Witness Name: Marc Turner
Statement No.: TBC
Exhibits: Nil
Dated: 27th June 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF MARC TURNER

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 14 June 2019 addressed to Hazel Thomson (Acting Director).

I, Marc Leighton Turner will say as follows: -

Section 1: Introduction

1. Name: Marc Leighton Turner
   Address: Scottish National Blood Transfusion Service, The Jack Copland Centre, 52 Research Avenue North, Heriot-Watt Research Park, Edinburgh EH14 4BE.
   Date of birth: GRO-C 1959.
   Qualifications: MB ChB, PhD, MBA, FRCP(Edinburgh), FRCP(London), FRCPath.

2. I am the current Medical Director of SNBTS, a position which I have held since April 2011. My principal responsibilities relate to oversight of the clinical governance of the organisation including compliance with the legal and regulatory responsibilities under SNBTS's Blood Establishment Authorisation, Human Tissue Authority licence and Advanced Therapy Medicinal Product manufacturing licences. I provide management to the SNBTS Medical and Clinical Scientist staff, the Tissues, Cells and Advanced Therapies Directorate and the Quality and Regulatory Compliance Directorate.

Section 2: Responses to criticism of Mrs Eileen Patricia Dyson

3. Please note that I was not a member of SNBTS in 1988 and although I have been a member of the organisation since 1994, I have not been previously aware of the contact from Mrs Dyson.

4. In paragraph 20 of her statement, Mrs Dyson states that she contacted the SNBTS twice, seeking the batch numbers for blood that she had previously received. She states that the people with whom she spoke were very unhelpful, rude and abruptly ended the call with her. She further states that staff were both uncooperative and obstructive when trying to obtain this information and that she was being lied to.

5. On behalf of SNBTS, I would like to apologise to Mrs Dyson regarding her experience when she contacted SNBTS, asking for the batch numbers of the blood that she had previously received.

6. SNBTS supplies blood components to hospital blood banks labelled with a unique number which retains traceability to the original donation without disclosing the identity of the donor. The hospital blood banks carry out pre-transfusion testing and issue blood components to patients. Patient data is therefore only held by hospital blood banks. At the time of Mrs Dyson's transfusions, SNBTS managed 4 of the hospital blood banks (in the Royal Infirmary of Edinburgh, Ninewells Hospital Dundee, Aberdeen Royal Infirmary and Raigmore Hospital Inverness). The other 28 hospital blood banks including all of those in the west of Scotland, were managed by the hospitals themselves. SNBTS will not, therefore, have had a record of the unique numbers of the blood components that Mrs Dyson received. These blood component numbers would have been documented in her medical notes / hospital blood bank records, held in Bellshill Maternity Hospital, Hairmyers Hospital and Monklands Hospital. Only with access to these numbers would it have been possible for SNBTS to trace back to the original donors/donations and test any archive samples of donations that Mrs Dyson received.

7. SNBTS would be willing to carry out a reverse lookback if the blood component numbers were available. In the absence of these, SNBTS believes that the blood transfusions Mrs Dyson received between April 1988 and February 1989 are the most likely source of her infection and offer our sincere apologies.

Statement of Truth

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

Signed GRO-C

Dated 27th June 2019.