1 Monday, 21 November 2011

2 (9.30 am)

3 DR JOHN FORRESTER (sworn)

4 Questions by MR MACKENZIE

5 THE CHAIRMAN: Good morning. Dr Forrester, if you feel
6 tired at all, just let me know. Yes, Mr Mackenzie?
7 MR MACKENZIE: Thank you, sir. Good morning, Dr Forrester.
8 Today we are looking at our topic C2, which is the
9 question of whether surrogate testing for non-A non-B
10 Hepatitis should have been introduced in the 1980s.
11 I would like to start, doctor, with looking at your CV,
12 please, which will come up on the screen. It's
13 PEN0170005.
14 We can see you have provided us with an outline CV.
15 We can see in 1942 you graduated with an MA with honours
16 in Classics at St Andrews and between 1942 and 1946 you
17 saw war service as an artillery officer. In 1952 you
18 obtained your medical degree at Oxford. Between 1952
19 and 1963 you were in general practice in England and
20 between 1963 to 1978 you came to the
21 University of Edinburgh as a lecturer and later senior
22 lecturer in physiology.
23 You also became a member of the physiological
24 society and a fellow of the Royal Society of Medicine.
25 Then, between 1978 and 1985, you were a medical officer

1 at the Chief Scientist's office in SHHD, mainly with the
2 biomedical research committee.
3 Then, between 1985 and 1988, you were a senior
4 medical officer in the SHHD with liaison duties with the
5 SNBTS. You retired in 1988.
6 Have you worked at all, Dr Forrester, since retiring
7 or have you stayed properly retired?
8 A. Yes, the Scottish Office gave me a splendid retirement
9 job. For one day a week I edited their journals for
10 five years.
11 Q. Thank you. We also see you state here that:
12 "Although the Inquiry papers make some reference to
13 my being a principal medical officer, this was never the
14 case, as the CV makes plain."
15 You also go on to say you are now 87 years old. Are
16 you still 87?
17 A. I'm 88 now.
18 Q. You say you retain no current recollection of the events
19 with which the Inquiry is concerned, but must rely on
20 the available records which you have examined as well as
21 you can. Would you like to make any comment on that,
22 doctor?
23 A. Only possibly to add very briefly another difficulty,
24 that in going through these documents I find, with my
25 memory now, that only about three days worth remain in.

1 That means that I simply cannot produce from my head,
2 even from my own memory, recollection of all these
3 documents. When I see them on the screen, no doubt
4 I shall be able to say something.
5 Q. The rest of the document relates to topic C3, viral
6 inactivation for blood products. We don't have to look
7 at this document any further, thank you.
8 I would next, doctor, like to take you to a document
9 showing the structure of the SHHD, including the medical
10 officers' structure, just so we can be clear about that,
11 please. It's [PEN0172506] at page 2508, please. We
12 have sought to set out the hierarchy among medical
13 officers and I think at the top is the chief medical
14 officer and I think Dr Iain MacDonald was the chief
15 medical officer while you were a senior medical officer
16 between 1985 and 1988. One down we see the deputy chief
17 medical officer and, during that period, Dr Graham Scott
18 would have been your deputy chief medical officer. Then
19 one down again, principal medical officer and the PMO,
20 whose remit included the SNBTS during the 1985 to 1988
21 period, was Dr Archibald McIntyre. Is that correct?
22 Thank you.
23 Looking under senior medical officers whose remit
24 included the SNBTS, we can see Dr Bert Bell fulfilled
25 that role from some time in the early 1970s until 1985

1 and I think Dr Forrester, you took over from Dr Bell
2 between 1985 until 1988. Is that correct?
3 A. I believe so.
4 Q. I'm grateful. I should ask, doctor, were there any
5 medical officers below you? Were there junior medical
6 officers?
7 A. No.
8 Q. Thank you. We can put that document to one side,
9 please. I wonder if we could go first, please to --
10 what I would now like to do, Dr Forrester, is take you
11 through a sequence of documents which show the
12 consideration given in 1986 and 1987 to the question of
13 surrogate testing within the SHHD. I think a suitable
14 starting point in that regard might be [SNF0010135].
15 Doctor, these are the minutes of a meeting of the
16 directors of the [Scottish] National Blood Transfusion
17 Service of 25 March 1986 and we can see under the list
18 of those present the last name is yourself. Was that
19 the practice, doctor, for the medical officer within
20 SHHD who is responsible for the SNBTS attending these
21 directors' meetings?
22 A. I am afraid I cannot say.
23 Q. I see.
24 A. I just don't know the answer to that.
25 Q. Okay. We can certainly see from these minutes that you

1 appear to have been at this meeting. If we can go,
2 please to the last page, and we can see item 5
3 "Surrogate testing for non-A non-B".
4 We can see a reference to the United States
5 FDA Advisory Panel's recommendation which, in short, was
6 a recommendation that, in America, blood banks start
7 surrogate testing of blood donations. I think that was
8 the -- really the catalyst for the matter being brought
9 to the fore in the UK, in 1986.
10 There is a discussion on --
11 A. I understand the question but I found it very difficult
12 to comment from my own memory.
13 Q. Yes. I'm not really going to ask you any questions
14 about this document, doctor. It simply seemed a natural
15 starting point in looking at the question of surrogate
16 testing and the consideration given to it within SHHD in
17 1986.
18 Could we then, please go to [SGH0027496]. This, we
19 will see when we go over the page, doctor, is a minute
20 of 26 March 1986 from yourself to Dr McIntyre, copied to
21 Dr Scott. So it seems quite clear that the principal
22 medical officer above you, Dr McIntyre, and also the
23 deputy chief medical officer, Dr Scott, were being kept
24 appraised of events. I think we will see that as
25 a recurrent theme when we go through the documents and

1 we can see the heading. This is a note or report of
2 a meeting of the directors on 25 March. If we go over
3 the page, please, and in paragraph 6, item 6 we see the
4 heading, "Testing of blood donations for non-A non-B
5 Hepatitis."
6 I'm not going to read this out but just take
7 a second to read through it, doctor. (Pause).
8 A. That's paragraph 6?
9 Q. Yes.
10 A. Yes. (Pause).
11 Q. We can see in the final sentence you stated:
12 "I also indicated that the department was perfectly
13 open to proposals for funding research in this field, if
14 research is required to determine the true size of the
15 problem and the likely effect of any proposed remedy."
16 Just to pause, doctor, this appears to be a note
17 written by you to inform or advise Dr McIntyre and
18 Dr Scott of the matters discussed at the directors'
19 meeting. Do you remember, would that have been your
20 practice at the time, after every directors' meeting to
21 write such a note to those above you?
22 A. I would guess the answer is yes, but I cannot remember
23 at all.
24 Q. Yes. Thank you. I think the next document, please, is
25 [SGH0028187]. If we look at the author of the letter,

1 this is a letter, doctor, from you dated 26 March 1986
2 to Dr Dan Reid at the communicable diseases surveillance
3 unit at Ruchill hospital. I think, in short, Dr Reid
4 was an expert in infectious diseases do you remember
5 that?
6 A. It says so:
7 "Communicable diseases surveillance unit." So he
8 was.
9 Q. Do you have any recollection of Dr Reid?
10 A. None, but I can see what I did there and what I had in
11 mind, so to speak.
12 Q. Okay. Now, again, please feel free to take a second to
13 read the letter. In short, you are writing to Dr Reid,
14 seeking certain information on post-transfusion non-A
15 non-B Hepatitis?
16 A. Yes.
17 Q. I don't propose to ask you any further questions on that
18 letter.
19 The next document -- I do propose asking you some
20 questions. The next document is [SGH0028142]. If we
21 can start on page 2, please, to see the author and the
22 date and we can see, doctor, your name, Dr Forrester,
23 and the date, 12 June 1986. If we go back to page 1 to
24 see the heading, please, we can see the heading,
25 "Transmission of non-A non-B Hepatitis by blood and

1 blood products: is it practicable to reduce or prevent
2 it by introducing ALT testing of donations?"
3 It doesn't seem to be, doctor, a note or a minute,
4 rather, addressed to anybody. But I think it appears to
5 be a note written by yourself, perhaps setting out the
6 result of your, perhaps, investigations. But I take it
7 you have no recollection of this --
8 A. I have no recollection. I would have to guess. But it
9 looks to me as though I might have prepared that to
10 circulate to whom it might concern and that it would be
11 available to me if anyone might ask, that I would
12 immediately be prepared to produce a reasoned account.
13 Q. So like a background note or briefing paper, that sort
14 of thing?
15 A. I'm just guessing but that's my guess.
16 Q. Thank you. If we go through the note, we will see
17 paragraph 1 tells us:
18 "The information in this note is mostly derived from
19 the PhD thesis ... completed in 1985 by Dr Dow under the
20 supervision of Dr Follett ..."
21 Do you have any recollection of that thesis?
22 A. Not now at all. This is the sole memory that I have
23 that I see before me.
24 Q. Okay. Paragraph 2 states:
25 "Hepatitis can be transmitted by blood and blood

1 products and is, in Scotland, an occasional but serious
2 consequence of blood transfusion."
3 In contrast with the USA with a higher incidence.
4 Question 3 we can read for ourselves, rather
5 paragraph 3. Paragraph 4 states:
6 "Non-A non-B Hepatitis, thus defined, is not
7 uncommon in the population; Dr Dan Reid reckons an
8 incidence for Scotland of 154 cases per year, but has
9 little confidence in this estimate because it can only
10 be derived by starting from the total of all hepatitis
11 cases reported (probably under reported) by clinicians,
12 and deducting the cases of Hepatitis B detected in
13 laboratories (probably fully reported). It is common
14 among drug users. But, in association with blood
15 transfusion it is very uncommon in the west of Scotland.
16 "Over the last 8 years, 1-5 cases are found each
17 year there, and there is no upward trend. There are
18 peculiar difficulties in identifying its presence in
19 haemophiliacs since their blood exhibits diverse
20 reactions because of repeated administration of blood
21 products, but Dr Dow found no evidence of any
22 substantial problem. Dr Dow reckons that the proportion
23 of donations infected with non-A non-B Hepatitis may be
24 18 per hundred thousand."
25 To pause, there, the question of haemophiliacs and

1 the note that Dr Dow found no evidence of any
2 substantial problem, that's perhaps slightly puzzling to
3 us, in that, I think, during the Inquiry we have heard
4 evidence that reports came through in the early 1980s,
5 perhaps 1982/1983, that all previously untreated
6 haemophilia patients developed non-A non-B Hepatitis
7 after use of factor concentrates regardless of whether
8 the Factor VIII concentrates were NHS origin or from US
9 donors or US-produced, rather. Do you have any
10 recollection of that problem in haemophilia patients,
11 doctor?
12 A. I have no recollection but, looking back on it now, it
13 looks as though this was overtaken by much better
14 information, arriving later.
15 Q. It may be something I can explore with Dr Dow -- I think
16 he is coming tomorrow -- but it does appear, I think
17 that, these reports were certainly, I think the first
18 report, published in 1983 and I think there were drafts
19 available 1982, I think -- but it may simply be you have
20 no recollection of this?
21 A. I have no recollection of that.
22 THE CHAIRMAN: I wonder if I could ask whether you would
23 have known, yourself, a great deal about this problem
24 from your own background at that stage, Dr Forrester?
25 A. No, sir.

1 THE CHAIRMAN: You had spent really quite a long time, ten
2 years, in general practice --
3 A. Yes, long before.
4 THE CHAIRMAN: -- long before, and then ten years as
5 a full-time teacher of --
6 A. That was about 17 years.
7 Q. -- of physiology. 17. So really is it fair -- and
8 I have to understand properly your position. Would it
9 be fair to take the view that, when you came into this
10 position, you didn't come with a great deal of current
11 knowledge of developing problems among haemophiliacs, or
12 what would your position be?
13 A. That was quite true, sir. I was a relayer of
14 information and the gatherer of information from the
15 different sources it could come in.
16 THE CHAIRMAN: Is that what we find in this report, in
17 effect?
18 A. That is what?
19 THE CHAIRMAN: What we find in this report, your passing on
20 material you had collected from others?
21 A. Yes, indeed. I hope accurately.
22 THE CHAIRMAN: Yes. I think it might be --
23 A. On the other hand some of it certainly turned out to be
24 obsolete later on. It was overtaken by events
25 altogether.

1 THE CHAIRMAN: Yes, but perhaps that might again reflect on
2 your own position. You would discover that event later
3 as information developed, I don't know. I don't want
4 you to be put in the position of appearing to be a fully
5 competent judge of these issues at the time if you were
6 not.
7 A. That is absolutely fair, sir and I don't think I attempt
8 to fulfil the role of a free-standing authority in these
9 matters at all.
10 MR MACKENZIE: Thank you, sir. I think that is helpful. On
11 that point, Dr Forrester, one can quite understand that
12 you came into this role in 1985. One of your
13 responsibilities being blood and blood transfusion and
14 that being something you hadn't had expertise in before,
15 or really much experience in before. Presumably those
16 above you, Dr McIntyre had obviously been a principal
17 medical officer with responsibilities for the Blood
18 Transfusion Service, I think for some time. Also,
19 I think, Dr Scott had been deputy chief medical officer
20 with responsibilities for blood and blood transfusion
21 for some time as well.
22 So presumably one can see and understand your role
23 maybe as a relayer of information, as collecting and
24 relaying information and not perhaps being in the best
25 position to judge the merits of various issues.

1 Presumably, Dr McIntyre and Dr Scott, with greater
2 experience in blood and blood transfusion, would have
3 been in a better position to judge the merits of the
4 issues that arose.
5 A. I think that is quite true, and I rely very greatly on
6 Dr McIntyre, for whom I had learnt to get a great
7 esteem, but I think, in effect, he was always in
8 a position of overlooking what I had done and I put it
9 to him in writing and if there was anything amiss he
10 would have told me.
11 Q. I understand, thank you. Returning to the note, please,
12 in paragraph 5 we see it's stated:
13 "The condition is not, as a rule, serious and most
14 of the cases detected have not even been jaundiced.
15 There may however be a tendency for it to become
16 chronic, and the long-term outlook is inevitably not yet
17 known. The case fatality rate is estimated in
18 a textbook consulted by Dr Dan Reid at less than
19 0.1 per cent, except in pregnant women, who are at much
20 greater risk (10 per cent if they contract it during the
21 last 3 months of pregnancy)."
22 Is that again, that paragraph, doctor, you setting
23 out what has been reported to you by others?
24 A. Certainly, and it was the way it seemed at the time. It
25 turned out, I think, to be wrong.

1 Q. Would you have -- is it likely you would have taken
2 any -- undertaken any research of your own, for example
3 were there medical textbooks available to SHHD medical
4 officers to consult?
5 A. Yes, they were always available in the library, and
6 medical journals.
7 Q. Is that something you would have done at the time, gone
8 to the library and consult --
9 A. I certainly did that from time to time.
10 Q. Yes, and when producing a note such as this, it would
11 have been open to you to go to the library and consult
12 yourself textbooks and journals?
13 A. Yes, indeed. My impression was this was the way it did
14 seem to able minds at the time. It doesn't mean it was
15 true in the end.
16 Q. We will come back to that shortly. Paragraph 6, we can
17 see for ourselves what is set out. Over the page,
18 paragraph 2, please -- sorry, page 2, paragraph 7, we
19 can see the second sentence:
20 "Dr Dow concludes that in Scotland cost would be
21 extremely high and benefit minimal, especially when only
22 a few cases of non-A non-B post-transfusion hepatitis
23 are reported each year."
24 Finally in paragraph 8:
25 "Dr Dan Reid and Dr Follett do not recommend the

1 introduction of ALT testing of Scottish blood donations
2 for the above reasons."
3 Is that final paragraph, doctor, perhaps consistent
4 with your role as we have just explored; that
5 paragraph 8 doesn't say that: I, Dr Forrester, do not
6 recommend the introduction of ALT testing. Rather, you
7 say Dr Reid and Dr Follett do not recommend. Is that
8 again consistent with your role being a reporting and
9 relaying of information role?
10 A. I think I would have thought it above my position to
11 take an independent view of that kind, but rather to
12 find people who knew.
13 Q. Thank you. I understand.
14 A. If they happened to know wrong, well ...
15 Q. The next document comes back to the question of state of
16 knowledge and what was available. Can we go, please, to
17 [PEN0171734]. Dr Forrester, this is an extract from
18 a textbook by Professor Mollison, "Blood transfusion and
19 clinical medicine", the seventh edition published
20 in January 1983. We have heard evidence that this was
21 the main UK textbook on blood transfusion at the time
22 and may in fact have been the only blood transfusion UK
23 textbook at the time. Can you remember looking at this
24 at all, during your time as a medical officer?
25 A. I don't remember consulting this at all. On the other

1 hand, I would have relied on sources of information,
2 both from people who treated haemophiliacs and from
3 people who produced blood products and would be familiar
4 with this all the time.
5 Q. Is this an example of the type of textbook that would
6 have been available in the medical library in the SHHD?
7 A. I would think so.
8 Q. Yes. Over the page, please. There are two passages
9 I would like to draw to your attention. At page 773
10 under the subheading, "Non-A non-B Hepatitis."
11 I'll just give you a couple of minutes just to read
12 that paragraph for yourself.
13 A. This is the second paragraph on the screen at the
14 moment?
15 Q. Sorry, no, we see the subheading, "Non-A non-B
16 Hepatitis."
17 A. Yes.
18 Q. Do we see the subheading at the top of the page on the
19 screen, "Non-A non-B Hepatitis." It's the paragraph
20 that follows under that.
21 A. Yes. (Pause).
22 Yes.
23 Q. The particular passage I would like to take you to
24 please, it's about half way down and it's towards the
25 right-hand side, the sentence commencing, "As a rule

1 ..."

2 "As a rule, non-A non-B Hepatitis ..."

3 Do you have that?

4 A. Yes.

5 Q. "As a rule, non-A non-B Hepatitis is symptomatically

6 mild, patients seldom need to be admitted to hospital.

7 Nevertheless, up to 60 per cent of cases have abnormal

8 ALT levels for more than one year. If a liver biopsy is

9 taken, most of the cases show histological evidence of

10 a significant chronic liver disease and approximately

11 10 per cent show features of cirrhosis."

12 A reference to a paper by Harvey Alter in 1980:

13 "A striking feature in non-A non-B Hepatitis is the

14 tendency for serum hepatic enzyme levels to fluctuate

15 markedly over a relatively short time."

16 Doctor, I don't suggest that there was a general

17 acceptance in the medical community in 1983 that NANBH

18 was a potentially serious disease. I think we have

19 heard evidence how the general acceptance, the medical

20 community, took some time to evolve during the course of

21 the 1980s.

22 But I do suggest this, that by this stage, early

23 1983, it was known firstly that half or more of patients

24 with non-A non-B Hepatitis had chronically elevated,

25 fluctuating ALT levels and secondly that liver biopsies

1 in a small number of selected patients showed evidence
2 of cirrhosis. What I would suggest, I think, is that
3 these two matters: the knowledge of chronically
4 elevated, fluctuating ALT levels in half or more
5 patients, and secondly, that there was some evidence of
6 cirrhosis, at the very least called for caution when
7 making statements about the potential seriousness of the
8 disease. Do you have any comments on that?
9 A. I don't think I can comment on that, after all this
10 lapse of time. I think I follow what you are saying,
11 but I don't think I could make any useful comment.
12 Q. I understand. So really your evidence was perhaps
13 largely restricted to what was recorded at the time in
14 print?
15 A. Yes.
16 Q. Thank you.
17 Now, the next document, please, is [SGH0016295].
18 This, doctor, is a -- you reporting again to Dr McIntyre
19 and Dr Scott following a meeting of the transfusion
20 directors on 25 June 1986. If we go, please, to the
21 bottom of the page, to paragraph 4, item 4 -- sorry, the
22 bottom of page 1, item 4, we see again:
23 "Testing donations indirectly in order to reduce
24 transmission of non-A non-B Hepatitis."
25 Obviously the directors have again discussed this

1 matter at the meeting and you, again, are reporting that
2 to Dr McIntyre and Dr Scott.
3 We see in the second sentence of this paragraph:
4 "An able PhD thesis of last year concluded that, in
5 the West of Scotland, any advantage would in no way
6 justify the cost and the loss of donations entailed."
7 One sentence on again:
8 "I have previously examined a copy of the thesis;
9 Dr Dan Reid's opinion is that non-A non-B Hepatitis is
10 heterogeneous and generally mild (except in pregnant
11 women), and that a testing programme cannot be
12 justified."
13 So again, doctor, that's consistent with you really
14 relaying or reporting the views of others: Dr Dow from
15 his thesis and Dr Reid, I think, from his letter to you.
16 I should by the way, say that it's quite clear, I think,
17 that Dr Reid did write a letter to you in response to
18 your letter to him we looked at earlier. But
19 unfortunately the Inquiry doesn't have a copy of
20 Dr Reid's letter to you and we have taken steps to try
21 and recover a copy but that hasn't been possible
22 unfortunately.
23 That's that document, thank you. The next one,
24 please, is [SGH0028146]. Now, this is a minute from
25 Dr Scott, dated 16 October 1986, to yourself,

1 Dr Forrester, and Mr Murray on the administration side.
2 It's headed, "SNBTS, non-A non-B hepatitis screening."
3 Dr Scott writes:
4 "I should like to know where this stands. CMO DHSS
5 is worried that if we go ahead, England and Wales will
6 have to follow suit. I think there must be consultation
7 with DHSS before we agree to provide funds for this
8 screening."
9 I take it, doctor, that you can't remember this
10 minute?
11 A. No.
12 Q. Can I ask more generally, please: what liaison was there
13 at this time, in the late 1980s, between SHHD and DHSS
14 on matters of common interest? Is that something [on
15 which] there would be liaison? Do you have any
16 recollection?
17 A. I have no recollection. I would have thought that any
18 liaison would be extemporised according to need, that if
19 we learned something likely to be useful to England, we
20 would pass it on and vice versa. I think you may be
21 wondering if there were formal intermittent meetings and
22 so forth, but I don't think that was the case except
23 between blood transfusion interests themselves.
24 Q. Could I again ask, again in a general way, what the
25 relationship was between SHHD and DHSS, as in: was it

1 considered to be a relationship between equals? Was it
2 considered that the views of DHSS carried greater weight
3 or vice versa, or what?
4 A. I don't think I could provide any formal opinion on
5 that. I understand what you are asking but it seems to
6 me to be beyond my ken.
7 Q. You don't have any recollection of the impression you
8 had at the time as to whether the views of DHSS carried
9 particular weight, carried no weight, carried any
10 weight, or would it again perhaps depend on a particular
11 issue, or you have no recollection?
12 A. I find it difficult to imagine there could ever have
13 been such an understanding about the weight they would
14 carry. The weight would be judged in each case, not
15 from any overall strategy.
16 Q. Yes. Okay. The next document, please, [SGH0028141].
17 This is your response, Dr Forrester, of 17 October 1986,
18 a minute to Dr Scott in response to his minute we just
19 looked at, and copied in to Mr Murray and Dr McIntyre on
20 the question of surrogate testing.
21 In short, doctor, by this stage the SNBTS had
22 applied for funding to introduce surrogate testing.
23 Again, in short, we saw from Mr Murray's written
24 statement that, while he was responsible for compiling
25 the various bids for funding on medical matters, he took

1 advice from the medical officers. If the medical
2 officers supported a particular bid for funding, he
3 would include it when the bid went on to finance, but if
4 the medical officers did not support a particular bid,
5 then he wouldn't include it. Does that accord with your
6 general recollection?
7 A. So far as it goes, yes.
8 Q. At the bottom of this minute we see you state:
9 "There seems no justification for introducing this
10 screening without gathering further British evidence,
11 because the American experience of frequent
12 post-transfusion hepatitis does not seem to be
13 duplicated here."
14 In that last sentence, doctor, it does appear as
15 though you have moved slightly from a role of simply
16 relaying or reporting information to giving an opinion
17 of your own. Does that seem fair?
18 A. Yes, I think that seems fair.
19 Q. Yes. Presumably what is stated in the final paragraph
20 of this minute will have reflected your views at the
21 time?
22 A. On the other hand, my view was accompanied by the
23 evidence as I saw it in the account here. It's
24 a reasoned opinion. That doesn't mean it's a right
25 opinion, but it's a reasoned opinion.

1 Q. Yes. Thank you. Could we then, please, go to -- we are
2 still in 1986, but now in November 1986 please,
3 [PEN0171554]. If we again start on the second page,
4 please, to see the date and author and we can see,
5 doctor, this is a note or minute by yourself, dated
6 1 December 1986.
7 If we go back to the front page again, please, we
8 can see it's addressed to Dr McIntyre but copied to
9 Dr Scott and Mr Murray, and, doctor, this is a report of
10 a meeting you attended as an observer. It was the UK
11 Working Party on Transfusion-associated Hepatitis, which
12 had been dormant for a number of years but then met
13 again on 24 November 1986. I think in this memo you are
14 recording what was discussed and I think here you are
15 perhaps back to the role of reporting or relaying what
16 was discussed by others.
17 If we can then go to the second paragraph, we can
18 see reference to: members had already seen a searching
19 and dispassionate written presentation by Dr Gunson and
20 Dr McClelland had taken us to an extract from that in
21 his evidence.
22 You then say:
23 "They considered the following issues:
24 "1. Is the American experience of frequent non-A
25 non-B Hepatitis in recipients of blood and blood

1 products reproduced here? The answer is no. Such
2 evidence as exists does bear out the American
3 experience, but to examine the question properly would
4 be a long and expensive business."
5 Question 2:
6 "Is ALT screening the application of
7 a straightforward yes/No test? The answer is no; it is
8 an arbitrary decision on where to draw the line ..."
9 Et cetera 3:
10 "Will better solutions emerge?"
11 A bit of a non-committal answer. Question 4:
12 "Is research indicated? The meeting felt that
13 a prospective study to discover the present burden of
14 transfusion associated non-A non-B Hepatitis was
15 impracticable on grounds of cost and huge sample size.
16 They propose instead a study to identify ..."
17 In short, donors. Over the page, please,
18 paragraph 5:
19 "There was some discussion of the cost of screening
20 all donations (perhaps 8 million pounds). I asked the
21 chairman whether he would advise screening if it were
22 free of cost. He said no."
23 Last paragraph:
24 "The position explicitly reached at the meeting is
25 to recommend research of no great significance or

1 scientific interest because the prospect of research
2 would serve to counter pressure from, for example,
3 haemophiliacs and haemophilia directors, to embark on an
4 indirect and largely ineffective form of screening,
5 which would lose us a certain amount of perfectly
6 harmless blood."
7 There is discussion after that about the number of
8 non-A non-B Hepatitis cases encountered annually among
9 haemophilia patients. I take it, doctor -- do you have
10 any recollection at all of this meeting?
11 A. I have no recollection of the meeting. I'm looking at
12 what I wrote, of course, but I have no independent
13 recollection of it.
14 Q. Yes. Are you able to tell us anything beyond what is
15 recorded in this note?
16 A. No.
17 Q. The next document, please -- we now move into 1987. I'm
18 sorry, it is [SGH0031657].
19 This is a document, Dr Forrester, that's headed,
20 "Material for PMO report". If we go to the bottom of
21 the page, we see it's written by yourself, dated
22 26 January 1987. If we go back to the top, please, can
23 you remember, doctor, what was this document for,
24 "Material for PMO reports"?
25 A. It would be material sent to Dr McIntyre for him to use

1 in compiling his own PMO report. He would probably
2 invite me to send in material on these topics which he
3 could include in his PMO report.
4 Q. How often would the PMO prepare his reports?
5 A. I couldn't tell the answer to that off my head.
6 Q. What happened to his reports? Were they for
7 distribution upwards, or what?
8 A. There again it was above my head, it was obvious he was
9 going to report to higher spheres but exactly which he
10 would report to, I don't know.
11 Q. I understand.
12 A. I could guess it would certainly go to the chief medical
13 officer and probably to someone higher on the
14 administrative side. But I think it was a routine
15 event, twice a year. I don't really know.
16 Q. Thank you. In paragraph 2 we see:
17 "Blood transfusion and non-A non-B Hepatitis."
18 Then we see:
19 "This 'hepatitis' is a residual rag bag when
20 Hepatitis B and Hepatitis A are excluded, and
21 consequently no specific test can detect it. It is
22 relatively benign."
23 Again, doctor, there perhaps seems to be -- that
24 seems to be you giving an opinion rather than purely
25 reporting what others have said to you. When you say,

1 "It is relatively benign".

2 A. I don't think that will hold water because I was in no

3 position to give an opinion on that. I didn't see any

4 patients myself and so forth, I'm sure this is simply

5 relaying the opinions of other people.

6 Q. Certainly, to be fair to you, Dr McIntyre and Dr Scott

7 would have been fully aware of your experience in blood

8 transfusion at this time and your expertise in

9 post-transfusion hepatitis. That would have been

10 a matter known to them?

11 A. Of its limited nature, you mean?

12 Q. Yes.

13 A. Oh, certainly.

14 Q. Again, the point I ought perhaps to put to you is, we

15 looked from Mollison at the reference firstly to half or

16 more patients having chronically elevated, fluctuating

17 ALT levels and, secondly, there being evidence that at

18 least some patients with NANBH went on to develop

19 cirrhosis. I think I had suggested that these two

20 points at least suggested there should be some note of

21 caution in giving an opinion on the likely seriousness

22 of the disease. That note of caution, I think, doesn't

23 appear in your account of the disease here. You simply

24 say, "It's relatively benign."

25 A. What do you think I should have written?

1 Q. Perhaps a note of caution along:

2 "There is evidence reported --

3 A. It may be relatively benign. I follow what you mean.

4 Q. It may be a matter of degree, perhaps, doctor --

5 A. Yes.

6 Q. -- but one, I think, doesn't see the type of evidence

7 set out in Mollison in your note here.

8 Now, the next document, please, is [SGF0012261].

9 These are the minutes of a meeting of the directors of

10 the [Scottish] National Blood Transfusion Service and

11 the haemophilia directors, held at St Andrew's House on

12 9 February 1987. We can see you are the chairman of the

13 meeting, doctor and then at page 3 of the minutes, at

14 2263 in item 7 at the bottom, "Non-A non-B Hepatitis

15 screening":

16 "Dr Forrester reported the results of the recent

17 transfusion-associated hepatitis working party meeting.

18 In the USA between 5 per cent and 25 per cent of

19 transfusions lead to the recipient contracting non-A

20 non-B Hepatitis. In the UK the figure is approximately

21 2.5 per cent and in Scotland, during the last decade,

22 there have only been 1 to 5 cases per annum. Non-A

23 non-B Hepatitis would appear to be relatively benign,

24 despite some risk of cirrhosis of the liver in the

25 long-term, unless the recipient is pregnant when the

1 effects can be very serious."

2 To pause there, doctor, the reference in the minute

3 to:

4 "Non-A non-B Hepatitis would appear to be relatively

5 benign, despite some risk of cirrhosis of the liver in

6 the long-term".

7 Do you think that is something you said at the

8 meeting or do you think that's something that others at

9 the meeting said. Because when one looks at the

10 beginning of the paragraph:

11 "Dr Forrester reported the results of the recent ...

12 working party ..."

13 I think it may be an inference that --

14 A. I have little doubt that that was the opinion of the

15 working party meeting.

16 Q. So you are reporting back the opinion of the working

17 party meeting?

18 A. Yes.

19 Q. So, certainly by this stage you appear to have been

20 aware that the working party were mentioning the risk of

21 cirrhosis of the liver?

22 A. Yes.

23 Q. Does that seem fair? This may be a point of detail, it

24 may not, but I also wondered, is there an inconsistency

25 between, on the one hand saying non-A non-B Hepatitis

1 would appear to be relatively benign, on the other hand
2 saying, despite some risk of cirrhosis of the liver in
3 the long-term. Are these really two inconsistent
4 statements?
5 A. I wouldn't see it that way.
6 Q. Why not?
7 A. There doesn't seem to me to be an inconsistency between
8 these two. If the risk of cirrhosis of the liver is
9 small, then it is relatively benign.
10 Q. But there is --
11 A. I'm not saying that that was the case, but supposing it
12 to be the case that cirrhosis of the liver is relatively
13 uncommon, then it is relatively benign.
14 Q. This may be overly simplistic but it does seem to me
15 that one way of looking at the statement is that what
16 was being said was that, on the one hand this disease is
17 generally harmless but, on the other hand, it may lead
18 to serious liver disease and possibly death. That's
19 where I saw a potential inconsistency. Or do you think
20 that's overly simplistic?
21 A. Yes, I do.
22 Q. Also perhaps, doctor, it depends if one is looking at
23 the question as a matter of epidemiology, as a public
24 health doctor, or from the individual's perspective.
25 Obviously, one can see that, as a matter of

1 epidemiology, one may say that, as a generality, the
2 disease appears to be relatively benign. But when one
3 comes down to the individual level, then for the
4 individual obviously a risk of cirrhosis is always an
5 important risk.
6 A. Possibly.
7 Q. Putting the point another way --
8 A. I did not really follow the line of thought.
9 Q. -- if you were to ask how serious is the disease, the
10 question you got may depend on who you ask?
11 A. I'm still having difficulty in seeing the inconsistency
12 between the two statements. They seem to me to be
13 reasonably consistent.
14 Q. Put it this way: how can something be relatively benign
15 if there is a risk of serious liver disease?
16 A. I think it's a numerical question, is it not? It can be
17 relatively benign in most cases -- in practically all
18 cases. Then again there was always a margin of error in
19 such cases; if somebody does die of cirrhosis it may be
20 from something else, if you see what I mean. So to
21 describe it as relatively benign doesn't seem to me to
22 have anything absurd or misleading about it.
23 Q. I can certainly understand the numerical explanation.
24 I can understand that.
25 A. Yes.

1 Q. Thank you. The next document, please, is [SGH0016653].
2 These are the minutes of a meeting of the transfusion
3 directors on 3 March 1987. We can see you are noted as
4 having been present, doctor. If we can go to page 5 of
5 the minutes, please, at 6657, item (f) at the bottom, we
6 see, "Surrogate testing for non-A non-B." just take two
7 minutes to read that, doctor. (Pause).
8 Then over the page, please. Again if you just take
9 two minutes to read the top few passages. (Pause).
10 Thank you. You see the recommendation by the
11 directors to the SHHD that surrogate testing for non-A
12 non-B should be implemented, with effect from
13 1 April 1988 as a national development, requiring
14 strictly new funding. The question is this, doctor: do
15 you remember what action, if any, you considered was
16 required by you in response to that recommendation?
17 A. I can only guess, but it looks to me as though this
18 recommendation was passing to the government Health
19 Department, through a channel other than me, which would
20 not be surprising at all. So, from my point of view, no
21 specific action on my part was required.
22 Q. What was that other channel?
23 A. I can't deal with that from memory.
24 Q. It's simply when you say it looks to you as if the
25 recommendation was passing through a channel other than

1 you, I just wondered what you had in mind by that, as in
2 did you envisage the directors --
3 A. I see. You mean would I be the messenger to carry from
4 the meeting the request?
5 Q. Yes.
6 A. I don't think -- it would be done in writing and
7 separately from my direct involvement.
8 Q. So you envisage the directors doing something more, as
9 a matter of procedure --
10 A. Yes.
11 Q. -- to bring the recommendation to the attention of the
12 SHHD?
13 A. Yes, I doubt very much if this minute would be the
14 channel.
15 Q. Certainly one possible procedure was through funding.
16 When SNBTS made their funding bid, they could include,
17 obviously as we will see they did, they could include
18 funds for such testing. That would be one procedure?
19 A. Yes.
20 Q. It does seem to have been the case, doctor that, after
21 these directors meetings -- it does seem to have been
22 the case that a day, or a day or two later you would
23 report to Dr McIntyre and Dr Scott on the matters
24 discussed at the meeting?
25 A. Yes.

1 Q. For some reason we can't find in our database of
2 documents a report immediately following this meeting.
3 But presumably it's at least possible you may have
4 followed what appears to have been your practice, in
5 reporting to those above you the matters discussed at
6 the meeting?
7 A. In any case a minute drawn up by me reporting on the
8 meeting to Dr McIntyre would not be a channel through
9 which a request for surrogate testing of this kind would
10 go. It was an information channel.
11 Q. So you would understand there to be some formal way for
12 the transfusion directors to make this request?
13 A. Yes.
14 Q. Either through a letter, perhaps by Professor Cash, or
15 perhaps by -- through their funding bids?
16 A. Yes, indeed.
17 Q. I understand. The next document, please, very briefly
18 look at [SGH0016652]. This is an administrative
19 document by Miss Corrie, secretary at the SNBTS. If we
20 go to the top of the page please, we see it's dated
21 13 April 1987 and it's simply Miss Corrie sending
22 Mr Murray at the SHHD a copy of the minutes of the
23 meeting we have just looked at. What I wondered was
24 whether there was a practice for Miss Corrie to type up
25 the minutes of the meeting, perhaps some weeks after the

1 meeting, and then send the draft minutes to Mr Murray
2 for his approval or comments. Do you have any
3 recollection of that at all?
4 A. I cannot tell.
5 Q. But it's certainly -- it does not seem to be the case
6 that the minutes were available straight after meetings.
7 Understandably there is some delay for the minutes to be
8 typed up and then approved and circulated and what have
9 you.
10 A. I agree.
11 Q. The next document, please, is [SGH0028127]. Over the
12 page, please. We can see this is a minute by
13 Dr McIntyre, dated 6 April 1987. If we go back to
14 page 1, please, we can see it's addressed to Dr Scott
15 and others, including yourself, Dr Forrester. Please
16 just take a few minutes just to read through the first
17 page. It's really a passage on page 2 I'm going to take
18 you to, but just out of fairness to you, just take a few
19 minutes to read page 1. (Pause).
20 Over the page, please. (Pause).
21 We see, in the second paragraph on page 2,
22 Dr McIntyre states:
23 "The directors of SNBTS are unanimous and are now
24 pressing fairly strongly that this screening should be
25 instituted. Though perfectly aware that it would be

1 costly and could not abolish transmission completely,
2 they could then claim to have taken all steps open to
3 them to reduce transmission. Before embarking on such
4 an expensive programme, it would seem logical to
5 participate in the proposed research and to delay any
6 further action until the results of this were known."
7 "If recipients of this minute are agreeable that
8 this is the correct line to adopt, then the Edinburgh
9 SNBTS will be asked to prepare a detailed proposal along
10 similar lines to that of their English counterparts."
11 So it certainly seems clear, Dr Forrester that at
12 this date, 6 April, 1987, Dr McIntyre understood that
13 the SNBTS directors were unanimously in favour of
14 surrogate testing. So, regardless of any reporting
15 which may or may not have occurred, or formal procedures
16 after the meeting in March, very soon afterwards
17 Dr McIntyre and also, by implication, Dr Scott, who was
18 a recipient of this letter, were aware of the SNBTS
19 directors' position.
20 One point which arises, doctor, is that
21 the November 1986 meeting of the UK working party on
22 transfusion-associated hepatitis recommended not to
23 undertake a large-scale prospective study involving the
24 following up of patients to consider surrogate testing,
25 but instead to restrict their study to looking at

1 donors. That's then really the proposed study that goes
2 forward, this question of following up donors, not
3 recipients. The view of Dr McIntyre as set out in the
4 second paragraph:
5 "Before embarking on such an expensive programme of
6 testing, it would seem logical to participate in the
7 proposed research and to delay any further action until
8 the results of this were known."
9 The proposed research is the proposed follow-up of
10 donors, not recipients, and the question really is: did
11 you have any view at the time as to whether that study,
12 following up donors, was likely to be of any value?
13 A. I venture that I would keep a very open mind, because it
14 was a very dark problem at that time.
15 Q. Certainly looking at things now, do you think it seems
16 logical to restrict one's study to donors rather than
17 also looking at recipients?
18 A. I don't think that I could hazard an opinion on that.
19 It would be not within my compass really.
20 Q. So we are back, perhaps, to you had attended a meeting
21 of the UK transfusionists working party and they were
22 really best placed to decide what sort of study there
23 should be.
24 A. I don't think I could comment on that either.
25 Q. Would you have considered they were better placed than

1 you to decide what sort of study there should be?
2 A. It would seem to me a very difficult issue.
3 Q. Yes. Presumably the more difficult the issue, I suppose
4 the more one would defer to experts on that issue?
5 A. Yes, and hope that they would agree.
6 Q. Yes. The next document, please, is a short one,
7 [SGH0028126]. Dr Scott, on 7 April 1987, a minute to
8 Dr McIntyre and copied to various individuals, including
9 yourself, Dr Forrester. The heading is, "Scottish
10 participation in UK research project on
11 transfusion-associated non-A non-B Hepatitis".
12 Dr Scott writes:
13 "I agree in principle with the procedure outlined in
14 your minute of 6 April: we must do whatever we can to
15 prevent the BTS going ahead with a full-scale
16 introduction of this testing -- or at least trying to
17 blackmail us into the provision of funds.
18 "The research proposal from Edinburgh will, of
19 course, have to be subject to the scrutiny of the
20 appropriate CSO group and the availability of finance.
21 I would not like to see it fail on the grounds of
22 finance because the stakes are high."
23 What do you think Dr Scott meant by use of the word
24 "blackmail"?
25 A. I really wouldn't like to speculate on what Dr Scott

1 might have had in mind there. I think it would be
2 presumptuous.
3 Q. We will have to ask Dr Scott perhaps.
4 A. Exactly so.
5 Q. Just to follow up the fate of the Edinburgh proposal for
6 inclusion in the UK multi-centre trial into looking at
7 ALT and anti-HBc in donors -- I'm not going to go to the
8 documents but for the record there is an [SGH0028079].
9 It's a minute from Dr Forrester to Dr Forbes, the
10 secretary of the chief scientist's office on the matter.
11 Separately, [PEN0160152], is a letter from Dr Forbes
12 of the chief scientist's office to Dr Smith, his English
13 equivalent, of 13 November 1987, explaining that the
14 biomedical research committee of the chief scientist's
15 office in Scotland had rejected Drs Gillon and
16 McClelland's application for funds to take part in the
17 UK multi-centre trial.
18 In short Dr Forrester, the application appears to
19 have been refused on scientific grounds. There seems
20 little doubt of that when one looks at all of the
21 documents, including the letters and views of the
22 assessors and referees.
23 If we can perhaps -- again this is for the record,
24 without going to it: [SGH0028058] is a minute from
25 Dr Forrester to Mr MacDonald of 14 April 1988. For the

1 record, without going to it, it is all along the same
2 line of funds not being available for the Edinburgh
3 centre for inclusion in the research. [SGF0012059],
4 a minute from Dr Moir, again at the chief scientist's
5 office, to Dr McIntyre.
6 I think there are three final documents I would like
7 to take you, please, to, Dr Forrester, the first of
8 which is this: [SGH0024672]. Over the page, please.
9 This is a minute dated 13 August 1988 from yourself,
10 Dr Forrester -- back to page 1, please -- addressed to
11 the chief medical officer, who would have been
12 Dr MacDonald, I think, at this time. It's copied to
13 Dr McIntyre, Dr Scott and Mr Macniven.
14 Item 1 doesn't concern us. We have looked at this,
15 I think, in another topic. This is the Punch and Judy
16 minute we looked at before. Then item 2, "Commercial
17 Factor VIII made by Alpha". Again the details don't
18 concern us but I will give you two minutes just to read
19 the minute, doctor.
20 A. This is minute 2 -- or paragraph 2?
21 Q. Read the whole minute, just out of fairness. Have
22 a chance to read it all.
23 A. This is the one, "Commercial Factor VIII made by Alpha"?
24 Q. Yes. (Pause).
25 We will see again it's the last paragraph, (e):

1 "We can't prudently make much of the point, but this
2 particular hepatitis is so benign, at least in the
3 short-term, that evidence of transmission has to be
4 specially sought, the patient not being ill at all in
5 the ordinary sense."
6 Again, in that formulation, paragraph (e), one
7 doesn't see a note of caution about giving an opinion on
8 the likely seriousness of the disease. Does that seem
9 fair?
10 A. At least I did say there, I say:
11 "At least in the short term". I was keeping an open
12 mind.
13 Q. Can I ask you this, doctor: how influential would your
14 views on the seriousness of the condition have been
15 within SHHD, both within the medical side and within the
16 administrative side?
17 A. Not very. They would only have been influential to the
18 extent that they drew upon the opinions of other people
19 in a much better position to judge -- as relayed by me,
20 if you like.
21 Q. One can quite see that in terms of your medical
22 superiors.
23 A. Yes.
24 Q. Presumably in terms of your administrative colleagues,
25 they would have had to defer to you in respect of your

1 views on the condition.

2 A. I think they would be much more likely to ask me: whose

3 views are you relaying? Or where did you get this from?

4 Partial answers to that do seem to be in the papers and

5 that is what they would look at.

6 Q. Thank you. I think there are two final letters that

7 I ought to put to you, doctor. One is [SNB0059240].

8 This is a letter from Professor Cash, dated

9 21 August 1986, to Mr Morison at the Scottish Home and

10 Health Department. We only came upon these letters

11 relatively recently. I take it, doctor, you have been

12 shown a copy of this recently?

13 A. Yes.

14 Q. I should preface my question with one remark:

15 I understand the question of the Sandoz's collaborative

16 research agreement. It has been suggested there may

17 have been a misunderstanding between two different

18 conditions: endotoxic shock syndrome and separately,

19 toxic shock syndrome. I should say to you, do you have

20 any recollection of the matters discussed in this

21 letter?

22 A. Not now. I have read this document several days ago and

23 I don't think I have any comment to offer upon it.

24 Q. In terms of --

25 A. I have no memory at all of the episode.

1 Q. Looking at the final paragraph on page 1, do you have
2 any comment you would wish to make on that final
3 paragraph?
4 A. None at all. From memory I can't comment on what
5 underlay that at all.
6 Q. Yes. We should for completeness look at the response by
7 Dr MacDonald. It's [SNB0132880]. This is Dr MacDonald
8 responding to Professor Cash, on 8 October 1986. We can
9 see in the third paragraph Dr MacDonald wrote:
10 "Dr Forrester is a knowledgeable and experienced
11 doctor who applies himself with great diligence to his
12 duties."
13 A. I find that very comforting.
14 Q. The final paragraph, there is a separate point raised
15 I would like to ask you about. Dr MacDonald writes:
16 "Unfortunately, because of the highly unfavourable
17 conditions of service in the medical Civil Service, we
18 have lost some very experienced colleagues, including
19 Dr Bell and at present we are operating four senior
20 medical officers under strength."
21 Do you have any recollection of problems with
22 staffing levels among the medical officers between 1985
23 and 1988?
24 A. Not so far as I was concerned. I have no recollection
25 of being hampered by lack of people to deal with.

1 I seemed to me to have the contacts that I would wish to
2 have, operating smartly.
3 Q. Certainly from your point of view you had a principal
4 medical officer, Dr McIntyre. We have seen his
5 involvement in the documentation we have looked at this
6 morning.
7 A. Yes, I never felt under any delay due to there being
8 nobody available to intervene or do anything.
9 Q. Thank you. I'm almost finished, doctor. Simply for
10 completeness, could we go, please, to [PEN0171752].
11 This is the first of the two statements you provided for
12 us. I think we have covered all of the ground. So I'm
13 simply going to take this statement as read and not ask
14 you anything further about it.
15 Finally, there was a supplementary brief statement,
16 [PEN0172052].
17 A. I'm sorry, am I being --
18 Q. It is simply doctor so the statements formally form part
19 of the Inquiry record that I refer to them, but we have,
20 I think, covered all of the ground that's set out in the
21 statement already. So I'm not going to go back over
22 them and similarly, this is your supplementary
23 statement. Again I think we will simply take that as
24 read without me asking you any questions about it.
25 A. May I thank you for enlarging on the screen the displays

1 because if they had not been enlarged I would barely be
2 able to read them.
3 Q. It does help me too and we have Mr Stempt to thank for
4 that.
5 Sir, I have no further questions for this witness.
6 THE CHAIRMAN: We will have a break.
7 (10.56 am)
8 (Short break)
9 (11.19 am)
10 THE CHAIRMAN: Mr Di Rollo?
11 MR DI ROLLO: Mr Dawson is asking the questions.
12 THE CHAIRMAN: Mr Dawson?
13 Questions by MR DAWSON
14 MR DAWSON: Thank you, sir. Dr Forrester, I have a few
15 questions for you, if that's okay. You have given some
16 evidence already about your role within SHHD and you
17 have told us about the extent of your experience of
18 blood transfusion matters when you arrived --
19 A. Yes.
20 Q. -- in your job there. Could I just ask you, what was
21 the role of the SNBTS directors group in informing
22 decisions made within SHHD?
23 A. I find that a very difficult question to answer. I'm
24 almost wondering what kind of answer I think might be
25 expected.

1 Q. You referred in your earlier evidence to deferring to
2 people with expert knowledge --
3 A. Oh, yes.
4 Q. -- and I'm wondering whether, in Scotland, the SNBTS
5 directors group was the body with expert knowledge of
6 blood transfusion matters to whom you might defer?
7 A. No. There would be no exclusive body. I would get
8 information where I could or where it appeared, on an
9 international basis. That would certainly be one of my
10 major sources of information, but certainly not the only
11 one.
12 Q. So your position is that the directors group was one of
13 the sources of information --
14 A. Yes.
15 Q. -- but not the only one?
16 A. No, not the only source. In that sort of field I think
17 you get information, if it's good information, wherever
18 you can get it.
19 Q. Okay. Thank you. You may or may not be aware that
20 Mr Macniven has already given some evidence in this
21 section last week in connection with his role in
22 relation to the non-introduction of surrogate testing.
23 He told us, in particular in relation to SNBTS
24 applications for funding, that he would often have
25 occasion to go back to the SNBTS directors after an

1 application had been made, to seek clarification of its
2 contents.
3 Did you often have occasion to go back to the SNBTS
4 directors group to seek clarification of medical
5 matters?
6 A. Not that I can recall. Are you thinking of applications
7 submitted to the chief scientist's office?
8 Q. I'm thinking of any applications in which you might have
9 had some involvement.
10 A. Yes, I see. No I don't think so.
11 Q. Thank you. Could I ask, please, to have up a document
12 which we have seen already? It's [SGH0028142].
13 Hopefully you recall this, Dr Forrester, it is one of
14 the documents you were shown earlier. I think this is
15 the one which you described as being a, "To whom it may
16 concern", type document?
17 A. Yes.
18 Q. If we just flip over to the second page, we will see the
19 date there and that's 12 June 1986, just to put it in
20 the correct place in the timescale. If we could flick
21 back to the first page, please, you are giving some
22 information here about the position, as you understood
23 it, as regards surrogate testing. I just wanted to ask
24 you a question in particular about paragraph 6. Could
25 we scroll down a little bit? You say in paragraph 6

1 that:

2 "In the absence of a specific test, for some years

3 the suggestion has been made that an enzyme test (ALT)

4 which detects faulty liver function, should be applied

5 to every donation."

6 You talk a little bit about the advantages and

7 drawbacks and, in the final sentence there, you say:

8 "Rejection of donations might reach 3 per cent, a

9 grave loss."

10 What I wanted to ask about that was whether, at that

11 time, you had sought the views of SNBTS directors as to

12 whether they would be able to cope with the type of loss

13 of blood that you had contemplated would result from

14 surrogate testing in that paragraph?

15 A. I have no recollection of having done so.

16 Q. Okay, thank you. Could I ask for another document,

17 which we have looked at as well, to be brought up? This

18 is [PEN0171554]. Hopefully you recall this document as

19 well, Dr Forrester. This is the note which -- this is

20 the memo which you sent to Dr McIntyre, giving details

21 of a meeting which you had attended of the working party

22 on transfusion-associated hepatitis, which had been

23 reconvened and had met on 24 November. Do you recall

24 that document?

25 A. No, I don't really recall any document apart from seeing

1 it.

2 Q. You recall being taken to it earlier this morning?

3 A. It's the only available memory I have. Sorry, which

4 paragraph?

5 Q. You recall being taken to this document earlier this

6 morning?

7 A. Yes.

8 Q. Could we just skip over to the second page, please? You

9 say there in paragraph 5:

10 "There was some discussion of the cost of screening

11 all donations (perhaps 8 million pounds)."

12 You say there:

13 "I asked the chairman whether he would advise

14 screening if it were free of cost. He said no."

15 You will recall that the chairman of that group was

16 Dr Gunson. As far as you can remember, your position is

17 that that represents accurately what you discussed with

18 Dr Gunson at the time?

19 A. Yes, I think so.

20 Q. Okay.

21 A. It seems to be rather a good question to ask.

22 Q. Could I just ask for a passage to be brought up from the

23 transcript from 16 November, please? It's at page 118.

24 THE CHAIRMAN: Which day is that, Mr Dawson?

25 MR DAWSON: That would be day -- I think it's 64. In his

1 evidence -- this is the evidence, Dr Forrester of
2 Dr Brian McClelland.
3 A. Yes.
4 Q. You recall him?
5 A. Yes.
6 Q. Do you recall him?
7 A. Well, yes.
8 Q. He was one of the SNBTS directors at the time.
9 A. Yes, I know -- I knew him.
10 Q. In his evidence, Dr McClelland told us that he had found
11 the material which Dr Gunson had presented to that
12 meeting on 24 November 1986 as being very persuasive in
13 his developing attitude towards being in favour of
14 surrogate testing.
15 A. Yes.
16 Q. At this point, Dr McClelland was asked how or whether he
17 could reconcile his interpretation of the Gunson
18 evidence and the passage that we just looked at from
19 your memo and, reading from line 17 onwards, he says:
20 "Looking back at this while I was preparing these
21 reports, I found this very hard to square. I would not
22 wish to conceal that at all. I think I have said it in
23 my statement. I find it very difficult looking back,
24 with the wisdom of hindsight, to understand how a group,
25 of which I was a member, could have this very well

1 prepared, well argued, well sourced, well informed paper
2 presented to us with these quite disturbing numbers and
3 then proceed to agree to do yet another study of
4 prevalence in donors."
5 I'm wondering if you might be able to assist us,
6 Dr Forrester, with the apparent inconsistency between
7 Dr Gunson's position as represented in your memo, that
8 he would not introduce surrogate testing even if it were
9 free, and the reliance placed by Dr McClelland on the
10 information Dr Gunson presented in favour of surrogate
11 testing?
12 A. I'm sorry, but with my recollection really totally
13 absent apart from my own note, I cannot help with this
14 at all. I see what you are asking --
15 Q. Yes.
16 A. -- but I cannot help at all.
17 Q. I appreciate that, thank you. Could we go back to the
18 previous document we were looking at, please, which was
19 [SGH0028142].
20 You told us earlier that you were generally, in
21 these types of memos, reporting information which you
22 had received from other people and you were taken to
23 a passage relating to the prevalence of non-A non-B
24 Hepatitis amongst the haemophiliac community.
25 Could you tell me, if you are reporting information

1 about the prevalence of non-A non-B Hepatitis in that
2 community, what the source of that information that you
3 are reporting would have been likely to have been?
4 A. Sorry, I know what you are asking but my memories --
5 apart from this, I have no independent recollection at
6 all.
7 Q. I see, thank you.
8 A. I can see what you are ask on asking, I'm not seeking to
9 insult you, but I just have no mental contents that
10 would help.
11 Q. Thank you. Could we look at document [SGF0012100]
12 please. I don't think this is a document to which you
13 were referred earlier but if we just scroll down to the
14 bottom, we will see it's another memo by yourself dated
15 10 February 1987. So we have moved on a little bit in
16 time. If we could just scroll up to the top, please,
17 you will see it's a memo going to Dr Moir in the CSO
18 department. In this memo you are again setting out the
19 background as regards surrogate testing at this time and
20 you refer -- you will see there -- in paragraph 3, to
21 the fact that:
22 "Joint consideration by SNBTS, SHHD, DHSS and the
23 English Transfusion Service indicates that, instead of
24 blindly adopting American practice, research should be
25 conducted, and a project involving 3 English and 1

1 Scottish transfusion centres is being planned."

2 Do we take it from this document -- it would appear

3 to be saying that at this stage, which is February 1987,

4 the general position appeared to be that more local

5 research was required into surrogate testing?

6 A. It certainly was the position of some people. Whether

7 it could be called the general position, I'm really not

8 quite sure. As you will know already, opinions varied

9 widely.

10 Q. Was it the position of SHHD at this time that that was

11 the course which should be adopted?

12 A. Quite honestly I couldn't tell you. Again I see what

13 you are asking. If I haven't written it down at the

14 time, then I don't know, I am afraid.

15 Q. Okay. Obviously, we have looked at another document,

16 which we may as well just have up to the screen, which

17 is [SGH0016653]. This is a document that you were taken

18 to earlier. It's the minutes of the SNBTS directors

19 meeting on 3 March 1987. This is the document in which

20 the recommendation was made by the SNBTS directors that

21 surrogate testing should be introduced. Do you remember

22 that document?

23 A. I saw this earlier today?

24 Q. Yes, indeed.

25 A. That's right, yes.

1 Q. Could we just skip over, please, to page 6658? That's
2 the passage you were referred to earlier, where the
3 recommendation is set out and you have already been
4 asked some questions about that. Would it be fair to
5 say that, within this minute, there is not very much by
6 way of detail as to what the directors thought process
7 was in recommending that surrogate testing be introduced
8 at this stage?
9 A. This is a report of a meeting.
10 Q. Yes, I think --
11 A. Well, that may simply indicate that they didn't discuss
12 the matter you mention in great detail at the meeting.
13 Q. I assume, given your earlier evidence, that you don't
14 have any recollection as to whether the reasoning was
15 discussed?
16 A. I'm looking at this. This is my complete memory.
17 Q. I understand.
18 A. I imagine I would have covered it in detail if it had
19 been important, but I'm just guessing.
20 Q. In his evidence about this, Dr McClelland, who also was
21 at the meeting, he actually accepted that this came,
22 "Rather out of the blue", was a phrase that he used, and
23 there isn't much by way of reasoning.
24 A. I am afraid I can't unravel that for you.
25 Q. Can you recall whether, in the aftermath of this

1 meeting, you attempted to try and contact anyone within
2 SNBTS to understand what their reasoning was behind this
3 recommendation?
4 A. I am afraid I can't tell. I see what you mean.
5 Q. I'm looking for -- at your evidence on whether you did
6 anything after the meeting. So it wouldn't be included
7 within the minute.
8 A. I can only guess, but it seems to me that I was
9 certainly not the channel through which the formal
10 application would pass. But I was aware of what was
11 going on. As I wasn't the channel for the formal
12 application, then I don't think I would have been
13 intervening in this way. I would expect the
14 directors -- the directors in their formal application,
15 to cover convincing detail of any kind.
16 Q. So your position is that you would have expected there
17 to be a formal application and for the reasons to be set
18 out in that formal application?
19 A. Yes.
20 Q. Therefore you didn't see any need for there to be any
21 further communication on your part with the directors?
22 THE CHAIRMAN: With respect, not "see any need", Mr Dawson.
23 It wasn't Dr Forrester's responsibility, so he didn't do
24 anything. I'm not sure that any of this is helping me
25 very much. Repeatedly to get the answer that

1 Dr Forrester can't remember what's not written down
2 isn't terribly helpful.
3 MR DAWSON: I understand that, sir and I'll move on from
4 this particular area.
5 Could I just ask you a question about another
6 document? It's [SGH0028076]. This isn't a document
7 that you have seen already but, if we just look at the
8 top there, we will see it's a memo which went to you,
9 Dr McIntyre and Dr Forbes. If we just scroll down to
10 the bottom we will see it's a memo from Mr Macniven
11 dated 2 October 1987.
12 I'm interested in the passage which is in
13 paragraph 2. You will see, about roughly half way
14 through, just beyond half way through, Mr Macniven says:
15 "But I think the worst of all possible worlds is
16 that research can not get off the ground ..."
17 This is in relation to surrogate testing obviously:
18 "I fear that, in those circumstances, we would be
19 subjected to increasingly irresistible pressure to spend
20 the money in any case, for the sake of improving, at any
21 price, the safety of blood and blood products."
22 I'm interested in exploring what he meant by the
23 phrase, "Increasingly irresistible pressure". Would it
24 be better for me to put that matter to Mr Macniven or is
25 that a matter with which you might be able to give me

1 some assistance, Dr Forrester?
2 A. I'm just brooding on that for a minute.
3 Q. That's fine. (Pause).
4 A. Yes, I take it this pressure would come from the Blood
5 Transfusion Service and can I say any more about that?
6 Q. If you can, I would be very interested.
7 A. I don't think there is anything in my memory about it at
8 all. I understand the words all right, but I don't
9 think I know anything further relevant about that.
10 Q. To be fair to you, obviously --
11 A. This matter of political pressure was mentioned in
12 a number of documents and phrases and so forth.
13 Q. Yes, thank you very much, Dr Forrester. I have no
14 further questions. Thank you, sir.
15 THE CHAIRMAN: Mr Anderson?
16 MR ANDERSON: I have no questions, thanks.
17 THE CHAIRMAN: Mr Johnston?
18 MR JOHNSTON: I have no questions, thank you.
19 THE CHAIRMAN: Anything arising? Dr Forrester thank you
20 very much indeed.
21 A. Thank you very much.
22 THE CHAIRMAN: I think we have put you under some pressure
23 to try and recollect events in the distant past, thank
24 you for doing your best.
25 MR MACKENZIE: Sir, the next witness is Dr MacDonald and

1 I wonder if I could seek a short adjournment while we
2 re-arrange the seating.
3 THE CHAIRMAN: I trust everyone is aware of Dr MacDonald's
4 hearing problems and if there are other gyrations that
5 are necessary, we can take care of them.
6 (11.38 am)
7 (Short break)
8 (11.44 am)
9 DR IAIN MACDONALD (sworn)
10 Questions by MR MACKENZIE
11 THE CHAIRMAN: If you can't hear, make sure that we know.
12 A. Thank you.
13 THE CHAIRMAN: To whom do I look first? Mr Mackenzie?
14 MR MACKENZIE: Thank you, sir. Good morning, Dr MacDonald.
15 Can you hear me okay.
16 A. Yes, thank you.
17 Q. Thank you. I would like to start, please, by looking at
18 your CV, which will come up on the screen. It's
19 WIT0030259.
20 Just going through matters chronologically, doctor,
21 we can see in 1950 you obtained your medical degree. In
22 1954 you obtained a diploma of the Royal College of
23 Obstetricians and Gynaecologists. In 1955, you obtained
24 a diploma in public health. In 1958, you became
25 a doctor of medicine and in 1979 you became a fellow of

1 the Royal College of Physicians. Then in 1978, is that
2 a reference to becoming a member of the Faculty of
3 Public Health?
4 A. Yes, it was public health medicine. At that time
5 I think they have simplified it to public health now.
6 Q. I see. I think that the Faculty of Public Health or
7 Public Health Medicine, I think is a joint faculty of
8 the three royal colleges of physicians in the UK.
9 London, Edinburgh and Glasgow?
10 A. That's correct.
11 Q. Thank you. Looking then at your appointments, please,
12 we start in 1950, when you were a house officer. Could
13 I then move forward to you joining the Scottish Home and
14 Health Department in 1964.
15 A. Yes.
16 Q. We can see you were a medical officer in the SHHD
17 between 1964 and 1966. You were then a senior medical
18 officer in that department, between 1966 and 1973 and
19 then a principal medical officer between 1973 and 1974.
20 You were then appointed Deputy Chief Medical Officer and
21 you held that post between 1974 and 1985 and you were
22 then Chief Medical Officer between 1985 and 1988. You
23 explain also that, between 1974 and your appointment as
24 Chief Medical Officer on 1 December 1985 there were two
25 deputy chief medical officers and before and after these

1 dates there was only one?

2 A. That's correct.

3 Q. Thank you. I think we have heard a little from another

4 witness as to why that was the case.

5 A. Yes.

6 Q. I would now, please, doctor, like to take you to your

7 first statement you provided for us on this topic. It's

8 [PEN0171702]. It will come up on the screen but if you

9 would prefer to use your hard copy, doctor, then feel

10 free to do that, if that's easier.

11 The first three paragraphs give us various matters

12 of biographical detail, which we don't have to go back

13 over. Then, if we could pick up, please, in

14 paragraph 4, which is under the heading, "The medical

15 staff in SHHD", so this is all by way of background to

16 how the SHHD was structured and operated, and we can see

17 that:

18 "Until 1974, SHHD had one deputy chief medical

19 officer, to whom principal medical officers reported.

20 Each principal medical officer headed a group of perhaps

21 3 or 4 senior medical officers and medical officers and

22 each PMO group had a defined remit. In 1974 a second

23 DCMO post was created and I was appointed to that post.

24 Responsibilities at that level had therefore to be

25 divided so that some PMOs reported to one DCMO and some

1 to the other."

2 You say:

3 "The PMO group with responsibility for blood

4 transfusion did not report to me, although our liaison

5 arrangements, to which I will refer in paragraph 5

6 below, ensured that I had some awareness in broad terms

7 of major developments."

8 Then:

9 "In 1985, when I was appointed CMO, SHHD reverted to

10 the arrangement prior to 1974 and had only one DCMO. As

11 chief medical officer from 1985 to 1988 I had a total

12 medical staff of perhaps 20 to 25 individuals."

13 Over the page, please. In paragraph 5 you refer to:

14 "Two practices in SHHD were intended to keep the CMO

15 and DCMO aware of the work in which medical staff were

16 engaged and of any special or difficult situations that

17 might be arising."

18 The two practices were firstly:

19 "A meeting was held every Monday morning, chaired by

20 the CMO or, in his absence, by a DCMO, and attended by

21 the PMOs heading each of our groups."

22 You say, "These were quite informal meetings and

23 notes were not made."

24 Secondly:

25 "SMOs and MOs wrote a monthly report indicating

1 briefly the activities in which they had been engaged
2 during the month. These were passed to their PMOs and
3 by them to the CMO and DCMOs."
4 You explain:
5 "Unfortunately these reports cannot now be found."
6 I think we have taken steps with the solicitor to
7 the Scottish Government seeking to recover these
8 documents but it hasn't proved possible?
9 A. That's right.
10 Q. In paragraph 5 we are again looking at things in general
11 terms. You say that:
12 "A CMO or a DCMO might decide to take the lead on
13 a particular issue with support from the relevant PMO
14 group because it had some unusual significance."
15 You give an example that when you were CMO:
16 "... I chose to take the lead in trying to introduce
17 measures to limit the spread of HIV by the shared use of
18 injecting equipment."
19 We can see what else is said:
20 "It was a serious matter, but also a sensitive
21 matter requiring agreement at a senior level in SHHD,
22 the consent of ministers and the cooperation of police
23 and others."
24 We can see for ourselves what's then said at the
25 bottom of the page. Over the page, please, page 3 we

1 can see paragraph 7:
2 "Medical staff were related to administrative
3 colleagues as advisers. While the administrative staff
4 were ultimately accountable for expenditure, the advice
5 of medical staff would be taken into account whenever
6 appropriate.
7 "The consideration given to the question of
8 introducing a surrogate testing for NANBH ... provides
9 an example of how this arrangement works in practice.
10 If departmental medical staff had been persuaded, after
11 consulting colleagues with relevant expertise, that
12 surrogate testing for NANBH was a reliable procedure
13 which would give few false results (positive or
14 negative) and be free from adverse effects, they would
15 have advised administrators accordingly and it would
16 have been highly likely that funding would have been
17 provided. In the event, departmental medical staff were
18 not sufficiently persuaded and advice reflected this."
19 We will go on to look at the detail of surrogate
20 testing shortly, doctor, but to what extent were you
21 personally involved in the decisions that required to be
22 taken regarding whether surrogate testing should be
23 introduced in Scotland?
24 A. I don't think that I was really involved personally.
25 I was, I think, kept fairly well informed of what my

1 colleagues were doing and I don't think that I really
2 had occasion to intervene. I was content to leave it on
3 that basis.
4 Q. Yes. Do you recall whether the issue ever came to you
5 for a final decision to be taken, or even a decision to
6 be taken on: should surrogate testing be introduced in
7 Scotland?
8 A. No. I'm not sure. It's quite long time ago. I'm not
9 quite sure that a final decision was ever taken.
10 I think we were still agonising over the question of
11 setting up research. Frankly, I just don't quite
12 remember the end of it, except that we didn't do it.
13 Q. Yes. In paragraph 7, five lines from the bottom, when
14 you say that:
15 "In the event, departmental medical staff were not
16 sufficiently persuaded and advice reflected this."
17 Which member or members of staff in particular would
18 that refer to?
19 A. That would be Dr Scott and Dr McIntyre and Dr Forrester.
20 Q. Yes. It wasn't a matter, I think, that -- or was it
21 a matter that came to you for your specific views on it?
22 A. Not in that sense. I think that I must have seen enough
23 paper to have a reasonable idea of what was going on
24 and, as I say, I didn't intervene.
25 Q. If you -- can you imagine a circumstance where you might

1 have intervened?

2 A. I think, if the advice appeared to be veering towards

3 introducing it, I would have found it necessary to

4 intervene.

5 Q. Why?

6 A. Certainly on two grounds. One is that I did have

7 reservations which will emerge in another paper that we

8 will perhaps come to. But I did have reservations,

9 mainly on the grounds that -- well, partly -- it

10 wouldn't be the complete answer to the problem as far as

11 the recipients of blood and blood products were

12 concerned, but it would also have repercussions on the

13 donors. Testing the donors, we know -- we don't know

14 the proportions that we would have found in this

15 country, but testing the donors would undoubtedly have

16 yielded a fairly appreciable number of positives, some

17 of which would be false and, at the other end, a fair

18 number of negatives, some of which would be false.

19 If you then -- what are you going to do about the

20 positives? You won't know which are false and which are

21 genuine. You bring them in and -- or you perhaps have

22 done your best to explain the position beforehand but

23 then some of them will have to be followed up and

24 I think we would -- there was some risk that we would

25 find that donors would be disturbed by this situation

1 and I think that was something which we really should
2 not have risked doing. That's one side of it.
3 The other is a point which I think has already come
4 out this morning, about DHSS. We will may, I think,
5 come to this later but the point that I think has to be
6 made is that DHSS and the Scottish Office, which
7 included SHHD, and for that matter, the Welsh Office,
8 were three different departments of the same government,
9 each responsible to a Secretary of State in that
10 government and the Secretaries of State were sitting
11 together round the same cabinet table.
12 On an issue of this kind, where there was a group,
13 the Haemophilia Society, and perhaps others, watching
14 all our moves carefully, if one of us -- and it might
15 have been us -- if one of us decided to institute
16 testing and the other didn't, that would be extremely
17 difficult to explain. One of us must be right, one must
18 be wrong, would be the reaction.
19 But it goes a little further than that because, as
20 I recall it, we were facing a situation in which the
21 Scottish directors were pressing for the introduction of
22 testing and the English directors -- I think pretty
23 unanimously at that stage, the English directors were
24 against it. I don't think we could ignore the fact that
25 there was a well informed body of opinion, not very far

1 away, with a different view.

2 So I think in that situation I would certainly need

3 to have become involved.

4 Q. Yes. Just to pause there, doctor, my understanding is

5 that in 1986 and 1987 you were perhaps aware, in general

6 terms, of the consideration being given by your medical

7 officers to the question of surrogate testing --

8 A. Yes.

9 Q. -- but you were not directly or personally involved at

10 that time?

11 A. Yes.

12 Q. I had raised with you the possibility of when you might

13 have become involved and --

14 A. Sorry did.

15 Q. Sorry, yes. I then asked you why might you have become

16 involved personally or directly involved, and you have

17 given an answer to that.

18 What I simply wonder is, hypothetically speaking, if

19 you had decided to become involved, let's say in the

20 middle of 1987, would your involvement have been to say:

21 "Hang on, those below me have recommended we now

22 introduce such testing, but I think there are wider

23 issues that need to be considered."

24 Or would your involvement in, say, the middle of

25 1987, have gone as far as saying:

1 "In my opinion we should not introduce such
2 testing."
3 A. That would be correct, but I think I ought to say that
4 Dr Scott and Dr McIntyre certainly had been in the
5 department long enough to be as well aware as I was of
6 the -- certainly of the difficulty of taking a different
7 line from DHSS.
8 Q. Yes. I will come back to explore that with you, but
9 just for the avoidance of doubt, hypothetically
10 speaking; if, in the middle of 1987, you had become
11 personally or directly involved in the question of
12 surrogate testing, would your involvement have been
13 simply to say, "Hang on, there are wider issues we need
14 to consider." Or would you have gone even further at
15 that time and have said, "We should not introduce such
16 testing"?
17 A. I think I would have to have gone further.
18 Q. I see. So, in the middle of 1987, you had formed a view
19 on whether surrogate testing should or should not be
20 introduced?
21 A. Yes, I think that was the view that Dr Scott and
22 Dr McIntyre were taking and I think Dr Forrester.
23 I would have accepted that view and agreed with that
24 view.
25 Q. I understand. Thank you. I'm sorry, I have taken you

1 off your statement a little bit. I would like now to
2 return to the statement and work my way through it,
3 please. We had reached, I think, paragraph 8 on page 3
4 under the subheading, "My first responsibility for blood
5 transfusion matters". And you explain that:
6 "As an MO/SMO I had responsibility, between 1965 and
7 1973, for the department's medical interest in blood
8 transfusion."
9 Et cetera:
10 "I believe I spent about a third of my time on blood
11 transfusion matters."
12 Paragraph 9 and then all of the next page moves into
13 fractionation and the manufacture of blood products and
14 I'm simply going to take that as read. It is of
15 interest and relevance but not for topic C2, I think.
16 So as I say, page 4, we will simply take all of that
17 as read, if I may. Also going to the top of page 5.
18 I would like then to come back to paragraph 15 and this
19 relates to your concern with blood transfusion as chief
20 medical officer and you say that:
21 "When I was one of two DCMOs, from 1974 until 1985,
22 the PMO group with responsibility for blood transfusion
23 did not report to me. When I became CMO from
24 1 December 1985, blood transfusion was, of course, part
25 of my overall responsibility for medical matters within

1 SHHD. However, the day to day concern with blood
2 transfusion, including the impact on it of HIV and
3 Hepatitis C infections was left in the hands of
4 experienced colleagues whom I knew well as competent and
5 conscientious individuals who had been undertaking this
6 for several years."
7 To pause, Dr MacDonald, you became CMO
8 in December 1985?
9 A. Yes.
10 Q. I think at that stage presumably, the experienced
11 colleagues, who had been working in blood transfusion
12 for many years, that must be a reference to Dr Scott and
13 Dr McIntyre?
14 A. Yes.
15 Q. Because we know that Dr Bell, I think, left in 1985 and
16 Dr Forrester replaced him?
17 A. Yes. That's right. I think Dr Bell had left shortly
18 before I became CMO.
19 Q. I understand. You then refer to a minute by
20 Dr Forrester, 1 December 1986. We will come back to
21 that. Over the page, please.
22 A. Yes, can I just a make a point here? The last sentence
23 there.
24 Q. Bottom of page 5, please.
25 A. Yes:

1 "That working party's advice went, of course, to
2 DHSS as well as to SHHD."
3 That was quite a common feature of our arrangements,
4 that we participated in the same working parties and
5 advice came to the two departments. Indeed, I would
6 think to the Welsh Office as well at that point.
7 Q. Thank you. Over the page, please, at page 6. We then
8 come to the set of common questions we asked all
9 witnesses.
10 A. That's right.
11 Q. Although I think the questions may have been slightly
12 more focused towards the SHHD in this instance. We
13 asked firstly.
14 "What consideration was given by the SHHD in the
15 1980s as to whether surrogate testing should be
16 introduced?"
17 In paragraph 16 you explain that:
18 "I did not have responsibility for blood transfusion
19 matters in the early 1980s, before I became CMO ... and
20 Dr Scott (the other DCMO at that time) had
21 responsibility for blood issues."
22 We can see what else is -- and you say:
23 "Thereafter [so once you become chief medical
24 officer] although blood transfusion was of course part
25 of my overall responsibility, the day to day concern

1 with this matter was undertaken by experienced
2 colleagues."
3 You have explained that and I think that's also
4 consistent with the documents we have looked at where
5 I think your name doesn't appear at all, or if it does
6 it's very rarely. The day to day business or
7 consideration is a matter really for Dr Scott,
8 Dr McIntyre and Dr Forrester?
9 A. Yes.
10 Q. The next question, the research funded by the SHHD.
11 I think we can take that answer as read and equally
12 paragraph 18. I would like to take that as read as
13 well, please.
14 Page 7. We then asked:
15 "What was the response by SHHD to each of the
16 requests by the SNBTS for funding to introduce surrogate
17 testing?"
18 In paragraph 19 you say:
19 "I have now seen the relevant PES documents. I did
20 not see them at the times when they were submitted to
21 SHHD. It would, however, have been exceptional for them
22 to have been shown to me, or for me to have been
23 involved in considering them."
24 I think we heard evidence from Mr Sandy Murray, as
25 to his role in collating the various funding bids,

1 taking advice from medical colleagues and then, I think,
2 the approval being required of Mr Macniven --
3 A. I'm sorry.
4 Q. I'm sorry, the approval being required of
5 Mr Duncan Macniven --
6 A. Yes.
7 Q. -- before the funding document was then sent to the
8 finance department. When Mr Murray sought advice from
9 medical colleagues on the different items for which
10 funding was sought, what level of medical officer would
11 be involved in giving advice to the administrative
12 colleagues?
13 A. I think probably Dr McIntyre, but if Dr McIntyre wasn't
14 immediately available and it was urgent, he might well
15 have asked Dr Forrester.
16 Q. Yes. Would Dr Scott or yourself have been involved in
17 giving advice to admin colleagues on funding bids in the
18 late 1980s?
19 A. Yes -- I wouldn't, simply because I wasn't handling the
20 detail of this. Dr Scott would. I think probably after
21 Dr McIntyre had seen it and perhaps identified a point
22 that he thought was more difficult than usual and might
23 have wanted to take it up with Dr Scott.
24 I don't think I would have expected to see these
25 documents.

1 Q. Thank you. The next question we asked was:
2 "The response by SHHD to the recommendation of the
3 SNBTS directors (agreed at their meeting on
4 3 March 1987) that surrogate testing should be
5 introduced with effect from April 1988."
6 We will come back to that minute shortly.
7 I should make one point. I think in your answer in
8 paragraph 20 you say:
9 "This was, in fact, a meeting of the SNBTS directors
10 and haemophilia directors ..."
11 I think that's wrong. I think it was in fact the
12 SNBTS directors only.
13 A. Oh.
14 Q. But we will come to look at the minute shortly.
15 A. Sorry, yes.
16 Q. I think it also follows that the meeting, because it was
17 simply that of the SNBTS directors, was not chaired by
18 Dr Forrester. But we will see that in the minute
19 shortly.
20 You say:
21 "The departmental response to the directors'
22 representation was negative, which is not at all
23 surprising in the light of Dr Forrester's account of the
24 meeting of the UK Working Party on
25 Transfusion-associated Hepatitis on 24 November 1986."

1 So really, I suppose the point one can make is that
2 the SNBTS directors were, in a way, going it alone --
3 A. Yes.
4 Q. -- by recommending the introduction of surrogate testing
5 because that wasn't the view of the UK Working Party on
6 Transfusion-associated Hepatitis.
7 A. I'm sorry, yes.
8 Q. It appears that that working party's view was to
9 undertake further research first. That, we have seen,
10 was also the view of the SHHD and also at least certain
11 transfusion directors in England as well.
12 The next question we asked was:
13 "The extent to which the cost of surrogate testing
14 was taken into account by SHHD in considering whether to
15 finance such testing."
16 You say:
17 "I cannot answer this question from my own
18 knowledge. Cost is always a factor that has to be taken
19 into account, but never without regard to any other
20 relevant considerations. In this instance, the other
21 relevant considerations were the doubt and uncertainties
22 described by Dr Forrester in his account of the meeting
23 of the UK Working Party on Transfusion-associated
24 Hepatitis on 24 November 1986."
25 We then at the bottom of the page asked why

1 surrogate testing was not introduced in Scotland.

2 You say:

3 "I cannot add anything to what is recorded in the

4 minutes referred to in the Preliminary Report.

5 Essentially, there was too much uncertainty about

6 various aspects of surrogate testing to justify

7 introducing it."

8 I take it, Dr MacDonald -- was that your view at the

9 time, for example, 1987, that there was too much

10 uncertainty about various aspects of surrogate testing

11 to justify introducing it?

12 A. Yes, I think it was. I had been CMO at that time for

13 over a year, so I think I would have been over that

14 ground with colleagues.

15 Q. Looking at things now, having had the opportunity of

16 looking perhaps at the preliminary report and with the

17 knowledge of Hepatitis C now, with the benefit of

18 hindsight would you be any more positive towards having

19 used surrogate testing for NANBH in the late 1980s?

20 A. I don't think so.

21 Q. Why not?

22 A. The position, I don't think, had really changed very

23 much, even by the time it was possible to screen for

24 Hepatitis C. I think the facts remain that you were

25 going to get quite lot of false positives, quite a lot

1 of false negatives, and you would not be able to make
2 a complete -- to eliminate the infection completely.
3 I don't see that the position had really changed in
4 any way that would have made me change my view.
5 Q. If, hypothetically speaking, it was reasonably
6 believed --
7 A. I'm sorry.
8 Q. If hypothetically speaking, it was reasonably believed
9 that the introduction of surrogate testing was likely to
10 reduce the incidence of post-transfusion hepatitis by,
11 say, 30 or 40 per cent -- if one accepted that, do you
12 think there then becomes a reasonable case for
13 introducing surrogate testing?
14 A. No, I think I would still have argued against it.
15 I think too much uncertainty still remained and I would
16 have put considerable weight on the possibility that
17 donors would find it disturbing. I think the one thing
18 that we really had to avoid, almost at any cost, was
19 disturbing donors because the whole enterprise depended
20 on them.
21 Q. Donors presumably are part of the equation but equally
22 patient safety, presumably, is an important part of the
23 equation too?
24 A. I wouldn't for a moment dismiss the question of patient
25 safety, but on the donor side you are dealing with

1 healthy individuals -- or at least they appear to be and
2 believe that they are healthy -- who come along with the
3 altruistic intention of giving blood.
4 You then find yourself having to subject some of
5 them to a series of investigations, at the end of which
6 you might be able to say to some of them, "Oh, don't
7 worry, you are not actually positive". To others
8 certainly you would have to say, "I'm sorry, we have
9 found that you were positive". But, even to the ones
10 where you said, "You are not positive, so go away and
11 don't worry", some people wouldn't find it easy to go
12 away and not worry.
13 Of course, at that time, as I understand the
14 position, there was no possibility of treatment. That,
15 I think, came rather later. So, on the whole, you were
16 exposing these people who had come along to give blood
17 to a situation that could be quite unfortunate. On the
18 recipient side, well, yes, of course, we wanted to do
19 the best we could for them, but you were dealing with
20 an established problem; it was a different situation
21 from that of the healthier, apparently healthy donor.
22 Q. Can we go back to your statement, please? We then asked
23 about the main discussions between the SHHD and the
24 Department of Health in England on the on research into
25 surrogate testing and whether surrogate testing should

1 be introduced. You say:

2 "There were obviously exchanges between individual

3 medical officers in these two departments. But I don't

4 know what might be covered in the reference to 'main

5 discussions'."

6 I think there were really two questions doctor.

7 Firstly, this relates specifically to surrogate testing:

8 what discussions or liaison was or were there between

9 English health officials and the Scottish health

10 officials in relation to surrogate testing. But also

11 the far broader question: in general to what extent did

12 the two health departments liaise with each other.

13 Dealing with surrogate testing in particular, do you

14 have any recollection of any liaison between the two

15 health departments in respect of surrogate testing?

16 A. I don't have any recollection and I don't think there

17 probably was any occasion when officers of the two

18 departments sat down on their own and said -- if

19 I understand your question -- said "let's sort this

20 out". I don't recall that sort of thing happening.

21 I do -- I'm sure that there was information flowing

22 between Dr Forrester and his colleagues in DHSS, again

23 at Dr McIntyre's level and I'm sure Dr Scott was

24 occasionally involved. So I think each department would

25 have a pretty clear notion of where the other stood but

1 it would be acquired in that way.

2 Q. Is the picture you are presenting, doctor, of liaison or
3 communication at all different levels, so certainly from
4 Dr Forrester with his counterparts in England,
5 Dr McIntyre, his counterparts and did that continue up
6 between deputy chief medical officer level and chief
7 medical officer level? Not just with surrogate testing,
8 but just as a general principle, was there such liaison
9 between the two departments at all levels?

10 A. Yes, that really went on at all levels and of course, we
11 are talking specifically of a very narrow subject. If
12 you look at the range of activities in the two
13 departments, there was an enormous range of activity.

14 Q. When you were chief medical officer, Dr MacDonald,
15 between 1985 and 1988, what was the relationship between
16 the two health departments, in terms of: was it
17 a relationship of equal partners, or did the English
18 department carry greater weight, or what?

19 A. Well, I think -- I'm not sure if I haven't touched on
20 this somewhere in something I wrote. I think the
21 position, as ministers would have seen it, was that the
22 DHSS would have been expected to take a lead on major
23 policy matters and Scottish, SHHD, and the Welsh Health
24 Department, would have been expected to fit their policy
25 around that. In other words, there can be a bit of

1 variation for local circumstances, but broadly the
2 policy would be evolved in DHSS.
3 Having said that, I think I should go on to say --
4 and we have touched on this already -- what very often
5 happened was that an expert group -- I mean, not just
6 blood transfusion, but in every respect -- an expert
7 group would be assembled in various ways, sometimes very
8 formally, by ministers, sometimes by the departments,
9 and there would usually be Scottish members.
10 I mean, if it was in some paediatric subject, they
11 would invite a paediatrician from Scotland who had an
12 interest in the subject, maybe more than one, and one of
13 our medical staff would attend these meetings, so that
14 we were getting feedback from that. In that way the
15 Scottish input was made. By that I mean to say, if
16 there were one or two Scottish members of the group,
17 they would be able to make an input and they would be
18 able to go back to colleagues in Scotland and perhaps
19 clarify their views and go back and this sort of
20 exchange would take place.
21 On the whole, I think it worked reasonably well.
22 I think the profession in Scotland was content with it.
23 I think they would have been less than content if DHSS
24 involved only their English colleagues, but they were
25 sensitive to it and I think it did work quite well.

1 Q. Yes. If, in the middle of 1987, SHHD officials,
2 including yourself, had taken the view that surrogate
3 testing was justified --
4 A. I'm sorry.
5 Q. I'm sorry. If, in the middle of 1987, the view was
6 taken in SHHD that surrogate testing was justified and
7 if you had also been of that view, if you had been
8 unable to convince your English colleagues of that,
9 would it have been open to Scotland to introduce such
10 testing in any event?
11 A. I think in a very theoretical sense. This was never
12 tested. I think what would have happened, I can,
13 I believe, have advised Scottish ministers that testing
14 should be introduced in Scotland. The CMO and DHSS
15 could have advised his ministers that it should not be
16 tested in England. I think we would have been bound,
17 each of us, to tell our ministers that the other
18 minister was being given the opposite advice. I don't
19 know what would have happened then.
20 I suspect that a solution would have been found
21 before it ever got to that length --
22 Q. I see.
23 A. -- but that's the sort of reality of the existence.
24 Q. Thank you.
25 THE CHAIRMAN: I suppose, if the two sides became totally

1 entrenched, it would become a decision --
2 A. I'm sorry, sir.
3 THE CHAIRMAN: If the two sides, Scotland and England, had
4 each become totally entrenched in their own view, it
5 would have become a matter for ministerial decision,
6 possibly at cabinet level at some stage?
7 A. Yes.
8 THE CHAIRMAN: Of course, no one can forecast precisely.
9 A. I'm sorry, sir.
10 THE CHAIRMAN: No one can forecast precisely what the
11 outcome of an issue of that kind might have been.
12 A. No, I think I would risk a bet on it.
13 THE CHAIRMAN: I wondered. Yes.
14 MR MACKENZIE: Dr MacDonald, if -- let me put it this way:
15 if, in the middle of 1987, you had sat down to apply
16 your mind directly to whether surrogate testing should
17 be introduced or not, would the fact that officials in
18 the Department of Health in England were against
19 surrogate testing -- would that have been a factor in
20 your decision-making and, if so, what weight would you
21 have placed on it?
22 A. I think that it would have presented us with quite
23 a difficult problem. I think we really -- we would be
24 going over the ground we have just covered. Would we be
25 prepared to advise our minister that it was worth taking

1 that particular view? The minister would certainly want
2 to know, in some detail, why the other view was being
3 taken in England. It's a question of how easily we
4 could have persuaded them. I think in this particular
5 issue we had a group of regional directors in Scotland
6 expressing one view, we had a group in England
7 expressing a different view. Circumstances in Scotland
8 and England were not different in relation to this
9 issue. Which one is preferable, the preferable view?
10 I think we would have to ask ourselves if we could
11 reasonably -- if we were prepared to put it to the
12 minister that we felt so strongly in favour of it that
13 we really wanted him to press it.
14 Q. You would have done that if you had felt so strongly
15 about an issue?
16 A. Yes, but -- I mean, in any issue of this kind, if there
17 had been a significant difference in circumstances
18 between Scotland and England, rather than just the
19 opinions of groups of staff -- if there had been that
20 sort of thing, there might have been -- and this is all,
21 of course, very hypothetical -- there might have been
22 a case to argue.
23 I don't think there are satisfactory answers to
24 these questions.
25 Q. Thank you, doctor. I would like now to put -- I think

1 we will just finish this statement. We had asked you:

2 "If surrogate testing for non-A non-B had been

3 introduced in Scotland, the extent to which the

4 incidence of post-transfusion NANBH/hepatitis C is

5 likely to have been reduced."

6 You answered:

7 "In the light of the unresolved uncertainties this

8 question is unanswerable."

9 A. Yes.

10 Q. We can put that statement to one side, please and turn

11 to the second statement you provided for us. This

12 document will come up on the screen. It's [PEN0172048].

13 Paragraphs 1 and 2 we can read for ourselves in the

14 interest of time. Paragraph 3, please.

15 In respect of the large-scale prospective study of

16 the type undertaken in America and proposed by

17 Dr McClelland in the early 1980s, in the third line from

18 the bottom we see you say:

19 "While such a study would have provided additional

20 information about NANBH in the UK, it seems doubtful

21 whether sufficient new information could have been

22 obtained in time to influence the decisions that had to

23 be made by blood transfusion services. The US TTV study

24 commenced in July 1974 but, in reporting on an interim

25 analysis in 1978, caution was advised in interpreting

1 the data, 'since the number of patients analysed to date
2 is small'."
3 Paragraph 4 you say:
4 "Other considerations have also to be taken into
5 account."
6 You refer to the duty of care towards donors, as
7 well as towards recipients, and the need to maintain an
8 acceptable balance between these two duties. We can see
9 what else you say there. Paragraph 5, you list various
10 quotes from the literature about the problems raised by
11 using a surrogate test and the problems in advising
12 donors. We can take all of that as read, I think,
13 because you set it out very clearly.
14 Over the page, please, question 6 referred to the
15 work of Drs Dow and Follett. We have got Dr Dow coming
16 tomorrow so I'll ask him about that.
17 I take it, doctor, that you have no recollection of
18 having personally read Dr Dow's thesis at the time?
19 A. No.
20 Q. Question 7, we asked if, in the second half of the
21 1980s, SHHD medical officers placed sufficient weight on
22 the likely prevalence and seriousness of
23 post-transfusion NANBH, and if their views in that
24 regard influenced their opinion on whether surrogate
25 testing of blood donors should be involved.

1 Could I pause, there, and ask you this: if one is
2 considering, let's say in 1987, whether surrogate
3 testing should be introduced, presumably -- and there
4 are a number of factors to take into account --
5 presumably one factor is a consideration of the
6 seriousness of the disease?
7 A. Yes.
8 Q. Then, if a condition is entirely harmless and benign,
9 then the case for testing to prevent the condition would
10 be reduced, but the more concerns one has about the
11 seriousness of the condition, then the more there
12 becomes a case for testing to prevent the condition. As
13 a generality does that seem reasonable?
14 A. Yes, but you can't -- at the same time you can't ignore
15 what you might call the quality of the testing.
16 Q. Yes. Presumably, there were a number of factors to be
17 taken into account in considering whether such testing
18 should be introduced. One was the quality of the
19 testing, the effect on donors, the likelihood of
20 increasing patient safety, seriousness of the disease,
21 prevalence of the disease and perhaps the cost of
22 undertaking testing as well.
23 A. Why yes.
24 Q. No doubt there will be other factors, but these will be
25 some of the main factors, I think.

1 A. Yes, indeed.
2 Q. Returning to paragraph 7, please, you refer to
3 Dr Forrester's note of 12 June 1986, which I'll come
4 back to shortly. We see the quote from that.
5 There are some other documents you refer to as well
6 and I will come back to some of these. So I think we
7 will simply take your answer 7 as read for now. As
8 I say, I will come back to ask you one or two of the
9 documents.
10 A. Yes.
11 Q. One point. On the third last line on page 3 you say --
12 the third last line:
13 "In his minute of 6 April 1987, Dr McIntyre is
14 reporting a situation as it existed and does not appear
15 to be endorsing views expressed elsewhere or expressing
16 a view of his own on the characteristics of NANBH."
17 This question of Dr Forrester not expressing a view
18 of his own on the characteristics of NANBH; would that
19 be consistent with your of your understanding of
20 Dr Forrester's role at the time?
21 A. I'm sorry, I'm not quite following you here.
22 Q. I'm sorry, we have jumped about. Could we go back to
23 page 3, please? Third line from the bottom.
24 A. Yes.
25 Q. Yes, it's Dr McIntyre, sorry.

1 A. Yes, it's Dr McIntyre, isn't it?

2 Q. I apologise, Dr MacDonald. It's entirely my mistake but

3 let me ask the question this way: we have heard evidence

4 from Dr Forrester this morning that his role was really

5 to ingather and relay information to others, rather than

6 him personally giving a judgment or opinion on, for

7 example, the characteristics of the disease, NANBH.

8 Would that be consistent with your understanding of

9 Dr Forrester's position at that time?

10 A. I think that's a reasonable position for Dr Forrester to

11 take. I think that if he had formed a view, the

12 expression of that view would have been welcomed. In

13 other words, I think we always were open to listening to

14 the views that might be offered.

15 Although it was a hierarchical set-up, it wasn't

16 a rigid one in the sense that you are only such and such

17 grade, so you mustn't, if you had reason to think you

18 should say something. In fact you could quite well find

19 that, because of some experience in the past, somebody

20 relatively junior to you knew more about it than you

21 did.

22 Q. Yes. Thank you. Then, the top of page 4, please. You

23 go on to say that:

24 "While the views of SHHD medical, officers may have

25 contributed to their opinions on whether surrogate

1 testing of blood donors should be introduced, these
2 views do appear to have been properly balanced."
3 I take it, doctor, you say that from having had the
4 chance -- for the purposes of this Inquiry, of going
5 back over some of the documents at the time?
6 A. Oh, yes, yes.
7 Q. Paragraph 8, question 5. We asked about:
8 "... the possible consequences if surrogate testing
9 of donors had been introduced in Scotland."
10 We can see what you say there. In paragraph 9 --
11 I'm interested, doctor, in the final sentence of
12 paragraph 9, where you say:
13 "The existence of these commercial producers cast
14 a long shadow over fractionation activities within the
15 NHS."
16 Really to ask what you meant by the reference to
17 "a long shadow". What's that a reference to?
18 A. I think this was a very peculiar situation, in which the
19 NHS was itself a producer and in that sense it was in
20 competition with commercial producers, in a way that
21 I don't think was quite replicated anywhere else in the
22 service. I think what struck me at the time, when
23 I wrote that, I was aware of the -- I had seen notes of
24 it -- that commercial producers, particularly in the
25 United States, were beginning to introduce surrogate

1 testing. In the way in which commercial operators work,
2 they would be presenting this in the publicity in their
3 advertising as an advantage. My stuff is better than
4 your stuff. I wouldn't be sure that that was altogether
5 fair but we, really, I don't think I felt that we could
6 quite adopt these standards.
7 So there was a lack of balance. There was also the
8 general pressure that we had -- we really had to be
9 producing material which not only was good in
10 a pharmacological sense, but also was easily
11 administered and all these sort of features. I think my
12 feeling was that, in some respects, the NHS was at
13 a disadvantage.
14 Q. Yes. One matter which occurs to me there is that
15 obviously in the 1980s, for example, the NHS in Scotland
16 was producing blood products, Factor VIII and IX
17 concentrates, equally available on the open market are,
18 perhaps US-produced, commercial products.
19 In the 1980s -- this is a very wide question -- it
20 may be unfair to ask you, but in the 1980s did the NHS
21 produce any other pharmaceutical products which may have
22 been in competition with commercial products?
23 A. I think there -- and I'm not sure about this. I think
24 there might be something like that in the field of
25 vaccines and immunisation products, but I'm not just

1 quite sure of that and whether that would be quite the
2 same problem.
3 Q. But it does perhaps seem to have been relatively rare
4 for the NHS to be producing a product which was in
5 direct -- or in competition with a commercially produced
6 product.
7 A. Yes.
8 Q. Which may have given rise to a set of unique or
9 particular issues?
10 A. I'm sorry?
11 Q. That, in itself, may have given rise to a set of quite
12 unique set of issues. Perhaps which wouldn't arise more
13 generally across the NHS?
14 A. Yes.
15 Q. In general across the NHS, the NHS can get on and do
16 what it thinks is best?
17 A. Yes.
18 Q. Without being subject to, at least in the 1980s,
19 perhaps, commercial supply.
20 I think that takes us into far wider territory. So
21 I'll stop your statement there, thank you, doctor. But
22 I would like to now ask you some questions about one or
23 two documents which we haven't looked at yet.
24 The first document, please, is [PEN0171734].
25 Doctor, this is an excerpt from a textbook by

1 Professor Mollison, "Blood Transfusion and Clinical
2 Medicine". The seventh edition published
3 in January 1983. If we go over the page, please -- we
4 did go over this with Dr Forrester and I'm not sure,
5 Dr MacDonald, if you were present at that stage, when
6 I took Dr Forrester to this passage this morning?
7 A. Yes, I was but I was over there and I really didn't hear
8 any of Dr Forrester's replies.
9 Q. Yes. Under, "Non-A non-B Hepatitis", about ten lines
10 down, if we look to the right-hand side -- I'll pick up
11 the passage commencing:
12 "As a rule, non-A non-B Hepatitis is symptomatically
13 mild. Patients seldom need to be admitted to hospital.
14 Nevertheless, up to 60 per cent of cases have abnormal
15 ALT levels for more than one year. If a liver biopsy is
16 taken, most of the cases show histological evidence of
17 a significant chronic liver disease and approximately
18 10 per cent show features of cirrhosis."
19 A reference to a paper by Alter in 1980:
20 "A striking feature of non-A non-B Hepatitis is the
21 tendency for serum hepatic enzyme levels to fluctuate
22 markedly over a relatively short time."
23 To pause there, doctor, is this the sort of textbook
24 that would have been available to medical officers in
25 SHHD in the 1980s?

1 A. I'm not sure if this particular one would have been
2 available immediately, but we had an arrangement that we
3 could draw on the pretty extensive library that DHSS
4 had, so in that sense we could have got it. They would
5 have sent it up to us.
6 Q. We have heard evidence that this was the main, perhaps
7 only, British transfusion textbook at the time. Would
8 you have assumed that your medical officers would be
9 aware of information contained in such a textbook?
10 A. Not really. I think that perhaps a medical officer who
11 had spent as long as Dr Bell had spent liaising with the
12 blood transfusion people -- I think he might well have
13 been aware of this. But I think there is a point -- and
14 I wondered if it was beginning to emerge this morning.
15 Generally speaking, we were not individuals who were
16 taking up anything resembling specialist positions.
17 There were one or two examples at variance with that,
18 but broadly speaking we really, I think, would have
19 regarded ourselves as generalists. This is quite an
20 interesting point because, as medicine has become
21 increasingly specialised -- and it has become more and
22 more so since my time -- there is a problem how you
23 bring it all together and decide as between one and the
24 other and realise what the implications are.
25 If I can give you an example from my own experience,

1 I joined the department in 1964. They advertised a post
2 for someone to advise on, I think it was, maternity
3 services and child health. I had done a little, not
4 technically good or particularly profound work and
5 produced one or two very modest papers in rather modest
6 journals and I got the job. Within about a year, the
7 DCMO at that time called me in and said he would like me
8 to take on the job we talked about earlier in the early
9 days of the service, when it was an association, and
10 also deal with the committee that advised on laboratory
11 services.
12 That was the sort of thing. I was never involved in
13 maternity and child health services again. So it is
14 this kind of lack of -- relative lack of specialisation,
15 maintaining a degree of generality that is what we
16 wanted.
17 Q. I can quite understand that, Dr MacDonald, but it was
18 a normal part of the job of medical officers to form
19 a view on the matter and to give advice, in particular
20 to their administrative colleagues --
21 A. Yes.
22 Q. -- perhaps from time to time, occasionally to ministers.
23 When a medical officer had to give advice, it does seem
24 to be an obvious starting point, in informing oneself on
25 a matter, to go to the main textbook in the area.

1 A. Yes, I think that's reasonable.
2 Q. Yes. So if a medical officer in SHHD is considering the
3 issue of post-transfusion hepatitis in the 1980s, does
4 it seem reasonable that one would go to
5 Professor Mollison's book?
6 A. Well, I'm a little hesitant to narrow this down to one
7 particular book, but I do understand the point you are
8 making, yes.
9 Q. Yes, and in particular --
10 THE CHAIRMAN: I wonder if I could follow a little because
11 I do want to get a feel for what you would have expected
12 your medical officers to do.
13 At one end of the range of possibilities is the
14 possibility that the MO would be expected to do his own
15 research, find out what the up-to-date position was and
16 advise on that basis.
17 I suppose at the other end of the spectrum, one
18 would seek out the author of the book and ask him what
19 the up-to-date position was, given that it might have
20 moved on since the last edition.
21 What would you have expected people to do?
22 A. In broad terms, I would have expected them to keep
23 up-to-date. I would -- how shall I put this? I would
24 perhaps warn him, if I was giving advice, that he has
25 always got to remember that the people he is dealing

1 with in the subject know a lot more than he does and he
2 is not going to get himself on to that level.
3 THE CHAIRMAN: So there is a difference between doing enough
4 research to know what the questions are and doing enough
5 to provide answers to them?
6 A. There is, and I think it's interesting you should put it
7 that way because I have sometimes felt that one of the
8 justifications for our existence is that we know the
9 questions to ask.
10 THE CHAIRMAN: Certainly there are people lined up out here
11 who are no doubt grateful to know that that's
12 a justification for their existence, doctor. But
13 looking at it from the service point of view, the health
14 service point of view, I wouldn't want to be carried
15 away with the notion that you need a lot of prima donnas
16 in research terms or development terms or whatever, if
17 that were not factually accurate.
18 A. I'm sorry, sir, I'm not ...
19 Q. I want to get a proper measure of what you think was
20 reasonably expected of the MOs at the time. I don't
21 want to exaggerate it by thinking of them as sort of
22 prospective prima donnas in research and development
23 terms, if that's not real.
24 A. Yes.
25 THE CHAIRMAN: What is the reality? What should one think

1 of?

2 A. I think they have to go some way towards mastering the
3 subject, but I think what we really expect of them is to
4 be able to come in and tell us what people out there are
5 thinking and be able to explain, to some extent, why
6 they are thinking it, but not to go too deeply into the
7 subject itself.

8 THE CHAIRMAN: In some ways you seem to me to be putting the
9 medical officers on a par with the administrative
10 officers, whose primary qualification seems often to
11 have been that they were not horses for courses.

12 A. No, I don't think it goes as far as that. I mean, if
13 that were the case, they could do without us. I think
14 there is a view in some quarters that leans in that
15 direction.

16 I think that -- just to go back to what I said
17 a moment ago, I think our function was to know enough
18 about medical matters to know what we ought to be
19 asking. I think if you -- leaving blood transfusion
20 apart and thinking more generally of the work, I think
21 that you can see situations in which someone without
22 a medical background is very easily swayed by
23 a persuasive clinician in the field who can put a good
24 case. There are other clinicians who can't put such
25 good cases, that's the kind of thing that we want to be

1 able to get at.
2 MR MACKENZIE: Thank you, sir. Dr MacDonald, could I look
3 at this in another way, please? Going back to the
4 extract on the page and the passage I read out
5 commencing:
6 "As a rule non-A non-B Hepatitis et cetera..."
7 A. I have it, yes.
8 Q. So reading that, so:
9 "The matter of up to 60 per cent of cases have
10 abnormal ALT levels ... for more than a year; if a liver
11 biopsy is taken ... approximately 10 per cent show
12 features of cirrhosis."
13 What I suggest, doctor, is this, that that passage
14 sets out knowledge of NANBH at the time and that,
15 I would suggest, one would presumably expect at least
16 some of the medical officers to have that knowledge if
17 they required to advise others, for example, admin
18 colleagues. It doesn't really matter where they get the
19 knowledge from, but that's the standard or level of
20 knowledge one would expect an SHHD medical officer to
21 have at around that time. Does that seem reasonable?
22 A. Yes.
23 Q. Thank you. Following from that passage, I do suggest
24 that, when making statements in 1986, for example, about
25 the potential seriousness of non-A non-B Hepatitis, the

1 evidence, as set out in that passage would at the very
2 least suggest a need for caution. Does that seem
3 reasonable?
4 A. Yes, caution, yes, but not absolute certainty.
5 Q. Yes. Then, the final matter I wish to take from this
6 extract before lunch, if I may, is over the page,
7 please. Under, "Frequency of post-transfusion
8 hepatitis", the author states:
9 "Anicteric cases of PTH are commoner than icteric
10 cases. For example, in a study reported from the USA,
11 in which 2,204 patients were followed, and in which PTH
12 was diagnosed in 241 patients, the disease was icteric
13 in less than one fifth of the cases. It follows that
14 repeat sampling of recipients is necessary if all cases
15 are to be detected and that only prospective studies are
16 likely to give a true indication of the frequency of
17 PTH."
18 Would that have been your understanding at the time,
19 doctor, in roughly 1986/1987, that if one wished to know
20 the prevalence of post-transfusion hepatitis in Scotland
21 and the UK, one would have to undertake a prospective
22 study of recipients of transfusion?
23 A. Yes, yes. But -- yes, that's right, that's correct.
24 Q. There is a logic to what is said, I think, in the
25 passage?

1 A. Yes.
2 Q. Sir, I have a few more documents. It may be convenient
3 to adjourn.
4 THE CHAIRMAN: I would like to get a feel, please, for the
5 sort of time that's required when you say you have a few
6 more documents, because I know that Professor James has
7 got one or two questions. Are we going to go over the
8 range of documents that we have seen already in this
9 context?
10 MR MACKENZIE: We perhaps have five or six.
11 THE CHAIRMAN: We will see whether we can pick up.
12 MR DI ROLLO: Yes, it is.
13 THE CHAIRMAN: I imagine, Mr Dawson that you have quite
14 a lot of questions that you do wish to ask Dr MacDonald?
15 MR DAWSON: No, I don't.
16 THE CHAIRMAN: How disappointing. He seems to be able to
17 answer, Mr Dawson. But you do not think you are going
18 to take time on it? Very well. If we can start just
19 a little bit earlier, it might help me solve some other
20 problems.
21 (1.03 pm)
22 (The short adjournment)
23 (1.56 pm)
24 THE CHAIRMAN: Mr Mackenzie?
25 MR MACKENZIE: Thank you, sir. Good afternoon,

1 Dr MacDonald. Before I go on to look at some more
2 documents, could I ask, please, what steps were taken by
3 yourself and your fellow medical officers to keep up to
4 date in developments in medicine?
5 A. Mainly, I think, we were dependent on reading journals,
6 sometimes attending meetings that would be organised by
7 Royal Colleges, universities. To be fair, it turned
8 out -- it did turn out to be rather difficult in
9 practice. The meeting you wanted to be at in Edinburgh
10 would crop up on a day you had to go to London, that
11 sort of thing. It was difficult, but we did try.
12 Q. Which journals did you read yourself?
13 A. BMJ obviously, The Lancet, several public health
14 journals.
15 Q. Did you expect your medical officers to read those
16 journals too?
17 A. Yes, and perhaps others that they were particularly
18 interested in and I wasn't.
19 Q. Thank you. Returning to the documents, please, the next
20 document is [SGH0028142]. If we go to page 2, you will
21 see the date and the author. We will see this is a note
22 by Dr Forrester of 12 June 1986. If we go back to
23 page 1, I think you have had a chance to look at this
24 before, Dr MacDonald, I think it's referred to in one of
25 your statements. I'm interested in paragraph 5,

1 please --

2 A. Hm-mm.

3 Q. -- where Dr Forrester sets out:

4 "The condition is not as a rule serious, and most of

5 the cases detected have not even been jaundiced. There

6 may however be a tendency for it to become chronic and

7 the long-term outlook is inevitably not yet known. The

8 case fatality rate is estimated in a textbook consulted

9 by Dr Dan Reid at less than 0.1 per cent, except in

10 pregnant women ..."

11 I did wonder, doctor, whether it would have been

12 better if that narration of the seriousness of the

13 disease had included the possibility of progression to

14 cirrhosis?

15 A. Yes, I think it would.

16 Q. We saw the extract from Mollison before lunch --

17 A. Yes.

18 Q. -- and I don't for one second suggest that there was

19 common agreement among the medical profession, certainly

20 in the first half of the 1980s, about the risk of

21 cirrhosis. But, certainly in Mollison in 1983, a risk

22 of cirrhosis is reported from studies?

23 A. Yes.

24 Q. Thank you. The next document, please, is [SGH0028146].

25 This is a memorandum from Dr Scott, of 16 October 1986,

1 to Dr Forrester and Mr Murray. On the question of NANBH
2 screening Dr Scott writes:
3 "I would like to know where this stands. CMO DHSS
4 is worried that if we go ahead England and Wales will
5 have to follow suit.
6 "I think there must be consultation with DHSS before
7 we agree to provide funds for this screening."
8 The impression one has from the document, doctor, is
9 that this was something between the CMO in England and
10 Dr Scott. Do you have any recollection of being
11 involved in this exchange?
12 A. No, but I think I have seen somewhere else in the
13 documents that I have looked at recently that it was one
14 of the medical staff, not the CMO himself, in DHSS who
15 indicated that CMO DHSS was worried. I'm not sure where
16 I saw that but I think that was probably -- I don't --
17 where are we? 1986, yes. I'm pretty sure that if the
18 CMO DHSS had been doing it personally, he would have
19 done it to me.
20 Q. Yes. In terms of the relationship between the SHHD and
21 DHSS, what's perhaps interesting is the reference to:
22 "The CMO DHSS is worried that if we [Scotland] go
23 ahead, England and Wales we have to follow suit."
24 So there certainly seems to have been some
25 apprehension in England that Scotland might actually go

1 ahead and introduce testing unilaterally?

2 A. I think we would need to look at other papers, but there

3 was indeed such an impression. I think that, if my

4 recollection from other papers is correct, this was

5 because Professor Cash and the Scottish regional

6 directors were pushing this so hard and I think my

7 colleagues in SHHD really had some difficulty in

8 persuading DHSS that their opinion wasn't necessarily

9 ours.

10 Q. But in terms of the question, could Scotland have gone

11 ahead and introduced testing unilaterally? Certainly it

12 appears from this minute that officials in DHSS took the

13 view that, as an option that, at least in theory, was

14 open to Scotland?

15 A. Yes, they may have seen this as an option but, following

16 on from the sort of discussion we had this morning,

17 I think it would have been a very theoretical option.

18 I think I probably ought to say that perhaps we had

19 a better understanding of where the Scottish Office

20 stood in relation to Whitehall departments than the

21 Whitehall departments sometimes had.

22 Q. I understand. Simply following on from that, when

23 Dr Scott states:

24 "I think there must be consultation with DHSS

25 before we agree to provide funds for this screening."

1 Would you go further and say that there must be the
2 agreement of DHSS or do you think, "Consultation", is
3 correct?
4 A. I think I would -- well, I think it's quite fair on
5 Dr Scott's part to phrase it that way. I would think he
6 probably had in mind agreement, and that would certainly
7 have been in my mind.
8 Q. I understand. The next document, please, is
9 [SGH0031657]. This is just a short document from
10 Dr Forrester of 26 January 1987. It's headed, "Material
11 for PMO report."
12 A. Yes.
13 Q. Can you help us: what were PMO reports? How often did
14 they take place and who were they to?
15 A. They were monthly reports. Did we touch on it?
16 I mentioned this in the first paper you looked at this
17 morning.
18 Q. Yes.
19 A. MOs and SMOs had to produce every month a report saying
20 what they had been doing during the month, not
21 a detailed exposition, but just so that DCMOs and CMO
22 could pick up any points they wanted to. The procedure
23 was that the MOs and SMOs handed these into the PMOs who
24 collated them and put the thing forward. So I think
25 this particular document would have been Dr Forrester's

1 contribution to Dr McIntyre's PMO report at some --
2 whatever the date was.
3 Q. These PMO reports would keep the CMO and DCMO informed
4 of the issues which medical officer staff were
5 considering?
6 A. Exactly and also it kept other PMOs because they also
7 saw them. One of the things we were always careful to
8 try and catch is if one PMO group had picked up
9 something that had some relevance to another group and
10 they perhaps hadn't picked it up.
11 Q. Thank you. Now, we can see under paragraph 2, "Blood
12 transfusion and non-A non-B Hepatitis (Dr Forrester)":
13 "This 'hepatitis' is a residual rag bag when
14 Hepatitis B and Hepatitis A are excluded and
15 consequently no specific test can detect it. It is
16 relatively benign."
17 The point, "It is relatively benign". Is perhaps
18 a fuller narration of the seriousness of the disease in
19 the Mollison extract we looked at? In particular,
20 firstly, the tendency for half or more patients to have
21 chronically elevated, fluctuating ALT levels and,
22 secondly, at least the possibility in some patients of
23 cirrhosis?
24 A. Yes.
25 Q. When the CMO -- rather, when the principal medical

1 officer, the deputy chief medical officer or yourself,
2 as chief medical officer, read a statement such as that,
3 "It is relatively benign," would either yourself, your
4 deputy or the principal medical officer have been
5 expected to have fuller knowledge about the disease?
6 A. Not necessarily but -- I mean, I can't say what this may
7 have stimulated, if it did.
8 Q. I think it just -- it's a snapshot and really no more
9 than that perhaps in capturing at least the view of
10 a senior medical officer in relation to the potential
11 seriousness of the disease. What I'm interested in
12 exploring is whether -- to what extent that may
13 influence the views of those higher up as to the
14 potential seriousness of the disease?
15 A. What was the date of this, by the way?
16 Q. That was 26 January 1987.
17 A. 1987, yes, early 1987. I'm not just quite sure of where
18 we would have stood at that point. Again I'm not --
19 this was -- this is obviously his contribution. I can't
20 recall what may have happened.
21 Q. Yes. Put it this way, trying to look at things in
22 a different way: it must at least be possible that
23 Dr McIntyre, Dr Scott and yourself had your own views,
24 perhaps from your own reading, as to the potential
25 seriousness of NANBH. Is that true as a possibility, at

1 least?

2 A. I think it is possible -- it is possible that we all

3 might, but I think it's more likely that Dr McIntyre,

4 because he was a PMO of the group that worked with this,

5 would have been a little more up-to-date, if that's the

6 right phrase, than certainly I would probably have been

7 at that stage.

8 Q. We may come back to that a little but the next document,

9 please, is [SGH0016653]. These are the minutes,

10 Dr MacDonald, of a meeting of the transfusion directors

11 in Scotland on 3 March 1987. Dr Forrester was in

12 attendance. We can very briefly, I think, go to

13 page 6657 please and under paragraph (f) at the bottom,

14 "Surrogate testing for NANB" picks up the reconvening of

15 the working party in transfusion-associated hepatitis.

16 Over the page, please, we can see the top paragraph:

17 "It was noted that some commercial plasma collectors

18 and non-profit blood collectors in the US had begun

19 surrogate testing ..."

20 Further down:

21 "The directors discussed the options open to

22 Scotland and agreed the following:

23 "To recommend to the SHHD that surrogate testing for

24 NANB should be implemented with effect from 1 April 1988

25 as a national development requiring strictly new

1 funding."

2 I'm not sure if you can recall, doctor, but do you

3 remember there coming a time when you knew the SNBTS

4 directors had recommended that surrogate testing should

5 be introduced?

6 A. Yes, I think I did. I can't be more precise than that.

7 I think it's one of the things that Dr Scott probably,

8 Dr McIntyre, if the opportunity arose, might have made

9 a point of telling me, because it obviously was going to

10 have major repercussions.

11 Q. Yes. Is such a recommendation something which you, as

12 the chief medical officer, would have expected to be

13 told about?

14 A. Yes, I think so.

15 Q. How would you have been told? Would there have been

16 a particular procedure or could there have been

17 a variety of ways for that to have happened?

18 A. It could have happened by Dr Scott or Dr McIntyre

19 copying this paper to me. It could have been done by

20 quoting that particular item. I think it's more likely

21 that they would have come into my room and told me

22 verbally.

23 Q. I suppose as well -- we made mention before lunch to the

24 Monday meetings, chaired by the CMO. I suppose that may

25 have been an opportunity and equally the monthly

1 reporting by the PMOs. That may have been an
2 opportunity for that as well?
3 A. It may have been, yes.
4 Q. But, in any event, at some point you did become aware
5 that this recommendation had been made?
6 A. Yes.
7 Q. Thank you. The next document, please, moving on is
8 [SGH0028127]. Over the page, please. We can see this
9 is Dr McIntyre's note of the memorandum of 6 April 1987
10 and back to page 1, please. We can see in the top
11 left-hand corner, it's addressed to Dr Scott and others
12 but I think your name does not appear there,
13 Dr MacDonald?
14 A. No.
15 Q. Is this another example of the issue of surrogate
16 testing being dealt with on a day to day level by those
17 officers beneath you?
18 A. Yes.
19 Q. We can see the heading, "Scottish participation in UK
20 research project on transfusion-associated non-A non-B
21 Hepatitis".
22 Over the page, please -- I'm sorry, doctor, have you
23 had a chance to read this note before?
24 A. I'm sure I have, yes.
25 Q. Please take two minutes just to go through it. (Pause).

1 A. Yes, I'm sure I have seen this one.
2 Q. We can then go over the page as well, please.
3 A. Yes.
4 Q. Then the second paragraph:
5 "The directors of the SNBTS are unanimous, and are
6 now pressing fairly strongly that this screening should
7 be instituted ... Before embarking on such an expensive
8 programme it would seem logical to participate in the
9 proposed research and to delay any further action until
10 the results of this were known."
11 So it seems to be this is a minute in which
12 Dr McIntyre is suggesting that there should be further
13 research first, before the introduction of further
14 testing, and seeks the views of various colleagues.
15 Really two points occurred to me, firstly that there
16 doesn't seem to be any mention that to determine actual
17 prevalence, one would require to follow up recipients
18 and the study wasn't designed to do that. That was the
19 first point that occurred. Secondly, there seems no
20 discussion of the potential seriousness of non-A non-B
21 Hepatitis and really the question is whether those two
22 points should have been included in the minute to allow
23 fully informed decisions to be taken?
24 A. Can we just go back? At what point did it exclude or
25 not include recipients?

1 Q. Yes. When the UK working party on transfusion
2 associated hepatitis was reconvened in November 1986,
3 the members of that working party -- so it was the
4 transfusionists themselves -- proposed that the UK
5 multi-centre study into surrogate testing should only
6 follow up donors.
7 A. Hm-mm.
8 Q. So it was the UK working party themselves, which
9 proposed that the study be restricted to donors.
10 Dr McIntyre's note, which we looking at, really is
11 concerned with that proposal from the UK transfusionists
12 to study donors.
13 A. Yes, I'm sorry, I'm still not quite grasping the point,
14 I'm sorry.
15 Q. Yes, at the end of 1986 -- put it this way -- start
16 again. In the early 1980s, it had been proposed, by
17 Dr McClelland, that there should be a prospective study
18 along the lines of the American study, following up
19 donors and recipients to give an indication of the
20 prevalence of post-transfusion hepatitis in the UK.
21 Come the end of 1986, the UK transfusionists meet
22 again, and the working party, and it's considered,
23 I think, impractical to carry out a prospective study of
24 recipients and therefore the working group suggests
25 restricting a prospective follow-up study to donors

1 only.

2 A. Yes.

3 Q. So that's all of the background. We had looked at the

4 extract of Mollison before lunch where the author had

5 set out that, to determine the true incidence of

6 post-transfusion hepatitis, a prospective study is

7 required; a prospective study of recipients.

8 But come late 1986, when the transfusionists meet up

9 again and now propose to only follow up donors, I just

10 wonder whether the SHHD medical officers at that stage

11 should have said: what's the point of such a study,

12 without including recipients?

13 A. Yes, I can see the point of the study might have been to

14 ascertain the amount of -- the state of infection among

15 donors. I think I saw a reference somewhere -- yes,

16 I think I did -- to the fact that -- did somebody not

17 try to ascertain how feasible it would have been? The

18 thing is that recipients may disappear, there are

19 patients in hospital who will be discharged.

20 Donors on the whole will tend not to disappear.

21 Once a donor, they very often continue to be donors and

22 even if they are not, they are the kind of people who

23 are not flitting around the country. Patients

24 discharged from hospital quite often -- from the point

25 of view of tracing -- disappear. I'm sure I have seen

1 a reference to this at one point.
2 Q. One can fully understand the practical difficulties of
3 trying to undertake detailed, regular, follow-up of
4 recipients. I think Dr McClelland's position ultimately
5 to us was that such a study, involving detailed
6 follow-up of recipients, would have been possible but it
7 would have required approval and support from the very
8 highest level, ie of government, with funding to match
9 it as well.
10 I don't think it was the case that the SHHD ever
11 proposed or suggested a prospective, large follow-up
12 study of recipients, I don't think.
13 A. No, I think that's right.
14 Q. In a way perhaps, looking at this memo, are we back
15 a little to the position we discussed before lunch of
16 the SHHD medical officer -- as to some extent
17 a generalist, relying on the expertise of others. So
18 when in late 1986 one has the expert transfusionist
19 group recommending a study of donors, then it may be --
20 I don't know, it may be to some extent the SHHD medical
21 officers would at least defer to some extent to those
22 experts.
23 A. Yes, but I would hope not uncritically.
24 Q. That's the point, I think. If one looks at Mollison,
25 saying that to determine the true incidence one must

1 follow up recipients, one doesn't, I think, see that
2 logic or reasoning in this memo.
3 A. Well, Mollison may have said that, but I would have
4 thought it warranted some further consideration. I see
5 the practical difficulties. I'm sure that I did see
6 some effort to establish how feasible it would be and
7 the answer was that so many of the people disappeared
8 after they left. We would try and trace them through
9 their old address and they are gone, or they live in
10 a different part of the country.
11 Q. The other point I suggested, doctor, was missing from
12 this minute was any discussion of the potential
13 seriousness of NANBH and in particular the risk of
14 cirrhosis. Is that a matter which ideally should have
15 been included?
16 A. Well, it wouldn't have been amiss to include it, but
17 what you are perhaps suggesting is that, if the
18 condition is serious, we should introduce a screening
19 method in which we don't have any great confidence. If
20 the condition was less serious, that would perhaps not
21 be so objectionable but -- I don't really follow that.
22 The screening method is either worth doing or it's not
23 worth doing.
24 You may want to tease this out a bit more but
25 I think the general view is that it -- the screening

1 method was not really good enough.
2 Q. Yes. I think we discussed before lunch there may be
3 a number of factors one ought to take into account in
4 considering whether to include such screening and one
5 would certainly have been the reliability of the test --
6 A. Yes.
7 Q. -- in detecting true positive and true negatives. It
8 does seem to me that that cannot be the only factor;
9 there must be other factors, presumably including the
10 prevalence of the disease in one's population and the
11 likely seriousness of the disease. There must be other
12 relevant factors, do you not agree?
13 A. I think one has to be a little careful about the
14 seriousness of the disease. I don't think it's in the
15 same sort of bracket as the levels of infection in the
16 population.
17 Q. I see. So you may accept seriousness as a relevant
18 factor but one with less weight, perhaps even much less
19 weight, than the other factors?
20 A. I would say so. We have seen sometimes the effect of
21 introducing screening methods and if the screening
22 method itself is not good, it may create more problems.
23 You see, the thing we come back to -- I know you are
24 trying to look at it in a particular way -- but come
25 back to is that this particular screening method was

1 certainly going to throw up problems as far as the donor
2 population was concerned. You really have to make sure
3 you give enough weight to that.
4 Q. Yes. The next document, please, is [SGH0024672]. If we
5 go over the page, please, we will see it's a minute from
6 Dr Forrester, 30 August 1988. Back to page 1, please,
7 this was addressed to yourself, Dr MacDonald, as chief
8 medical officer --
9 A. Yes.
10 Q. -- and copied in to others. The point that concerns us
11 is not paragraph 1 -- we have seen that in a different
12 topic. Under paragraph 2, the details don't concern us
13 of the commercial Factor VIII made by Alpha but, over
14 the page, the final paragraph on page 2 in paragraph
15 (e):
16 "We cannot prudently make much of the point, but
17 this particular hepatitis is so benign, at least in the
18 short term, that evidence of transmission has to be
19 specially sought, the patient not being ill at all in
20 the ordinary sense."
21 It's really a question of whether that paragraph
22 accurately sums up the state of knowledge of the
23 seriousness of the disease, as at August 1988?
24 A. Well, Dr Forrester did include the phrase, "At least in
25 the short term".

1 Q. Would you have understood, on receipt of that minute,
2 that firstly half, if not more, of patients with the
3 disease suffered chronically elevated fluctuating ALT
4 levels and secondly, that for some patients at least,
5 there was a risk of cirrhosis?
6 A. Sorry, I don't think that particular paragraph -- it
7 really excludes that. It's specifically about, "At
8 least in the short term".
9 Q. Put it this way, doctor: it's quite hard for us, as
10 outsiders, to get a feel for what the perception was
11 among medical officers in the SHHD as regards the
12 potential seriousness of hepatitis because all we have
13 to go on, of course, are the documents, the records.
14 One doesn't tend to see a particularly full
15 explanation or account of the potential seriousness of
16 the disease; rather, we have quite short comments such
17 as this. So really what I wonder is whether these short
18 comments such as this do accurately set out the
19 understanding or view of medical officers at the time as
20 to the potential seriousness of the condition or whether
21 I'm missing something, whether there was a greater
22 awareness that isn't necessarily set out in the
23 documents?
24 A. I think there was a greater awareness but I come back to
25 the point: I don't think Dr Forrester was touching on

1 that, but that doesn't mean to say that he wasn't aware
2 of it.
3 Q. Okay. There are three final documents, please. Firstly
4 [LIT0010328]. If we look, this is the letter, published
5 in The Lancet -- the top of the page, please. We can
6 see the date is 4 July 1987. If we go over the page,
7 please, we can see the authors are the SNBTS directors,
8 including Dr Perry. Back to page 1, please. I take it,
9 doctor, that is a letter that you will have seen, at
10 least in the run-up to the Inquiry?
11 A. I think I have -- yes. Yes.
12 Q. The title of the letter:
13 "Testing blood donors for non-A non-B Hepatitis:
14 irrational, perhaps, but inescapable."
15 In short, the SNBTS directors set out that the time
16 has now passed for a full -- a large study into -- a
17 prospective study into surrogate testing and that the
18 introduction of surrogate marker testing is now
19 virtually inescapable for three reasons. Do you
20 remember seeing or becoming aware of this letter at the
21 time?
22 A. I really can't say.
23 Q. One reason, the first reason why such testing is
24 virtually inescapable is setting -- is a reference to
25 the new strict product liability legislation coming into

1 force.
2 A. Yes.
3 Q. Do you have any recollection as to whether that was
4 considered by the medical officers in SHHD in their
5 wider consideration of whether surrogate testing should
6 be introduced?
7 A. I wasn't involved in that. I'm sure that Dr McIntyre
8 and probably -- yes, I think Dr Scott also would have
9 been aware of that. But I think it was an issue on
10 which the chief pharmacist was taking the lead. Of
11 course, it was very much a matter on which we needed
12 legal advice.
13 I have never quite -- it may be remiss on my part
14 but I have never quite established what advice had been
15 received before this particular statement, for example,
16 had been made. Certainly something that had to be taken
17 into account.
18 Q. Did you consider it was a matter for your department to
19 take legal advice on this legislation or was that
20 something you left to the chief pharmacist's office?
21 A. Well, the chief pharmacist was part of our department.
22 So that wasn't really a distinction.
23 Q. Yes. Do you remember ever taking legal advice on the
24 new legislation?
25 A. I don't, no.

1 Q. Do you know whether your department did -- whether your
2 medical officers did?
3 A. I don't know whether the medical officers did on their
4 own or whether that was -- may have been sparked off by
5 the chief pharmacist.
6 Q. Okay. Two final letters, please, doctor. Firstly
7 [SNB0059240]. Doctor, this letter came to light
8 reasonably recently but I think you have seen a copy
9 recently?
10 A. Yes.
11 Q. I should say that, in relation to the second paragraph,
12 the Sandoz collaborative agreement, there has been
13 a suggestion that there may have been
14 a misunderstanding.. ?
15 A. I saw that.
16 Q. You saw that, yes. It's really the last paragraph of
17 the letter and simply to ask whether you have any
18 comment on the last paragraph?
19 A. That's the one about --
20 Q. On page 1, I'm sorry.
21 A. I think we are on page 2 now, are we?
22 Q. Yes, I think we will go back in a second. Thank you.
23 I should have said, it's the last paragraph on page 1 --
24 A. :
25 "This most recent episode ...?

1 Q. It's really the second half of the paragraph, the last
2 three lines.
3 A. Yes.
4 Q. Do you have any comment on that?
5 A. I think that it's rather a sweeping statement and --
6 well, as you will know, it didn't move me to feel that
7 I had to take the action that Professor Cash wanted me
8 to take.
9 Q. If we then finally go to your letter of response, it's
10 [SNB0132880]. This is your letter of response to
11 Dr Cash of 8 October 1986.
12 A. Yes.
13 Q. We can see what is set out there, including what's set
14 out in the third paragraph.
15 A. Sorry, which paragraph?
16 Q. The third paragraph.
17 A. Oh, yes.
18 Q. Presumably that sets out your view at the time?
19 A. Yes. The information about the -- a delay in the AIDS
20 validation studies, I'm sure came from Dr Scott and
21 possibly Dr McIntyre.
22 Q. Thank you. There is a separate matter in the final
23 paragraph stating:
24 "Unfortunately, because of the highly unfavourable
25 conditions of service in the Medical Civil Service we

1 have lost some very experienced colleagues, including
2 Dr Bell and at present we are operating four senior
3 medical officers under strength."
4 If I pause there, was -- were the staffing levels
5 among medical officers between 1985 and 1988 -- did that
6 create a difficulty for you in any way?
7 A. Between 1985 and 1988?
8 Q. Yes.
9 A. 1985, things weren't too bad but we had -- I may not
10 have expressed that as well as I should. When I say we
11 have lost some experienced colleagues, I wasn't meaning
12 that they had upped and away. People retired and we
13 were looking for replacements. Yes, things were
14 beginning to look difficult by the time I was writing
15 this letter.
16 Q. Did those -- what, if anything, resulted from these
17 difficulties, in terms of the medical officer service
18 being able to carry out their day to day duties?
19 A. I think it did put -- it certainly put stress on us.
20 I don't think that we neglected any, one might say
21 essential duty, but I'm sure that there were things we
22 should have looked at and would have looked at if we had
23 been more fully staffed that we didn't do.
24 Q. Would surrogate testing come within that category?
25 A. I don't think so.

1 Q. I suppose we have seen a number of documents where we
2 can see the consideration which was given to that issue.
3 A. Yes.
4 Q. Just finally on that point, doctor, were there
5 difficulties in staffing around the time HIV testing was
6 being considered, around the start of 1985?
7 A. I don't think so. Yes, that was before I was CMO. But
8 I would have been involved in the staffing matters at
9 that point. No, I don't think really think so.
10 Q. Thank you, Dr MacDonald. Sir, I have no further
11 questions for Dr MacDonald but we were, I think, going
12 to swap seats, if I may, before Mr Dawson were to carry
13 on.
14 THE CHAIRMAN: Oh, yes, certainly. Do we need to leave or
15 do we think that the exercise can be carried out while
16 we are all here?
17 MR MACKENZIE: I think we can just carry on, I think.
18 Questions by MR DAWSON
19 THE CHAIRMAN: Do you need to get switched on or tooled up
20 or whatever you do there? All right? Ready to go?
21 Yes, Mr Dawson?
22 MR DAWSON: Thank you, sir. Good afternoon, Dr Macdonald,
23 can you hear me okay?
24 A. Yes, at the moment, thanks.
25 Q. I would just like to ask you some questions initially

1 about the roles and responsibilities within SHHD during
2 the time that you were CMO.
3 A. Yes.
4 Q. As far as blood transfusion matters were concerned,
5 you said earlier that the medical officers working
6 within your department were generalists and not
7 specialists; is that correct?
8 A. Broadly, yes.
9 Q. Do I take it from that that, particularly related to
10 blood transfusion, there were no people there with any
11 great experience of blood transfusion?
12 A. That's correct.
13 Q. As far as blood transfusion matters were concerned,
14 would it not be accurate to say that you had the benefit
15 of an expert group, from whom to take advice and seek
16 information, namely the SNBTS directors?
17 A. Yes.
18 Q. On a complicated issue such as surrogate testing, what
19 efforts would you have expected your officers to have
20 made to understand fully the reasons for the SNBTS
21 directors' recommendation that such testing be
22 implemented?
23 A. I would have expected them to go into this pretty
24 thoroughly.
25 Q. Could we have up, please, document [SGH0016653]? You

1 were showed a moment ago the document which contained
2 the recommendation of the SNBTS directors from
3 3 March 1987. There is very little in that document by
4 way of explanation as to the rationale behind the
5 recommendation. Against a background of very little
6 detail of the rationale behind the recommendation having
7 been given, would you have expected your officers to
8 institute a dialogue with the directors about what their
9 reasons had been?
10 A. Yes.
11 Q. That's it there. This is the document I was referring
12 to, just to remind you Dr MacDonald. Sorry about that.
13 This is the document in which we have the recommendation
14 you will see set out in bold there, that:
15 "Surrogate testing for non-A non-B should be
16 implemented with effect from 1 April 1988."
17 It might be actually useful to go to the previous
18 page so we can just see the entire section.
19 You can see that the section is introduced,
20 "Surrogate testing" at the bottom there. There is
21 reference to the UK Working Party on
22 Transfusion-associated Hepatitis and there is a proposal
23 for a study referred to. If we can go over the page
24 again, please and you see there at the top it says --
25 there is a reference to some commercial plasma

1 collectors and then we have the recommendation set out
2 there.
3 Would it be fair to say that there is not an awful
4 lot of detail there as to the reasoning behind the
5 recommendation?
6 A. Well, in one sense, yes, but I think that if you look at
7 that first paragraph that's up there just know, I think
8 that we were conscious of the fact that what the
9 commercial collectors and others were doing was really
10 playing a powerful part in the decision that came later
11 to recommend that we go on with it.
12 Q. So was it your understanding that that consideration was
13 playing a powerful part in the rationale of the
14 directors?
15 A. Yes.
16 Q. Okay. Would it be fair to say that this recommendation
17 came as a surprise to SHHD at this time?
18 A. I think it probably did come as a surprise at that
19 precise moment, but I think there was an awareness that
20 it was coming, it was on the way. But I think at that
21 point it was a surprise.
22 Q. Against the background to this recommendation that you
23 have just been discussing there, would you have expected
24 your officers to institute a dialogue with the directors
25 after the recommendation, so that they understood fully

1 what the reasons for the recommendation were?
2 A. I think they did really -- I think they would really
3 have understood at that point. I think it was clear
4 that the regional directors shifted their position and
5 I think that it was reasonably clear that that was for
6 what one might call protective reasons.
7 Q. Can you tell me what you mean by protective reasons?
8 A. That, because the commercial collectors, and the others
9 in the US, were doing surrogate testing, they would be
10 vulnerable to litigation if they didn't.
11 Q. So as far as you are concerned, your understanding of
12 the reasoning at that time was really bound up with the
13 issue that's discussed in the top paragraph there, to do
14 with competition between the NHS as a producer of blood
15 products and commercial producers?
16 A. Yes.
17 Q. Can you try and explain to me what advantage you
18 understood surrogate testing would have for -- as far as
19 blood products produced for haemophiliacs were
20 concerned?
21 A. Well, blood products are a particularly interesting one,
22 because I think it would probably have surprisingly
23 little benefit. I think the critical thing to remember
24 here is that, by this time, it wasn't really a question
25 of one infected donor giving one infected bag of blood,

1 which was transfused into one patient; every drop of
2 plasma that could be squeezed out of that was going into
3 the pool for processing and that really meant that these
4 pools had very substantial numbers going in. That
5 really meant that, unless the screening process could
6 identify and eliminate all the genuine positives, you
7 weren't going to achieve very much.
8 Q. Were you aware, as chief medical officer at this time,
9 that the thinking of certain of the directors, certainly
10 in the SNBTS, had been influenced heavily by
11 a perception at this time that surrogate testing would
12 have significant safety benefits as far as blood
13 transfusion patients were concerned?
14 A. When you say blood transfusion patients, are you meaning
15 patients other than the ones being given products?
16 Q. Yes.
17 A. No, I don't think I was aware of that and I'm wondering
18 if I should have been.
19 Q. Okay. I'll just move on to a slightly different area.
20 You have answered a number of questions from
21 Mr Mackenzie on the issue of knowledge surrounding the
22 severity of non-A non-B Hepatitis at around this time.
23 A. Knowledge affecting the ...?
24 Q. Knowledge of the severity of non-A non-B Hepatitis.
25 A. Yes.

1 Q. Could you just tell me where you would have expected
2 your medical officers to get up-to-date information on
3 the current understanding of the severity of that
4 condition?
5 A. I think that the regional directors would -- I would
6 expect -- have kept themselves fairly well informed or
7 tried to. But the more obvious source, I'm sure, would
8 have been physicians who were specialising in the
9 diagnosis and treatment of these patients.
10 Q. So you would have expected there to be a dialogue
11 between SHHD medical officers and, both haemophilia
12 doctors effectively, and transfusion doctors on that
13 issue?
14 A. I think something of that kind, yes.
15 Q. Okay, thank you. Could I just look very briefly --
16 THE CHAIRMAN: Before you go on, could I ask a question?
17 You have not referred to any possible role of Dr Cash as
18 national medical director in this context. Did he have
19 a role as a source of advice and comment?
20 A. Oh, certainly, yes. He would be the one who would -- he
21 would convey the views of the other directors, but add
22 a view of his own.
23 THE CHAIRMAN: That's why I'm asking because I think
24 Mr Dawson, and indeed I think Mr Mackenzie, has taken
25 you directly to the transfusion directors and the

1 haemophilia directors and I would like to make sure that
2 we take in the role of Dr Cash or someone holding his
3 position.
4 A. Yes, that would be essential. In fact, the position of
5 national medical director was created around -- I think
6 it was 1973, just before the reorganisation and the
7 Blood Transfusion Service became part of the CSA. Part
8 of the reason for doing that was to have a figure in
9 that position, to whom we could turn.
10 THE CHAIRMAN: You might like to ask about what level the
11 contact would be, Mr Dawson. I'm finding it difficult
12 to shout at Dr MacDonald, but I think it's reasonably
13 clear now why I'm interfering.
14 MR DAWSON: Yes, indeed, sir. What -- can you explain what
15 role Professor Or Dr Cash would have had in that
16 dialogue, as far as you are concerned?
17 A. He would -- I think I would say he would have been
18 really our adviser, although I believe, while I was not
19 involved, I believe he was designated as our consultant
20 adviser and I think he gave that up.
21 Q. When was that? Do you recall?
22 A. It must have been -- I think it was getting on towards
23 1985, I think.
24 Q. Right. So by the time that we are talking about here,
25 which is really 1986 to 1988, he had given up that

1 official role?

2 A. No, he didn't have that official role, but he was

3 obviously the leader of the transfusion directors, as it

4 were.

5 Q. Did that giving up of that official role change his

6 relationship with you in any way?

7 A. Not in practice, I wouldn't think.

8 Q. So he remained an important source of information on

9 these types of matters?

10 A. Yes.

11 Q. Could I just refer you to a document which you have seen

12 already, just to remind you of it. It's [SGH0031657].

13 Hopefully you recall this document, which you looked at

14 earlier?

15 A. Oh, yes.

16 Q. If we see at the top, it's entitled, "Material for PMO

17 report". If we scroll down to the bottom we see it is a

18 document which appears to have been prepared by

19 Dr Forrester in January 1987. In particular I just

20 wanted to remind you of the passage under paragraph 2,

21 where we seem to have an explanation of blood

22 transfusion and non-A non-B Hepatitis:

23 "This hepatitis is a residual rag bag when

24 Hepatitis B and Hepatitis A are excluded and

25 consequently no specific test can detect it. It is

1 relatively benign."

2 Could I just refer to you another document, please.

3 This is paragraph 9.1 of the preliminary report.

4 I assume you are familiar with the inquiry's preliminary

5 report, Dr MacDonald?

6 A. Sorry, are we on to something --

7 Q. Yes, it has not quite come up yet. I'll just wait until

8 it does. I assume you are familiar with the Inquiry's

9 preliminary report, Dr MacDonald?

10 A. Yes.

11 Q. Yes. This is an extract from chapter 9, in particular

12 I want to refer you to paragraph 9.1 where there is

13 a summary of the position which has been reached at this

14 stage in the narrative, if you like, which says:

15 "From about 1985 onwards there appears to have been

16 a growing awareness that non-A non-B Hepatitis (NANB

17 hepatitis) was a potentially serious and progressive

18 disease which could lead, over time, to cirrhosis of the

19 liver, hepatocellular cancer and death."

20 There is a reference there, number 1, if we just

21 scroll down to the bottom -- I obviously don't want to

22 go into any of these in detail but you will see there,

23 Dr MacDonald, there are a number of references

24 supportive of that proposition and there are a number of

25 articles, in particular, which one finds in The Lancet

1 from 1985. Are these the types of documents to which
2 you would have expected your medical officers to have
3 regard in keeping themselves up to date, in particular
4 as regards the perceived severity of non-A non-B
5 Hepatitis at that time?
6 A. Yes, I don't think I would have expected them to read
7 them all. But some of the more accessible ones. But
8 how much time they would have for this depends -- really
9 depends on what pressures they were under.
10 Q. But, as you said earlier, if they didn't have time to
11 look at these documents, then the SNBTS directors group,
12 in particular Professor Cash, would be a source of
13 information --
14 A. Oh, yes.
15 Q. -- about this?
16 A. Yes.
17 Q. Could we just scroll back up to 9.1. Do you accept that
18 the summary, which given in 9.1, on the basis of these
19 documents, appears to be inconsistent with the summary
20 given by Dr Forrester in the 1987 document we looked at
21 a moment ago, about the severity of the condition?
22 A. Can we go back to that, please?
23 Q. Of course, it's [SGH0031657]. I referred you to the
24 first paragraph under number 2.
25 A. Yes. Well, I think perhaps something should be added to

1 the relatively benign statement to qualify it. Yes,
2 I think a little more could have been said.
3 Q. Okay, thank you. Just moving on to a slightly different
4 area. In relation to surrogate testing, there would,
5 would there not, have required to have been a number of
6 practical elements considered before testing could be
7 introduced.
8 A. Yes.
9 Q. Do you think that's right?
10 A. Yes.
11 Q. I'm thinking, for example, about considerations of
12 training for staff, equipment, measures to replace blood
13 lost to the donor system and, as I think you have
14 mentioned already, potential counselling for donors.
15 These are all things that would have had to have been
16 considered. Is that correct?
17 A. That's correct. I think counselling is perhaps -- one
18 should elaborate a little more. It's not simply
19 a matter of counselling and advice but there would be
20 a number of donors identified who would have to be
21 referred to a physician, subjected to laboratory tests,
22 reviewed for a period of at least some months, I would
23 have thought, before it would be possible to offer them
24 an opinion as to whether they were infected or not. In
25 other words, whether they were the false positives or

1 genuine positives. Yes, there is quite lot involved in
2 this.
3 Q. Given that there was quite a lot involved in it, would
4 you have expected to have received, from the SNBTS
5 directors, at about the time of their recommendation,
6 advice and information about these practical areas?
7 A. I would -- yes, I would have expected them to have
8 raised the issue. I think they might have done it by
9 saying to us, "You will need to do something about
10 this".
11 Q. In the absence of any information or view on these areas
12 from the directors, would you have expected your medical
13 officers to seek out such information and views from the
14 SNBTS people?
15 A. I think that would -- I think that would depend on where
16 we thought we were going. Yes, you are right, but
17 I think that it was by no means clear that we were going
18 to go down that road.
19 Q. Okay, thank you. Could I just take you to another
20 document, please? It's [PEN0171554]. Could I just
21 explain to you this document you will see the title,
22 which is, "UK Working Party on Transfusion-associated
23 Hepatitis". In the first line we have:
24 "This working party was established in 1981 and has
25 been active for some time ... It reports to English and

1 Scottish BTS directors ... It was convened on
2 24 November 1986."
3 I think this is one of the meetings that you refer
4 to in your own statement. Could we just go over the
5 page, please?
6 THE CHAIRMAN: Before you do, there is something intriguing
7 in the top right-hand corner. What does that
8 handwritten note say? Does it say something about
9 a precedence book?
10 A. About, sorry, sir?
11 THE CHAIRMAN: A precedence book?
12 A. Yes, yes.
13 THE CHAIRMAN: I may have misread it, but that's the best
14 guess I can make. If so, it suggests the existence of
15 a document of some significance that I had not heard
16 about otherwise than on this document.
17 A. I think -- I think it's all clear except for the first
18 word on the second line, I think.
19 THE CHAIRMAN: I think the first word on the second line
20 might be "I":
21 "I have note in precedence book ..."
22 Is my guess.
23 A. Yes, that doesn't make sense to me, but that's what it
24 looks like, yes.
25 THE CHAIRMAN: But the expression, "Precedence book" means

1 nothing to you.

2 A. No.

3 THE CHAIRMAN: Perhaps I have inspired someone to tell me.

4 Sorry, Mr Dawson for interrupting, but if there is

5 something of significance there, I would like to know

6 what it is.

7 MR DAWSON: Indeed. You will see at the top this is a memo

8 which is circulated to Dr McIntyre, Dr Scott and

9 Mr Murray. If we go over the page, please, we can see

10 the author of this document was Dr Forrester and its

11 date, 1 December 1986. Could we just scroll further up

12 the page, please? Obviously what we have here is

13 Dr Forrester reporting to other members of the team, if

14 you like, what had happened at the meeting and he says

15 there:

16 "There was some discussion of the cost of screening

17 all donations (perhaps £8 million). I asked the

18 chairman whether he would advise screening if it were

19 free of cost. He said no.

20 "The position explicitly reached at the meeting is

21 to recommend research of no great significance or

22 scientific interest because the prospect of research

23 would serve to counter pressure from, for example,

24 haemophiliacs and Haemophilia Directors to embark on an

25 indirect and largely ineffective form of screening,

1 which would also lose us a certain amount of perfectly
2 harmless blood. Figures were produced at the meeting
3 for the total number of non-A non-B Hepatitis cases
4 encountered either annually among haemophiliacs (A and
5 B) and patients with von Willebrand's disease. The
6 average UK total per year is 35 over the past 6 years
7 but 1985 saw a sharp decline to 11 in all. A proportion
8 of these cases among haemophiliacs and similar patients
9 are asymptomatic."
10 Would it be fair to say that this is the kind of
11 document that would be relied upon by the SHHD team
12 looking at the issue of surrogate testing in reaching
13 a view as to whether this is a matter which should be
14 put to ministers or not?
15 A. I don't think that we would have put that kind of
16 wording if we had been going to ministers. I think that
17 it might have been explained in different terms. But we
18 were not, in fact, contemplating going to ministers at
19 that point.
20 Q. What I'm trying to get at, Dr MacDonald is the
21 information which is contained in this memo, about what
22 happened at that important meeting, would be information
23 which would be part of the department's consideration of
24 whether to go to ministers or not.
25 A. Well, can I -- sorry, can I just take up this last point

1 about going to ministers? If our view had been that we
2 were going ahead with screening, we would certainly have
3 gone to ministers and set it all out in a submission.
4 If our view had been -- as it was at that stage --
5 either we hadn't made up our minds or we weren't going
6 to put it forward, we may not have troubled ministers
7 with that statement, except if we anticipated some
8 pressure from the Haemophilia Society or from the media.
9 We might have then said to ministers, "Look, this is
10 something that we are still looking at, or that "we
11 don't think we should be pursuing." That's the
12 question -- that's the point about going to ministers.
13 I take it this is Dr Forrester reporting faithfully
14 what he took from that meeting. I think one must be
15 truthful and say that -- and I think this applied at
16 that stage to -- certainly to the directors in England
17 and perhaps a bit later for the ones in Scotland. But
18 we were really trying to, I think, give ourselves a bit
19 more time and not be rushed by the pressure coming from
20 the commercial producers. Then, as far as the Scottish
21 directors were concerned, that seems to become
22 overwhelming.
23 Q. As the former chief medical officer, does the first
24 sentence of the second paragraph there seem slightly
25 unusual to you, in particular the suggestion that the

1 members of this working party, who were scientists,
2 would recommend research of no great significance or
3 scientific interest because of the prospect that
4 research would serve to counter pressure from certain
5 groups?
6 A. I don't think we have actually got the minutes of that
7 meeting, have we? I think one would need to look at
8 what precisely was said and how far this might be
9 a gloss put on it when Dr Forrester was writing up his
10 note.
11 Q. Just taking it as it's stated there, does it seem to you
12 unusual that that should be the position taken by
13 scientists, effectively putting what appears to be
14 political pressure at the forefront of their thinking?
15 A. Well, they were more than scientists. I think they had
16 administrative responsibilities as well, most of them.
17 Perhaps it's unusual to be, shall I say so, frank.
18 Q. Thank you very much. Just move on to a slightly
19 different area. You have given some evidence already
20 about the fact that, in considering surrogate testing,
21 you would have placed considerable weight on the
22 position of donors. Is that correct?
23 A. Yes.
24 Q. It is, is it not, an important part of the
25 responsibilities of the SNBTS directors to consider the

1 position of donors. Is that right?
2 A. Yes.
3 Q. Given that, would you have expected your medical
4 officers to seek a clear explanation from the SNBTS
5 directors as to why they had recommended surrogate
6 testing, despite the fact that it might have some impact
7 on donors?
8 A. I think it's fair that that question should have been
9 put. I'm not quite sure how fair it is to, as it were,
10 to put the onus on our medical staff. We said a moment
11 ago that there was an element of surprise in -- when the
12 Scottish directors came forward with such a firm
13 recommendation.
14 I think that point, the one about the safety of
15 the -- rather the interests of the donors should have
16 been come up and -- well, I'm a little surprised.
17 I mean, I had a pretty close association with the
18 regional directors at an earlier stage. To a certain
19 extent it was another generation, but I would have
20 expected that to have emerged and to have been given
21 more attention.
22 Q. What was the quality of the working relationship between
23 SHHD and SNBTS at this point in time -- talking about
24 late 1986 into 1987?
25 A. I wasn't directly involved. I think -- I think I would

1 have to say that it was a little difficult.

2 Q. Could you expand upon that?

3 A. What I learned, I suppose mostly from casual

4 conversations with colleagues like Dr Scott and

5 Dr McIntyre -- I think they had some difficulty in

6 understanding, at times, just where the regional

7 directors stood and would be a little uncertain if the

8 position that they seemed to be taking was the position

9 they were going to hold. I'm not referring specifically

10 to this surrogate testing issue, but I think there was

11 an uneasy relationship.

12 Q. If there was this underlying uncertainty, I think you

13 have put it, using that word, would it not have been all

14 the more important that both parties try and understand,

15 as clearly as they possibly can, when recommendations

16 are made, what the nature or the reason for that

17 recommendation is?

18 A. I think you are obviously right. I think that might not

19 have been altogether easy.

20 THE CHAIRMAN: I think you have to tell me why,

21 Dr MacDonald. This is not an area where we can be

22 superficial. If there are fundamental problems of

23 relationships that had an impact on decisions that were

24 taken, I suspect, however unwillingly, I have to know

25 about them.

1 But I can't be doing, in effect, with superficial
2 comments that simply raise the fly, but don't take it
3 much further: so could you explain, please?
4 MR DAWSON: The chairman, I think, is looking for more
5 concrete and specific examples of perhaps the
6 difficulties in the working relationship that you have
7 outlined, Dr MacDonald. Can you be of any assistance to
8 him in that regard?
9 A. I think it's difficult because I wasn't directly --
10 I wasn't directly involved in this, but ...
11 Q. The nature of the proposition which I'm making, which
12 might be of assistance, is to the effect that it does
13 seem that there may have been a degree of communication
14 breakdown between the SNBTS directors and the SHHD at
15 this time. Do you think that's a fair proposition?
16 A. It's a possibility.
17 Q. In your view, as the chief medical officer at the time,
18 can you tell me yes or no whether there was such
19 a communication breakdown?
20 A. I don't think I can be as definite as that.
21 Q. Right --
22 THE CHAIRMAN: Mr Dawson, perhaps you can deal with this but
23 there is a difference, of course, between
24 a communication breakdown, which suggests
25 a non-communication of ideas, and a difference of

1 opinion so fundamental that, even if it were
2 communicated directly, it wouldn't have led to
3 agreement. So I think I have to know whether it's just
4 non-communication or communication of such differences
5 of view that they were irreconcilable. What is it we
6 are talking about? You have raised it and I think
7 I have to understand where it's going.
8 MR DAWSON: Absolutely, sir. The chairman has raised
9 a distinction between a situation where there might be
10 a lack of communication --
11 A. Yes.
12 Q. -- and a situation where there might be difficulties
13 based on a fundamental difference in opinion and around
14 the surrogate testing issue, if we deal with the first
15 area, first of all, was there a lack of communication,
16 which caused problems?
17 A. I wouldn't -- I don't think there was a lack of --
18 I don't think there was a lack of communication.
19 I think that it appeared, certainly on the surface, that
20 Dr Cash and the regional directors were changing their
21 position and it appeared to us that they were changing
22 it for a reason that we would not have regarded as
23 a proper assessment of the merits of the screening
24 procedure.
25 I think that, to try and address the chairman's

1 point, there was a difficulty -- and I saw it without
2 being involved in it. There was a difficulty in that
3 Dr Cash's lines of communication seemed to be a bit
4 erratic. He didn't quite see the distinction between
5 medical issues on which he should have come to the
6 medical staff, as he quite often did, and more
7 administrative issues which he should have channeled
8 through the CSA management to the administrators in the
9 SHHD.
10 One example is -- so I suppose I was involved
11 slightly. One example is that letter that we had up on
12 the screen two or three minutes ago, to Mr Morison about
13 Dr Forrester. That should have come to me. Why did he
14 put it to Mr Morison? Did he think that by doing that,
15 he would get a different answer from what he was going
16 to get from me? I think that's the kind of thing that
17 caused our medical staff a bit of difficulty.
18 Q. Do you think that, on the issue of surrogate testing
19 specifically, you felt confident that the medical
20 officers, who were working under you, had a proper and
21 full understanding of the issues surrounding that topic
22 and in particular the reasons for the recommendation
23 made by the SNBTS directors to introduce such testing?
24 A. Yes, I think so. I'm just -- I'm pausing because I'm
25 just wondering about the point about the influence of

1 the commercial -- the way the commercial producers were
2 behaving. I think they were fairly frank about that,
3 the regional directors, and I think it was clear that it
4 was protection that they were -- necessary protection in
5 their view.
6 Q. Sir, I'm planning on moving on to a slightly different
7 area. Are there any remaining questions, I have very
8 few left?
9 THE CHAIRMAN: It doesn't matter. I don't want anybody
10 being rushed. So we should have a break.
11 MR DAWSON: Okay.
12 (3.20 pm)
13 (Short break)
14 (3.39 pm)
15 THE CHAIRMAN: Right, Mr Dawson.
16 MR DAWSON: Thank you, sir. Dr MacDonald, could I just take
17 you to a document to which you referred just before the
18 break. This is [SNB0059240].
19 This is the letter to which you have been taken
20 already and to which you referred. It is the one which
21 I think you described as relating to Dr Forrester.
22 Could I just read out some parts of this, please. It's,
23 of course, the letter from Dr Cash to Mr Morison, dated
24 21 August 1986, in which Dr Cash says:
25 "Dear Hugh, I must once again request that

1 consideration be given by appropriate colleagues in SHHD
2 to give Dr JM Forrester duties which do not include an
3 interface with the Scottish transfusion service.
4 "I cannot begin to understand the problems but the
5 quality of Dr Forrester's remarks at the last PDT
6 subcommittee meeting, in the context of the Sandoz
7 Collaborative Research Agreement, were with regarded by
8 my colleagues, particularly Dr McClelland and myself as
9 bordering on insulting. They also revealed a depth of
10 scientific/medical understanding that was remarkably and
11 disturbingly shallow."
12 Then certain further remarks about the circumstances
13 leading up to the letter. At the bottom of that
14 paragraph Dr Cash says:
15 "Dr Forrester did not take the trouble to make
16 contact with me in the period between 6 August and the
17 BTS subcommittee to further discuss the matter, and
18 indeed had clearly briefed you, in my opinion, wrongly,
19 for our meeting on 18 August.
20 "This most recent episode has all the hallmarks of
21 the events which took place in late 1985, which led to
22 a six month delay in the AIDS validation study of our
23 plasma dried blood products. A delay which would have
24 been much longer without the intervention of yourself
25 and the CMO.

1 "Taken together along with other episodes of only
2 minor importance, I must, with regret, conclude that the
3 SNBTS directors have little or no confidence in the
4 person who currently provides the vital medical link
5 between the operational part of the Blood Transfusion
6 Service and SHHD."
7 It appears that Dr Cash is suggesting, first of all,
8 that this is not the first occasion on which he has had
9 to bring up this matter. Secondly, that he and the
10 SNBTS directors had lost confidence in Dr Forrester.
11 Thirdly, that something required to be done about it --
12 and he makes a suggestion as to what could be done --
13 and fourthly there is a reference there to an episode
14 relating to lack of communication between Dr Forrester
15 and Dr Cash before briefing Mr Morison.
16 I take it that, when this letter came to you, you
17 treated this as an extremely serious matter?
18 A. Yes.
19 Q. Can you tell me what impact this state of affairs had on
20 the consideration of the issue of surrogate testing?
21 A. I don't think that I can go into that amount of detail.
22 No, I really can't relate this precisely to that
23 particular issue.
24 Q. Perhaps if I put it this way: what steps did you take,
25 after this was brought to your attention, to try and

1 ascertain what practical effect this breakdown in
2 confidence was having on the proper discussion of
3 important issues, such as surrogate testing?
4 A. Well, first of all, as stated in my reply, just going to
5 the last paragraph there, Dr Forrester, as we have
6 said -- I said in my letter back, had not been involved
7 in that issue at all. I was -- I felt that the first
8 paragraph was really a very sweeping, extreme sort of
9 statement and I wasn't very confident that I could
10 accept it at face value.
11 I think there is some doubt now as to whether this
12 was quite as it's set out there from Dr McClelland's
13 evidence, although obviously I didn't know that at the
14 time.
15 I think that's about all. Having discussed it,
16 obviously, with Dr Scott and Dr McIntyre, I, as you will
17 know from the reply, came to the conclusion that the
18 situation should be monitored and that was done;
19 Dr McIntyre was asked to look at it.
20 Q. You have focused there on the specific incident which
21 has given rise to this letter, but does this letter not
22 indicate that there is a more general lack of confidence
23 and issue with communication amongst -- between
24 Dr Forrester and the SNBTS, irrespective of this
25 particular issue?

1 A. I think I would have wanted more information and that
2 was why I thought the situation should be left and
3 monitored.
4 Q. What was the outcome of the monitoring exercise which
5 Dr McIntyre undertook?
6 A. I don't think any further problem arose.
7 Q. What was the nature of the monitoring exercise which he
8 undertook?
9 A. I cannot tell you that.
10 Q. Why not?
11 A. That was left to Dr McIntyre.
12 Q. Thank you. Could we just look at your response for the
13 sake of completeness, a document that we have gone to
14 already. It's [SNB0132880]. Obviously this is your
15 response, which you were taken to earlier --
16 A. That's right.
17 Q. -- and I think you were taken to the final paragraph and
18 asked some questions about the highly unfavourable
19 conditions of service in the Medical Civil Service. In
20 the final sentence there you say:
21 "As you recognise ..."
22 This is in reference to the second page of Dr Cash's
23 letter:
24 "... the BTS has never been the simplest
25 organisation to deal with for many, many years and

1 several of us have the scars to prove it."

2 Can you tell us what it was that you meant by that

3 comment at that time?

4 A. I think that comment was stimulated by a paragraph on

5 the second page of Dr Cash's letter, which --

6 Q. If you would like to go back to that, we certainly can.

7 It's page 2 of [SNB0059240]. Yes, it's that paragraph

8 at the top, where it says:

9 "I would not wish to claim that all the fault lies

10 with Dr Forrester. I'm sure he may experience much

11 difficulty in dealing with certain SNBTS medical

12 colleagues and, in particular, myself. This I very much

13 regret but, in our defence, I would wish to emphasise

14 that we have never had this type of difficulty with

15 Dr Forrester's predecessors. Faced with this apparently

16 intractable problem I must therefore conclude that the

17 only practical option for resolution is an accommodation

18 by colleagues in SHHD".

19 I assume that's the paragraph you are referring to?

20 A. That's the one.

21 Q. What was it that you meant by the comment at the end of

22 the reply?

23 A. Can we go back to that page?

24 Q. Yes, indeed. Thank you.

25 A. Yes that really was -- I was simply picking up the point

1 that -- trying to end on perhaps a lighter, less severe
2 note, that I had noticed that he had agreed that the BTS
3 had never been an easy organisation to deal with.
4 I didn't fasten particularly on the detail of what he
5 said and I was referring to the fact that I, among
6 others, had dealt with it for a very long time. It
7 wasn't simple and it seemed reasonable to pick up that
8 point.
9 Q. There doesn't seem to be any attempt at all in that
10 letter -- and please tell me if I'm getting the wrong
11 impression -- to try and build any bridges, if you like.
12 The reference to the past suggests that that wasn't your
13 intention. Is that a correct interpretation?
14 A. No, no. Are you still talking about the final sentence?
15 Q. I'm talking about the entire letter.
16 A. Yes. I don't think that Dr Cash's letter suggested that
17 he would have perhaps been receptive, or that it was
18 necessarily a good time to try to build bridges.
19 Q. Okay. Thank you. Moving on to a slightly different
20 area, could I ask you to have a look at document number
21 [SGH0028126], please? I think this is a document we
22 have seen already, Dr MacDonald. It's a memo, you can
23 see there, from Dr Scott to Dr McIntyre, dated
24 7 April 1987.
25 A. Yes.

1 Q. This one is in response to the detailed explanation of
2 Dr McIntyre's views on surrogate testing in the minute
3 of the day before, which one can see from the first
4 paragraph.
5 A. Yes.
6 Q. In that memo, Dr Scott says in the second paragraph:
7 "We must do whatever we can to prevent the BTS going
8 ahead with a full-scale introduction of this testing, or
9 at least trying to blackmail us into the provision of
10 funds."
11 Could you give me some explanation as to why it was
12 that Dr Scott thought it was appropriate that SHHD
13 should do whatever it could to prevent the Blood
14 Transfusion Service going ahead with the introduction of
15 testing?
16 A. Can you just remind me of the date?
17 Q. Certainly. It's 7 April 1987.
18 A. Yes, I think that at that -- well, we have been over the
19 ground. We in SHHD were not convinced that we should go
20 ahead with this. We certainly knew that same view was
21 held by DHSS. I think there was a fear, because I think
22 there was some reference to it in something from
23 Dr McIntyre around that time, that Professor Cash might,
24 with the money already available to him, although it had
25 not been -- at least surrogate testing had not been part

1 of the explanation put forward for getting the money --
2 but that he might with the money available start and
3 then it would have put pressure on us to continue; put
4 us in the position of having to make a statement to the
5 effect that this couldn't continue.
6 Q. Can I just refer you back to --
7 THE CHAIRMAN: Don't leave. The first line refers to "BTS"
8 which I think might either be the United Kingdom
9 organisation on the whole, or the English and Welsh
10 version as distinct from SNBTS. What do you think is
11 referred to here?
12 A. I'm sure it's SNBTS.
13 MR DAWSON: I just want to refer you back to a similarly
14 brief memo from about seven months before that, again by
15 Dr Scott. It's [SGH0028146], please. Again, I think
16 this is one that we have looked at before. It's
17 16 October 1986, so six or seven months before the one
18 we have just looked at. It's Dr Scott writing another
19 memo to Dr Forrester and Mr Murray, where he says:
20 "I should like to know where this stands".
21 This is obviously surrogate testing:
22 "CMO DHSS is worried that if we go ahead, England
23 and Wales will have to follow suit."
24 I asked you a moment ago why it was that you thought
25 that Dr Scott was saying in April 1987 that SHHD should

1 be doing whatever it could to prevent the SNBTS going
2 ahead with full-scale introduction of the testing?
3 What I would like to suggest to you is that the
4 reason why he said that you had to do whatever you could
5 to prevent that happening was that the primary
6 consideration of SHHD throughout this period was that
7 there should not be any divergence in practice between
8 England and Wales and Scotland.
9 A. I don't think that that -- it was an important
10 consideration, certainly, but I think that the staff in
11 SHHD did attempt to form an opinion of their own and
12 that opinion was that we should not go ahead. I think
13 that, if we had agreed with the Scottish directors'
14 view, Dr Scott would have said so, even if the outcome
15 eventually for the sort of reasons that were discussed
16 this morning, had been different.
17 Q. Okay. Thank you. You were asked some questions by
18 Mr Mackenzie earlier about the position -- which I think
19 is a fair summary of SHHD's position in the middle of
20 1987 -- that it favoured the research which was being
21 proposed at that time, rather than going ahead with
22 testing. Is that right?
23 A. Yes.
24 Q. Do you think that, at that time -- I'm talking about the
25 middle of 1987, after the recommendation had been made

1 by the SNBTS directors -- SHHD medical officers had
2 a full and proper understanding of the research that was
3 being proposed at that time?
4 A. It was certainly being put to the chief scientist's
5 organisation, but I would expect them to have seen it --
6 yes, I would expect them to have that knowledge.
7 Q. Would I be correct in saying that, one of the reasons
8 why SHHD was in favour of research in a general sense
9 was that such research would give local information from
10 which conclusions might be drawn about the usefulness of
11 surrogate testing?
12 A. That would have been, certainly, advanced as a reason
13 but I think there was some doubt as to how much research
14 would be needed and for what length of time.
15 Q. I think as I understand the questioning that
16 Mr Mackenzie was putting forward, the point he was
17 trying to propose is that the research being put forward
18 at that time was looking at donors only and not
19 recipients. I think you answer by giving some details
20 of the difficulties that would be associated with
21 recipient-based testing, but is it not the case that, at
22 that time, the research which was being proposed would
23 give one only a very limited understanding of the
24 usefulness of the testing. Therefore the focus on the
25 research in SHHD was perhaps misplaced.

1 A. I wouldn't have said it was it was misplaced. As you
2 have said, there was a difficulty about the -- pursuing
3 the donors. That would certainly have limited the value
4 of it.
5 Q. In what respect would it have limited the value of it?
6 A. We wouldn't have established what the outcome would have
7 been as far as the recipients were concerned.
8 Q. What would the impact of that have been as regards
9 forming conclusions about surrogate testing?
10 A. I think it would have limited what we would have learned
11 from it.
12 Q. I repeat the question: what could it have told you about
13 surrogate testing and its usefulness?
14 A. I think it really would have told us, if anything, the
15 distribution of positives in the donor population.
16 Q. Okay. Can I just take you to one final document,
17 please, Dr MacDonald? I don't think this is one we have
18 looked at before. It's [SGH0028076]. We can see from
19 the top this is another memo which is going to
20 Dr Forrester, Dr McIntyre and Dr Forbes in the CSO. If
21 we just go down to the bottom, it's one written by
22 Mr Macniven, dated 2 October 1987, so we are moving,
23 again, a bit further forward in time.
24 If we look at paragraph one, we can see there that
25 he is thanking Dr Forrester very much for his helpful

1 minute of 1 October and he is making reference there to
2 issues relating to funding.
3 A. Yes.
4 Q. In particular, in the second paragraph, he highlights
5 what the purpose of the minute is. He says:
6 "I am a little anxious about the timescale implied
7 by your minute. I'm very anxious indeed for our
8 decision (on whether or not to put resources into NANB
9 testing) should be properly informed by research
10 evidence. If that evidence justifies testing, then it
11 is very important that we should be able to find the
12 money to start it quickly. If it does not justify
13 testing it is equally important that we should not have
14 allocated money to the SNBTS for the purpose, thereby
15 sterilising it for other uses.
16 "But I think the worst of all possible worlds is
17 that research cannot get off the ground: I fear that, in
18 those circumstances, we would be subjected to
19 increasingly irresistible pressure to spend the money in
20 any case, for the sake of improving, at any price, the
21 safety of blood and blood products."
22 I just wanted to ask you in particular about the
23 line in which Mr Macniven says that:
24 "The worst of all possible worlds is that research
25 cannot get off the ground."

1 Would it be fair to say, at this stage, that
2 Mr Macniven, at least, was under the impression that the
3 research would give him some information or
4 justification for surrogate testing?
5 A. Yes, I think that's clear in that paragraph.
6 Q. Did that represent the overall understanding of the
7 team, if you like, within SHHD that was dealing with
8 this, as regards what that testing would show?
9 A. I'm sorry, could you ...?
10 Q. Do you think that that represented the generally held
11 view amongst the team in SHHD dealing with this, ie that
12 the testing would be useful, as regards giving
13 information on the usefulness of surrogate testing?
14 A. I'm not sure of the answer to that one.
15 Q. Right. Was that your understanding of the proposals
16 being made at that stage, as regards testing?
17 A. I didn't see the proposals at that stage.
18 Q. Mr Macniven refers there to the fact that if there were
19 no testing:
20 "We would be subjected to increasingly irresistible
21 pressure to spend the money in any case for the sake of
22 improving (at any price) the safety of blood and blood
23 products."
24 I'm interested in whether you might be able to help
25 me with the concept of the irresistible pressure that

1 might exist if research didn't go ahead. From whom
2 would that irresistible pressure have come?
3 A. Well, I don't know quite what was in Mr Macniven's mind
4 at that point. I don't know how far he was -- can
5 I check the date of this --
6 Q. Certainly, it's 2 October 1987.
7 A. 1987, yes. I don't know how far he was aware of the
8 anxiety among the regional directors and Professor Cash
9 that, because of the way in which the commercial
10 producers were apparently moving, we would be compelled
11 to do likewise. I think he might well have been aware
12 of that but I can't really give you a probable answer.
13 Q. Perhaps that's a matter I could address to Mr Macniven
14 more properly. Could I just, however, put to you one
15 final thing about this minute. One might think, from
16 the details of the second paragraph here, in particular
17 in light of what we have discussed about research, that
18 there was a preoccupation within SHHD with undertaking
19 research, whatever its purpose, at all costs, as a means
20 of putting off making a decision about surrogate
21 testing. I would just like to get your reaction to that
22 suggestion.
23 A. I think it was reasonable to argue that we didn't have
24 sufficient information to know exactly how it would work
25 out in our population and therefore we should look to

1 the possibility of research. At the same time, I think
2 it has to be admitted that that would postpone a final
3 decision inevitably.
4 Q. But was it the postponement of the final decision that
5 was really the priority at this time?
6 A. It certainly -- it is certainly fairly clear that
7 neither DHSS nor SHHD were persuaded that we should go
8 ahead with surrogate testing.
9 Q. Okay, thank you very much, Dr MacDonald. Thank you,
10 sir. I have no further questions.
11 THE CHAIRMAN: Mr Anderson?
12 MR ANDERSON: I have about four questions. Doctor, can you
13 hear me all right?
14 A. Yes, it sounds very good, thank you.
15 Questions by MR ANDERSON
16 MR ANDERSON: Could we look together at this letter of
17 21 August 1986. It's [SNB0059240]. You have told us
18 that, in August 1986, you were the chief medical officer
19 is that correct?
20 A. Yes.
21 Q. Can you remind me, please, who Mr Morison was?
22 A. He was one of the two undersecretaries who dealt with
23 health and he was the one who administratively had
24 responsibility for the affairs of the
25 Common Services Agency. He was a member of the

1 management committee of that agency.
2 Q. I'm obliged to you. Am I right in thinking that he
3 would be, in the hierarchy, one above you as it were.
4 Would that be right?
5 A. In no, in hierarchical terms, if one can compare medical
6 and administrative, I was one above him.
7 Q. I see. You see the letter started:
8 "Dear Hugh, I must once again request ..."
9 A. Yes.
10 Q. Were you aware of any prior requests?
11 A. I wasn't. I discussed this, as I said in my reply, with
12 colleagues and the colleagues were obviously Dr Scott
13 and Dr McIntyre. If any previous requests had been
14 made, they would come to them. I don't remember but
15 obviously it's years ago -- I don't remember them
16 telling me that there had been any previous requests.
17 If it had been made on the administrative side, then I'm
18 sure we would have heard about it because, as you saw in
19 this instance Mr Morison immediately passed the letter
20 to me.
21 So I really am not aware of what that amounted to.
22 Q. All right. You see in the final couple of lines,
23 doctor, that what Dr Cash says is:
24 "I must, with regret, conclude that the SNBTS
25 directors have little or no confidence in the person who

1 currently provides the vital medical link ..."

2 Do you see that?

3 A. Yes, that's the bottom of the third paragraph, yes.

4 Q. Yes. Would you accept that what this letter appears to

5 seek to address is a question of communication; the link

6 between the SNBTS and the SHHD?

7 A. Yes, yes, it is clearly about communication.

8 Q. You see, I think previously you suggested, when it was

9 proposed to you that there may be a communication

10 problem -- you said, "Yes, that's a possibility". But

11 isn't it really quite clear from this that you are

12 dealing with a communication problem? Is that not fair?

13 A. Yes, I think that's clear.

14 Q. Leaving aside personalities or questions of fault or

15 whatever, would you accept that this letter on the face

16 of it, appears an attempt by Dr Cash to do something

17 about that problem?

18 A. Yes.

19 THE CHAIRMAN: It seems to be an attempt to bury the problem

20 by getting rid of one end of the communication link.

21 A. Yes.

22 THE CHAIRMAN: Yes.

23 MR ANDERSON: Thank you, doctor.

24 THE CHAIRMAN: Yes, Mr Johnston?

25 MR JOHNSTON: I don't wish to ask any questions, thank you,

1 sir.

2 THE CHAIRMAN: Mr Mackenzie?

3 Dr MacDonald thank you very much indeed. Right.

4 Now, are we adjourning? Is that it?

5 MR MACKENZIE: Yes, sir, Dr Dow joins us tomorrow.

6 (4.08 pm)

7 (The Inquiry adjourned until 9.30 am the following day)

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