – 46
    b. (W2035)
        i. Paragraph 48

6. I attach to this statement exhibits **[WITN7738002-003]**. These are extracts from the Trust's records detailing various aspects of W2012's care which are relevant to the criticisms made in both her and W2035's statements.

Section 2: Background

7. W2012's records refer to either the blood transfusion she received in 1989 (whereby she received four units of blood at University College Hospital London following a manual removal of the placenta) or the plasma exchanges given in 1989 as the source of the infection. We cannot be certain whether W2012 acquired hepatitis C from the blood transfusion or from plasma exchanges given in late 1989. It is indisputable, however, that W2012 acquired hepatitis C from a blood product. Her diagnosis was confirmed in 1993. She was first seen in the viral hepatitis clinic on 22 January 1998 by Professor Dusheiko's registrar and was subsequently managed by Professor Dusheiko. I looked after W2012 from November 2015 after taking over Professor Dusheiko's viral hepatitis clinic at the Royal Free Hospital.

Section 3: Response to Criticisms of W2012

8. At paragraphs 17 – 18 W2012 states:

"I would have liked to receive leaflets with more information in them about the seriousness of HCV, how I had been infected and what the future would hold for me. I think this information should have been provided to me at the time of my diagnosis, and that I should have been taken into a private room to speak with a doctor about it.

Instead, I was told in passing that my dad had been tested for HCV but didn't have it, so they were not sure where I had got it from, and that I would need to have dialysis separately from now on. I had no context for this, and was told in a busy corridor with lots of people around, and no privacy. I was embarrassed, and while I was informed about the impact that HCV would have on my dialysis, I was not given any information about the seriousness of the condition itself."

9. Relatively little was known about hepatitis C at the time of the discovery of the virus in 1988 and at the time of diagnosis of W2012. I agree that the conversation W2012 recalled she had on a busy corridor was inappropriate and unprofessional, and I am very sorry for the distress this must have caused her.

10. Following her diagnosis, W2012 was linked to the hepatitis and renal clinics and would have had many subsequent consultations to appraise and inform her about hepatitis C.

11. At paragraph 19 W2012 states:

"I also do not understand why I was persistently asked by medical professionals if I had used drugs or had a 'bad upbringing'. By that point it should have been in my records that either the blood transfusion or the plasma exchange were the main cause of HCV infection, as I did not take any form of drugs or participate in any other risky activities from which I could have contracted the virus."

12. It is well documented in W2012's medical notes, including in her referral to Professor Dusheiko that the risk factors for her acquisition of the hepatitis C virus were blood transfusions. When W2012 was first seen in Professor Dusheiko's clinic on 22 January 1998 by Dr Simon Whalley, a research fellow, it was again noted that the risk factors for hepatitis C were a blood transfusion in 1989 and plasma exchange. Whilst the possible cause of the acquisition of the virus appears to be well-documented and does not refer to drug use, I cannot comment on what exactly was discussed with W2012 during earlier consultations with medical professionals. It would have been good medical practice for professionals to ascertain potential risk factors at first consultations, without stigmatising

the patient. We would not expect physicians or nurses to have persisted with questions around drug use and we apologise if this happened.

13. At paragraph 20 W2012 states:

"Although I was told about the precautions to be taken during my dialysis, I was not given any information about how to avoid infecting W2035 or other family members. I therefore became very concerned about infecting him and having him tested regularly. I bought W2035 a whole new set of cups, towels, everything he might need to use in the house – and told him they were presents and he was not to use anything I had touched. When he was about five, I phoned the British Liver Trust and asked them if I could transmit the infection to him by sharing household items, and they told me I couldn't, but I was still terrified I would…'

14. During the consultation with Dr Whalley on 22 January 1998, it was noted that W2012 was concerned that she could pass hepatitis C to W2035. She was reassured that this was most unlikely and that transmission of the virus is via blood. As W2012 states, she did seek advice from patient liaison groups and she would have had numerous opportunities to question physicians and nurses in the hepatitis and renal clinic. The advice W2012 was given by the British Liver Trust was correct.

15. At paragraphs 43 – 46 W2012 states:

"In 2010 I was offered a course of pegylated interferon and ribavirin. However I had to stop this treatment after 12 weeks as I developed pancytopenia (WITN2012009). There was a miscommunication between the HCV nurses and the doctors managing the treatment during this time, resulting in me suffering from the pancytopenia and severely low haemoglobin for a period of time before the doctors realised the effect that the treatment was having and asked that I stop the treatment. The nurses had sent emails to the treatment team saying that my haemoglobin was very low and they needed to increase my dose of EPO, which was medicine I was taking to bring up my blood count, so that I would be able to tolerate the interferon treatment. However, the doctors on the treatment team failed to read these emails and didn't increase my EPO does enough, so my blood count went down rapidly and I was unable to tolerate the treatment. When the doctors finally read the nurses' emails properly and realised that they should have increased my EPO dose more, the nurses said it was good that the miscommunication was resolved in time because it could have killed me…I believe that if the doctors had

increased my EPO dose to the amount that was requested by the nurses at the time that it was requested, I would have been able to tolerate the full course of interferon treatment and could have cleared the virus then."

16. W2012 developed severe pancytopaenia (a fall in haemoglobin (red cells), white cells, and platelet counts) during interferon treatment. Her haemoglobin had fallen to 6.1% and W2012 was noted to have *"marked thrombocytopaenia"* (low platelet count). A change to W2012's erythropoietin (EPO) dose would not have countered the fall in white cells and platelets as this agent stimulates red cell production. In weighing up the potential benefits versus the harms of continuing the interferon and ribavirin treatment, it was felt that it was unsafe for W2012 to continue this treatment and so it was discontinued. I have found no reference to a 'miscommunication' with regards to the EPO dose. When W2012 was seen by Professor Dusheiko on 27 May 2010, one month after stopping treatment, it was reiterated that she had developed pancytopaenia (see **Exhibit 2 [WITN7738002]**). W2012 had stated during the consultation that she attributed the anaemia in part due to inadequate EPO dosing, however Professor Dusheiko's opinion was that the pancytopaenia was likely to be due to bone marrow suppression by interferon. At this appointment it was mentioned that there had been some response to the virus with interferon and therefore it was unfortunate that the treatment needed to be stopped due to the pancytopaenia. This would have been a decision based on safety grounds after considering the risks and benefits of continuing treatment.

Section 4: Response to Criticism of W2035

17. At paragraph 48 of his statement, W2035 states:

"I am also concerned about how my mum has been treated by hospital and community professionals over the years. My mum is constantly not believed by social workers when something is wrong, and has to bring herself to hospital because they won't offer her assistance. I feel doctors see her as a burden; her current GP has tried to have her move to another practice to avoid having to treat her. When she has tried to ask questions about HCV over the years, she has always been ignored. And when she has been treated at the Royal Free Hospital, often things have gone wrong. Her kidney was scarred during a biopsy, doctors left a hole in her stomach when performing her latest kidney transplant, her leg had to be operated on multiple times before amputation, and multiple infections have been missed by doctors, resulting in them worsening significantly before being treated. I feel that my mum is not given the best medical care because the professionals make

judgments about how she got her infection and assume she is a drug user without looking into her history. Then when she tries to advocate for herself, they ignore her. After all of this, the least she should be entitled to is respect, assistance and adequate treatment."

18. I cannot comment on the allegation that W2012's GP has tried to move her to another practice to avoid having to treat her. In relation to the care provided by Royal Free Hospital, it is not correct that W2012 would have received inferior, detrimental or suboptimal treatment because of a supposed misperception of the route of acquisition of hepatitis C. W2012 has numerous complex comorbidities which have been addressed over the years. Staff recall that W2012 is a patient who showed considerable fortitude. She was regularly seen in the viral hepatitis clinic. I believe none of the individuals who provided care in the viral hepatitis, renal and other clinics would have lacked compassion and empathy for the plight of this patient, nor would they have been judgemental. On review of the clinic letters from nephrology and hepatology clinic appointments, the overall picture is one of a good relationship between the clinicians and the patient. W2012 was engaged with and received support from the Trust renal clinical health psychology service. In April 2017 I wrote in support of W2012's application via the Special Category Mechanism where I outlined the psychological and social problems that W2012 was experiencing due to the diagnosis of chronic hepatitis C and her other complex medial conditions.

19. W2012 underwent left below knee amputation in June 2018 after failed revascularisation (angioplasty) attempts, due to peripheral vascular disease. She subsequently experienced infection of the amputation stump, treated with debridement and skin graft. She was frequently reviewed in the vascular surgery clinic. She was seen by the doctors and physiotherapists in the rehabilitation department following this to arrange fitting of a prosthesis.

Section 5: Other issues

20. At paragraph 30 of W2012's statement, she queries whether the hepatitis C had caused her kidneys to fail or whether this was the result of pre-eclampsia. It is not possible to say for certain which of the two had caused W2012's kidney failure. Chronic hepatitis C has been associated with membranous glomerulonephritis (inflammation of the kidney that can result in impairment of renal function) and therefore may have contributed to her renal disease. However, I note that the renal failure occurred acutely following the onset of pre-eclampsia, which is a known cause of acute kidney injury.

21. At paragraphs 32 – 33 of her statement, W2012 states:

*"Dr Davenport, my renal consultant at the Royal Free Hospital, eventually referred me to Dr Dusheiko, Consultant Hepatologist, for my HCV-related investigations. However, it seemed there was initially some confusion as to the status of my HCV infection, and failure of the doctors for a period of years to take it seriously and investigate treatment options. In 2000, there is a letter in my records from Dr Dusheiko to my GP which says "From a liver point of view, things remain completely stable with no evidence of any active hepatitis from her blood picture. She continues with dialysis three times a week and I don't think there is any need for us to have any more input in her care other than just to keep an eye on things. There is certainly no indication from treatment at present." (**WITN2012004**).*

Because the dialysis kept my liver function results down and my symptoms down, I think this may be why doctors did not consider treatment for me as I appeared to not be suffering many effects of the virus. However after I had my kidney transplant, the medication I was put on to prevent rejection of the transplant decreased my immunity, which made the virus much stronger than it had been when I was on dialysis."

22. During a clinic consultation on 29 May 2009, Professor William Rosenberg, consultant hepatologist, reiterated to W2012 that the only available treatment for chronic hepatitis C, interferon therapy, could not be used because W2012 had a (functioning) renal transplant.

23. In letters by Dr Dusheiko he stated that serum aminotransferases (also known as 'liver function tests') are not an accurate guide to necro-inflammatory change or fibrosis in the liver in patients on haemodialysis, or in immunosuppressed patients. It was apparent from our readings, and the Fibroscan readings (an ultrasound-based evaluation of liver fibrosis (scarring)) that progressive hepatic fibrosis was occurring. Progression of the liver disease was always a consideration, however the transjugular liver biopsy in 2002 showed little hepatic fibrosis.

24. W2012 is correct that immunosuppression following her kidney transplant would increase levels of hepatitis C viraemia and potentially worsen her liver disease. Although pegylated interferon and ribavirin can be used in patients with renal failure on dialysis, the pharmacological clearance of pegylated interferon in end stage renal disease is impaired by

30-40%. The response rates of hepatitis C virus from pegylated interferon therapy are suboptimal, particularly in patients with genotype 1 infection which was the infecting strain in this patient.

25. Interferon was contraindicated after W2012's renal transplant as outlined in Professor Rosenberg's clinic letter, 29 May 2009 (see **Exhibit 4 [WITN7738003]**). Professor Dusheiko had suggested measurement of her interferon lambda 4 (IL28B) genotype in 2010. A single nucleotide polymorphism in the IL28B gene is a major determinant of response to interferon. Interferon may aggravate renal disease, and is contraindicated in patients after renal transplantation because of the high risk of acute kidney rejection.

26. Sadly W2012's renal transplant failed in 2009 and she recommenced haemodialysis. This provided the opportunity to consider re-treatment of chronic hepatitis C. This coincided with the emerging availability of all-oral treatment with directly acting antiviral agents (DAA). Prior to this, there was a period where a combination of interferon and DAAs were used in some patients. This was outlined by Professor Dusheiko when he consulted with W2012 on12 December 2010.

27. Variations in the IL28B gene are thought to predict outcome success with interferon treatment, particularly in those with genotype 1 infection. At the time of this clinic appointment, Professor Dusheiko will have been weighing the risks and benefits of treatment and this information would have assisted in his decision making. One of the key elements in this was ascertaining the amount of liver fibrosis. The liver biopsy performed in 2002 had reported only minimal fibrosis (scarring). Subsequent Fibroscan testing had reported conflicting results. IL28B polymorphism testing may have provided additional information in terms of deciding whether to consider treatment at that point, or to wait for improved treatments with less side-effects.

28. Professor Dusheiko outlined the risks of an interferon / DAA combination treatment when they became available (this treatment option was not available at that point). He outlined that her previous interferon treatment had shown some response (ie a reduction in the hepatitis C virus level during treatment), but that again there would be a risk of anaemia (low red cell count). At a subsequent consultation, on 26 June 2011, a repeat Fibroscan had indicated a much more reassuring fibrosis status (significant fibrosis rather than advanced fibrosis or cirrhosis) and this test was shown to be more accurate than previous Fibroscan readings (eg less variation in the readings (the Fibroscan result is based on an average of several readings in one sitting)) and the decision was therefore made to wait for

all-oral DAA treatments (ie those without interferon) to become available. W2012 completed a 12 week course of Harvoni (comprising ledipasvir and sofosbuvir) in August 2016, achieving a sustained virological response which is considered a cure. I continued to follow her up in clinic where I had no concerns regarding her liver.

29. At paragraph 39 of her statement, W2012 states:

"In 2004 it was noted that the Royal Free did not have a health psychology service, but that that kind of service would have been beneficial for me because I had already been assessed by the clinical psychology team twice and no longer met their criteria for further assistance, but I required further input regarding my anxiety around health conditions (WITN2012006)."

30. Whilst W2012 did have visits with a clinical psychologist and psychiatrist, I would agree that the hepatitis service would have benefitted from access to a psychological support team.

31. At paragraph 54 of her statement, W2012 states:

"I believe that there were other direct acting antivirals that I could have taken earlier if Harvoni was not available for kidney patients yet, but Harvoni was the drug funded by the NHS so it was the only option."

32. Harvoni had to approved by NICE. At that time, Harvoni was not licenced for the treatment of chronic hepatitis C in renal failure; sofosbuvir is cleared by the kidney and a deleterious pharmacological accumulation of GS-331007, the major metabolite of sofosbuvir, has been reported in patients with an estimated glomerular filtration rate (eGFR, a measure of kidney function) of less than 30 ml/minute, meaning this could not be safely administered to W2012. W2012's case was discussed at the viral hepatitis multidisciplinary meeting (MDT) on 28 April 2016, where a 12-week course of Harvoni was approved for W2012. The MDT noted that the alternative treatment, Abbvie-3D had not been tested in trials with patients with renal transplant and there was thought to be a possible risk of renal transplant rejection or toxicity from changes in the blood levels of immunosuppressive medication that W2012 was taking if Abbvie-3D was used (known as drug-drug interactions). Therefore the appropriate treatment choice was Harvoni, which was approved and resulted in a cure of hepatitis C.

33. At paragraph 8 of his statement, W2035 states:

"I believe that many times decisions were made to treat or not to treat my mum for various conditions without giving her adequate information to make an informed decision. Several times she went into surgery without knowing what procedure was going to be done. She always refused to have a liver biopsy due to its invasive nature and the risk to her kidney but was eventually pressured into having one and then the biopsy caused her kidney transplant to fail."

34. In relation to the investigations, treatment, operations and procedures offered to W2012 over the years, there is evidence of regular and frequent consultations with clinicians and W2012 would have given signed and informed consent prior to any procedures. Likely risks and discomforts should have been explained to her prior to procedures and treatment.

35. In response to W2035's statement that the liver biopsy caused her transplant to fail, I note from the clinic letters that the third renal transplant failed in November 2009 due to arterial thrombus and it was postulated that this may have been due to propagation of a deep vein thrombosis as the failure occurred after a flight. It would therefore seem highly unlikely that the failed transplant was related to the liver biopsy in 2002.

Statement of Truth

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

Signed GRO-C

Dated 12-1-24

Table of exhibits:

Notes/ Description	Exhibit number
Letter from Professor Dusheiko to Dr Postgate dated 27 May 2010	WITN7738002
Letter from Professor Rosenberg to Dr Postgate dated 29 May 2009	WITN7738003