Friday, 25 March 2011

(9.30 am)

THE CHAIRMAN: Good morning.

MS DUNLOP: Sir, the witness today is Dr Brian McClelland again.

THE CHAIRMAN: I don't think I should swear Dr McClelland again. I'm beginning to swear the same person so often that we will dispense with that.

DR BRIAN MCCLELLAND (previously sworn)

MS DUNLOP: I'm not sure really sure how it works.

THE CHAIRMAN: I have never been in this position before. The witness is not really continuing his evidence. He is coming back for separate episodes but it appears to me a bit excessive. Unless anyone has got any objections, we will dispense with that.

Good morning, Dr McClelland.

Questions by MS DUNLOP

MS DUNLOP: Dr McClelland we are not quite able to pick up where we left off because we are now looking at a different topic but we do recognise you from your last appearance and I'm not going to take you through your CV and so on again. We are just really going to start with the material we have on our topic, which is B1.

In particular I would like you to have your statement on this, which is [WIT0030036]. I think you

may have a hard copy of it?

A. I have.

Q. Which is perhaps easier for you. The other document which I will be making repeated reference to is something called a narrative, which is [PEN0010001]. And perhaps we can begin by having them both together on the screen.

This is a narrative which has been prepared by the Inquiry team in an attempt to bring together all the material that we have about leaflets and public information generally in the early to mid 1980s.

Of course, there are other papers which have been provided. You, I think, were responsible for a paper entitled "Actions taken by SNBTS to protect patients from AIDS", which has something on this topic and then Dr Gillon also produced a paper called "Donor selection policies and procedures", which again touches on this topic, but I think there is a danger of our getting sidetracked if we try to look at all four of these simultaneously. So my intention is to concentrate on these two for a moment.

The first question that you were asked was about what, as it were, had been the trigger for you to take action in the early months of 1983. It seemed clear to the Inquiry team that you had had some material from the

United States. If we can scroll down through your statement. You have explained in response to question 1 that what you actually had was a copy of the morbidity and mortality weekly report dated 4 March 1983, the MMWR. This is dealt with in our preliminary report. So I think if we can cancel the right-hand document and look at a page from the preliminary report, which is [LIT0010568].

That's it, isn't it, doctor?

A. Yes.

Q. Right. We can see that this comes from the CDC, which is the Centres for Disease Control -- is that right? -- in Atlanta. Yes. And there is a narrative of the state of play as at March 1983. Perhaps we can slowly go down this page. We can see it's a report of interagency recommendations. Worth noting perhaps are some of the figures which are given in the first paragraph about how many cases of AIDS there had been reported to CDC. There were 1200 reported from 34 states. Over 450 people had died. Case fatality rate exceeding 60 per cent for cases first diagnosed over one year previously, that it is a gradually increasing number:

"Most cases have been reported among homosexual men with multiple sexual partners, abusers of intravenous drugs and people from Haiti."

And then:

"Recently [however] 11 cases of ... life-threatening opportunistic infections and cellular immune deficiency have been diagnosed in patients with haemophilia. Available data suggests that the severe disorder of immune regulation underlying AIDS is caused by a transmissible agent."

Then if we go on little bit further down, please, we then see that the distribution was paralleling that of Hepatitis B, which is transmitted sexually and parenterally. Blood products or blood appear responsible for AIDS among haemophilia patients who require clotting factor replacement. The likelihood of blood transmission supported by the occurrence of AIDS among IV drug abusers. Then reference to:

"Recently an infant having developed severe immune deficiency and an opportunistic infection several months after receiving a transfusion of platelets derived from the blood of a man subsequently found to have AIDS."

I think that particular transmission was reported in a number of different publications:

"The possibility of acquiring AIDS through blood components or blood is further suggested by several cases in persons with no known risk factors who received blood products or blood within three years of AIDS

diagnosis."

Could we go to the next page, please. Some information about identifying individuals at risk for transmitting AIDS. Then if we can perhaps go down to the actual recommendations, these are preceded by a paragraph noting that there had already been in the United States a number of statements on the prevention and control of AIDS emanating, we can see from the National Gay Task Force, the National Haemophilia Association, the American Red Cross, the American Association of Blood Banks and so on. And there are, in particular, five recommendations which we can see. We can look at number 2, and you have quoted this yourself in your statement:

"As a temporary measure members of groups at increased risk for AIDS should refrain from donating plasma and/or blood. The recommendation includes all individuals belonging to such groups even though many individuals are at little risk of AIDS."

So the thinking here seems to be, as it were, to cast the net wider than might be strictly necessary because of the priority of identifying those people who had to be identified, as it were. So it didn't matter, perhaps, if one took in more false positives. You are nodding. You would agree with it?

A. Absolutely.

Q. That's the thinking that seems to be underlying at least these recommendations?

A. Yes.

Q. If we also look at another passage that you yourself have quoted at the end of the second paragraph on page 2. We can see that the end of the second paragraph says that:

"The persons who may be considered at increased risk are ..."

Then there is just the list:

"Those with signs and symptoms suggestive of AIDS, sexual partners of AIDS patients, sexually active homosexual or bisexual men with multiple partners, Haitian entrants to the United States, present or past abusers of IV drugs, patients with haemophilia and sexual partners of individuals at increased risk."

I'm sorry, can we go back down. Just to highlight that paragraphs 4 and 5, on to the next page. We can see that group 4 relates to blood transfusion and then recommendation number 5 refers to the development of safer blood products for use by haemophilia patients. And the National Haemophilia Foundation has made specific recommendations for the management of patients with haemophilia.

So certainly what is coming across from this publication is an identification of risk associated with blood transfusion and the administration of blood products. Is that a reasonable comment?

A. Absolutely. What perhaps doesn't come across from this text is it had quite a tortured origin as I think I referred to in the other paper that you mentioned in your introduction. I quoted from that a personal account by a Dr Bruce Evatt who was an employee of the Centres for Disease Control, who was really essentially the focal point of the discovery of the occurrence of AIDS in patients with haemophilia, and together with some colleagues from the CDC was the person who motivated the preparation of this statement in the MMWR. It is notable that the FDA initially was not enthusiastic to issue a statement.

So there was a lot of turmoil, several meetings of the Blood Products Advisory Committee in the United States, before this rather unusual interagency statement was introduced.

Q. Right. So rather a difficult genesis in America?

A. It had a very difficult genesis and I think the account by Dr Evatt, maybe, you know, may have certain biases. It gives a very vivid picture of just how difficult and how much opposition and reluctance to acknowledge the

idea that this infection was probably being transmitted by blood.

Q. We actually pre-produced in our narrative one of the American leaflets. If we can close down this MMWR document, please, and go back to the narrative. We can see on page 1 that this is an extract from the text of a leaflet which emanated from the American Red Cross and we can see that the form of the leaflet has been to list people who are thought to be at increased risk of developing AIDS -- this is reading from about half way down the page on the right -- then to list the groups and then say -- and this is at the bottom of the page under the heading "What should I do?" -- that:

"If you are an individual in a group at increased risk of developing AIDS, we ask that you refrain from donating blood at this time."

So that appears to have been the style of at least the American Red Cross leaflet. Then if we can go to look where this is dealt with in our preliminary report, if we could see [LIT0012482].

This is chapter 8. Looking from paragraph 8.12 onwards, the real page of this I think is 189. This is an attempt really to recap on the lead up to these recommendations as well, that there had been, in the summer of 1982, a report of pneumocystis pneumonia and

[in] three persons with haemophilia and then a report from the BMJ in July 1982 of AIDS in Denmark. Then the meeting on 19 August 1982 where obviously the deaths, three deaths in the patients with haemophilia in America had been discussed.

If we can go down to the bottom of that and on to the next page and perhaps go down, we can see the awareness that's starting to develop in Scotland and then look down to the footnotes as well. The reports in the MMWR in December. Three haemophiliacs referred to in the July publication have died and then the reference to the infant who had apparently developed the syndrome:

"These reports raise serious questions about the possible transmission of AIDS through blood and blood products."

Then can we leave the preliminary report and go back to your statement and on to the second page of your statement, please.

If we can go further down the left-hand document, please, we asked you what lay behind your decision and you have really largely covered this already, that you were aware of the evidence emerging from the summer of 1982 and also you had the MMWR publication and then you say:

"I recall another factor that increased our

awareness of the need to take some form of preventative action during 1983. One or two local newspapers had started to suggest that AIDS would become a problem in Edinburgh."

So it seems that all these factors really came together and made you decide that the time had come to put pen to paper. Is that right?

A. Absolutely.

Q. And then can we go over to the next page of your statement, please. As far as the actual text is concerned, you say that:

"The most obvious approach was to follow the principles of the US public health services interagency guidelines which made use of epidemiological data to identify subgroups ... slightly adapted the recommendations ... for Edinburgh."

I wanted to look then at your first draft. I think perhaps what we will do is stick with the narrative because it includes an extract from your first draft. If we can turn to the next page, please.

I should say for the record, sir, that the actual leaflet, draft leaflet, is [SNB0037153].

By 24 May you had a draft leaflet and you tabled it at a meeting of the co-ordinating group.

I wanted to look, Dr McClelland, at the style of

this leaflet and most of the significant text is set out. The style in short is to identify in response to a question "Who can get the disease?" what might be described as the groups at risk. Is that right? Do you see that:

"Who can get the disease?"

It says:

"AIDS has been occurring, particularly in the USA, in certain people who are apparently susceptible."

Then there is a list of five groups of people:

"Homosexual men, particularly those with multiple partners, drug abusers, sexual contact with people with AIDS, patient immigrants to the USA and haemophiliacs who may be more susceptible or may become infected by their use of blood products which may have come from a blood donor with AIDS."

Then you go on to say:

"Can it be transmitted by blood transfusion?"

To which you answer:

"It appears it can."

If we turn over the page, we see another question:

"Whose blood could be a risk?"

You say:

"All our information about at risk groups comes from the USA. However, until more is known about the cause

and spread of AIDS, we would ask the following groups to refrain from donating blood: homosexual men, women who continually have multiple sexual partners, partners of bisexual men, anyone who abuses drugs and anyone who has been in contact with a case of AIDS."

Doctor, in your answer 2.1, if we look at your statement on the left-hand side and go to the next page, please. About two thirds of the way down you have repeated a question that came from the Inquiry team and said you weren't entirely sure which draft this question refers to. In fact, the full form of the question was:

"In your first draft why did you use the wording 'homosexual men' rather than 'sexually active homosexual or bisexual men'?"

The point that we were really trying to make, which obviously has been slightly lost, I think, in the communication, is that the style of your first draft is to identify, as it were, two different groups, so you have your list of at risk groups and then you have a list of people who are asked not to donate blood, whereas in the American leaflet there was simply one list of groups of people and then a request that anybody in those groups not donate blood, if you see the difference I'm making?

A. Yes.

Q. So really what the question was getting at was when you, in this first draft in May 1983, formulated your list of people who were being asked not to donate blood, you appear to have cast the net slightly wider, in including in particular, as your first group, homosexual men. With that explanation of what the question was really getting at, do you want to elaborate on why you did it that way?

A. I think first of all it is essential to say that we didn't, as I have said elsewhere in my statement -- I have not got detailed sort of contemporaneous notes of precisely how we came to these various wordings. So I'm dependent on either memory or supposition to be honest to try and answer these questions.

As is quite obvious, there were multiple drafts and what we were, I think, endeavouring to do was to produce something that would include all the -- the intention of which was to exclude from donation -- or discourage from donation, perhaps I should say -- any groups of people who had already been identified by the epidemiological evidence that was available from the United States.

I think at the same time we were probably trying to make some adjustments in the wording for two separate reasons. One was, in successive drafts, trying to come up with wording which was not more offensive to people

than it had to be. Secondly, wording that was as unambiguous as we could make it, and thirdly that where we felt there might be some areas that perhaps hadn't been adequately identified in the very first version, which had come from the United States, we were prepared to try and extend a little bit more because we had the advantage of coming second, if you like.

Q. Yes.

A. And I think those factors probably -- the fourth one, of course, was that as the months went on, new information was becoming available quite rapidly, which also we attempted to reflect as accurately as we could in successive drafts of the document.

As I recall, we had introduced category 2 and I'm not sure that -- I think that was something that was not expressed in that way in the original American leaflet, if my recollection is correct. And that was an attempt at a polite way of saying prostitutes, and we had many attempts over the succeeding few years to try to find wording that actually people understood that was not, as I say, gratuitously sort of offensive to individuals.

So I think those are the factors that led to the successive drafts. For the modification in each of the drafts I do find it very difficult to give, blow by blow, precisely what the thinking was.

Q. Yes. I entirely accept what you are saying, Dr McClelland. There was an attempt to satisfy a number of different goals, as it were, and that no doubt led to a degree of compromise in the end?

A. Most certainly.

Q. Yes, but perhaps it would do us good to look at the leaflet rather than this extract from it. Could we have [SNB0037153].

This is really, I think, a better illustration of the point I was trying to make, that if you look at the left-hand side you have a list of groups at risk, as it were, one to five. One of those groups, we notice, is haemophiliacs, and then on the right-hand side you have your list of people who are asked not to give blood. Of course those two groups don't match. So given your reference to the desire to produce something that wasn't ambiguous, would you accept that perhaps even in retrospect, having groups which didn't match might have been slightly confusing?

A. I think that's a perfectly reasonable comment. I mean -- I have absolutely -- I do not know because we didn't carry out any sort of market research on these very early versions of the document, as to what the level of comprehension was. It was a concern right from the start that it was one thing to produce a piece of

paper and actually, however you attempted to deploy that, if you like, to publish that to the relevant population, there were very serious questions about, you know, what would be the best way to ensure, first of all understanding -- well, first of all that people read it, secondly, that they understood it and thirdly, that it in some way influenced their actions.

So these are -- you know, were -- remain very challenging problems. I wouldn't wish to defend the precise organisation and wording of a very early draft of something that was done, you know, all that time ago. It could certainly be improved.

Q. Thank you. I think really, to sum up before we leave this text, what's of interest for our purposes is firstly how the groups were described and the request not to give blood was formulated and, secondly, the reference to people with haemophilia that, at least from your point of view, that was in as a group of people that were at risk really from your first draft.

So perhaps noting that, we can leave the leaflet and look at what happened next. You were asked why the text of the leaflet changed soon after 24 May. I mean, the draft we have just been looking at was a draft current in May.

Perhaps we could look at another document now,

[SGH0026759]. You see this is a press release, which was issued on 21 May 1983. What we can see from it firstly, perhaps if we scroll down, the press release says that it was erroneous to describe the disease as "sexually transmitted". Is that itself erroneous, Dr McClelland?

A. Clearly it is erroneous.

Q. Then if we look at page 2, the heading "Panic unfounded". It says at the end of the first paragraph:

"There are no confirmed cases of AIDS in haemophiliacs in the UK."

Indeed, I think that was something that actually featured in your first draft as well. There was already a young man, a 20-year old man in Cardiff, who was ill in hospital and this appeared in the bulletin of the Public Health Laboratory Service for the week ending 6 May 1983. The young man in hospital in Cardiff was described in the bulletin as the first case of AIDS in a person with haemophilia in the UK.

It is difficult, I know, after all this passage of time but did you have any awareness of a person with haemophilia being ill with AIDS in Cardiff?

A. I have no recollection of being aware of that. It is entirely possible that I would have been informed of it because I, you know, lived sort of next door to the

haemophilia specialist and one of my consultants had previously been a haemophilia-treating haematologist in Liverpool. So we got fairly up-to-date information about the situation with haemophilia but I honestly cannot remember if I was aware of that case or not.

Q. Sorry, doctor, I didn't quite catch that. You said you lived next door to?

A. My office -- the haematology department in the old Royal Infirmary was literally partly embedded geographically in the blood transfusion service. So Dr Ludlam and his colleagues who were responsible for the haemophilia care were frequent visitors, you know, and we had regular conversations and by this time it was a major topic of conversation for anyone involved with either haemophilia or transfusion.

Q. I see.

A. So I may well have been informed but I have no recollection.

Q. Right. Can we go further down that page, please. We see that certainly there was a degree of opposition to your first draft, certainly opposition to any suggestion that people who were homosexual shouldn't be able to give blood, which is described as a panic-stricken measure. We see also from that paragraph that the thinking is criticised because it didn't address itself

to halting the possible creation of a disease virus. It was only a measure aimed at preventing transmission within blood products.

Then can we look at the last page of this press release, please? Page 4, it should be.

Press called upon to exercise restraint. But there was also a hope from the people who drafted the press release that the press would exercise a responsible attitude to reporting of the disease. And from what you can remember of that time, Dr McClelland, was that based on some pretty alarmist reports which had appeared in certain sections of the press?

A. Oh, absolutely. There were some famous headlines about killer blood and things like that. It had already been good front page material in the UK.

Q. Another document which goes with this is [SGH00026698]. This is an extract from a publication called "Gay News". If we go to the very bottom, please, we can just see in italics on the left-hand side:

"Gay Scotland, 9 July August 1983."

We can see, if we go back up a little bit, in the middle column, a paragraph which is more black, and then counting down two paragraphs from that:

"SHRG has secured a major success in its consultations with medical authorities by having

a proposed leaflet withdrawn because it was seen as antigay and likely to cause panic. A revised leaflet drawn up jointly by SHRG and the Southeast Scotland Blood Transfusion Service has now been agreed."

So it looks, Dr McClelland, as though at least part of the explanation for why the first draft didn't ever become an issued leaflet seems to have been opposition from some commentators. Yes?

A. I have got in front of me at least one other draft that precedes the earliest one that you showed. I think it is important to say that all these sort of typed things were, I think, work in progress. Perhaps we should go back and look at the original documents. The very first one that was actually issued was in typescript but --

Q. We are certainly coming to that.

A. But it was blue, it was in blue typescript. Some of the documents here were never issued. They were, as I recall, sort of working documents looking at both how it could be laid out, you know; not only the content but how we might present it. So I'm not absolutely clear now about the time relationships.

At some point in the period between May/June of 1983 we became very much aware that there was a major issue among the gay community in Edinburgh, that they felt they were going to be stigmatised by this and that's an

issue that persists to this very day. We felt that the only way to approach this was to very positively engage with the gay community, and the people who were the spokesmen were Derek Ogg, who will be known to some of you, and a colleague of his, Nigel Cook. We actually brought in somebody who had a very good working relationship with them, which was Dr Alexander Macmillan who was one of the consultants in the sexually transmitted disease department. As a result of that, we tried to work with them on the creation of a wording that they were able to endorse. As you can see from this piece on the screen, they eventually did, and I think we were fairly clear that we were trying to get the best out of a difficult situation, and rather than producing a leaflet which perhaps had the wording that we would have chosen, that would be totally rejected by the gay community, we were trying to strive for something that could not only be accepted but endorsed, and quite a lot of work was done over that summer to actually, you know, as I think I said in my statement, to actually, you know, promote this leaflet and the general approach within the gay community in Edinburgh.

So I'm sure the wording was amended possibly more than once as a result of dialogue -- actually sitting round a table with these guys.

Q. I think, doctor, the sort of collaboration that you are describing actually mirrors what seems to have happened in the United States, because when we looked at the beginning at the MMWR publication in March 1983, one of the groups mentioned was the National Gay Task Force. So it is clear that you were really following the same sort of path as had been followed in the United States in attempting to reach something that everyone felt they could sign up to, as it were?

A. Whether we were fully aware of how this had been approached in the United States I can't remember, but we were faced with a very difficult situation, where a group of people who we were confident at that time -- we subsequently had to perhaps revise that judgment in the light of new data, but we were fairly confident in the summer of 1983 that the primary group at risk would be gay men who were sexually very active. That's what all the information was saying.

We felt we would have achieved very little if we had gone ahead with something that was rejected out of hand. But then, as now -- and in Scotland as in the United States -- there was no such entity as a unanimous opinion representing the gay community.

Q. Just to note from that extract from Gay News, which is still on the screen, that Dr Sandy Macmillan does

feature. So certainly we have understood from you that he was quite heavily involved in all of these discussions as well from his perspective as a consultant in sexually transmitted diseases.

A. He was an extremely constructive contributor to getting this process started.

Q. Yes. I thought perhaps, doctor, I would ask you to look at Dr Gillon's statement. Now I'm breaching my own rule that I set about getting confused with the four different papers but this one is [SNB0143125].

Could we go to page 9 of this document, please. I just wanted to give you a minute, Dr McClelland. I'm sure you have seen it before but not today. It is the paragraph that begins:

"The reason for this seemingly timid approach ..."

Could we get the whole of that paragraph on the screen, Dr McClelland, and just give you a moment to read through it again.

A. The timid approach that Dr Gillon is referring to is --

Q. Do you want to go back to page 8?

A. Yes, just to be sure that I answer the question --

Q. Right. Can we go back to page 8. Yes, it is the whole of the section beginning:

"Identifying donors ..."

A. Yes. That's fine, thank you.

First of all I think I would say -- I think what Dr Gillon was aiming to do with this paragraph was to give, you know, a relatively sort of high level view of the range of attitudes that were apparent or expressed among the sorts of senior -- the sort of director level in the Blood Transfusion Service in the UK at the time.

Q. You are balking slightly at the use of the word "timid" are you?

A. No, I'm just trying to make sure that I have understood the question.

Q. The question is just whether you agreed with the way Dr Gillon had put it?

A. Absolutely. I think the approach -- in Scotland, in England there was a very, very deep reluctance to start to do something which had never been done before really in donor selection practice, which was to go anywhere near the question of people's sexual behaviour, and there was very deep-seated reluctance to do that.

Q. Yes. I think we can understand, even from the evidence we have heard in the Inquiry so far, that there would be a number of strands to that. For example, the appreciation of the altruism shown by donors in coming forward and offering to give blood for no tangible return, for example.

A. Well, the practical desire not to make the process of

attending to give a blood donation so unpleasant and intrusive that people simply would decide not to come, which had major implications. It's a no-win situation because if you are sufficiently aggressive and intrusive to try to identify at a point prior to donation all individuals who might possibly have some slightly or very increased risk of carrying a transfusion-transmitted disease, you move towards a position where you seriously risk not having enough blood to meet essential patient requirements. So you get a sort of public health challenge, whichever you do, and you have to walk dawn the middle of this very difficult tightrope. Looking back one can debate extensively whether, over this period, the transfusion service has got the balance right, whether they were too patient orientated or too donor orientated, and there will be many opinions about that.

Q. Yes. Dr McClelland, I wanted next to look at what was the first published leaflet from Southeast Scotland Blood Transfusion Service, which is [SNF0013397]. This is "some background to the recent publicity". Is this the one that was blue?

A. I think so, yes.

Q. I'm sorry, we are only doing black and white.

A. That's okay.

Q. Can we go to the next page, please?
A. That is definitely the first one that was actually deployed.
Q. Right. Perhaps the particular points that we would want to take from it -- and we have discussed this really a lot already -- is who can get the disease. That has been changed. The first described group has been changed. But we also note that you are saying in your answer to the question "Who can get the disease?" number 4, haemophiliacs and number 5, recipients of blood transfusion.

So you are saying that really very clearly in your description of the groups at risk. We can also see that as a matter of style you have followed the approach that we saw in the American leaflet of really just having one list of groups, and under "Whose blood could be a risk?" saying, on the right-hand side:

"If you are in one of the groups, please don't give blood."

Perhaps, as we said earlier, that's slightly simpler for people to follow?
A. I think we must have come to conclusion that the earlier drafts, as you have suggested, were confusing.
Q. What has been done, however, Dr McClelland, particularly in relation to group number 1 -- men who have multiple

partners of the same sex -- is that it is really left to the reader to judge whether they might fall into that group because there is no guidance at all as to what "multiple" might mean.

A. Well, absolutely, and this is a problem that has been discussed and explored again repeatedly over, I think -- probably still is being debated, although I'm not personally involved in the policy on donor selection now.

What we were trying to do here, I think -- and this was probably a consequence of our discussions with Mr Ogg and his colleagues -- was to remove the word "homosexual" which was seen as being offensive. I think we were also trying to do something else, which was to be a little bit more specific. We were trying to avoid the word "promiscuous" which is also very pejorative, but to indicate that what we were concerned with were people who had a lot of sexual partners.

I think we already were sufficiently well-informed at that stage to realise that in the population of the UK there are, you know, quite a substantial proportion of people who might be terming themselves "homosexual" who are actually not sexually active. This is the first, if you like, manifestation of a dilemma which afflicts this whole area, because if you adopt the sort

of Justice Krever's precautionary approach, where you are reduced to an absurd position where you say, "We will not take blood donations from anybody who had sex". Later on in this we have repeatedly addressed issues of heterosexual transmission, which clearly is an issue, and how many sexual partners is too many to be a blood donor and how do you ask.

Also we have addressed the issues over the years of people from populations or parts of the world where the prevalence of HIV is much higher, and how do you address that issue without becoming highly racially discriminatory. So this is just the tip of a huge iceberg of unresolvable problems. And that was our best crack at coming up with a workable wording. And if somebody had asked us at the time, say "How many is too many?" the answer would have been, "We really don't know". And we still really don't know. Because HIV can be contracted with a single sexual encounter between men and men or men and women.

Q. Yes. We also noted, doctor, that in relation to the other aspect which is of interest to the Inquiry -- that is people with haemophilia and recipients of blood transfusion -- this leaflet is really taking it as a given that AIDS can be transmitted in those ways.

A. I think by this time Dr Anne Smith and myself who

drafted this, we had little doubt that the evidence that had been assembled by the CDC had to be interpreted as showing that this was a blood transmissible disease. We think we really had no doubt about that.

Q. Indeed, if we could go back to your statement and look at page 5 of your statement, we see at the bottom of the page that you were asked a question:

"What led to the change from 'Can it be transmitted by blood and blood products?' to 'How can it be transmitted by ...'"

And your answer is:

"It may well be that this change reflects an awareness that the evidence had accumulated to the point where there was little or no doubt that AIDS could be transmitted by blood and that the message to donors should reflect that degree of certainty."

I take it that is your position?

A. That is my position.

Q. Yes. I wanted, Dr McClelland, at this point to put to you a question which has been posed by somebody who has been in touch with us, who has been very deeply affected by all of these events. Can you look please at a page from the preliminary report, which is [LIT0012486]. Can we go to the bottom of this? This is page 193. Do you see that in paragraph 8.25 there is quoted quite a big

passage from a letter that was distributed in May 1983 by the Haemophilia Society. The text having been drafted by a prominent haemophilia clinician. Do you see that, doctor?

A. Yes.

Q. Let me just give you a minute to read the couple of paragraphs from the extract.

A. Yes, I'm familiar with this text.

Q. Right. The question which has been posed to us and which I'm therefore posing to you is: is there not an inconsistency between, on the one hand, people involved in blood transfusion saying that those with haemophilia, those receiving blood transfusion are at risk, even to the extent that they are asked not to donate their own blood, and the tone of this letter and other similar material, which is actually quite reassuring? This is all contemporaneous material. Is there an inconsistency?

A. Absolutely, clearly, there is.

Q. Yes.

A. I think this is extraordinarily reassuring advice and it is one example of many very reassuring statements, as it were, risk-minimising statements, that were made over this period, which -- I can't honestly say -- I can't recall whether at the time I sort of scrutinised these

statements and said, "Gosh, that's very -- that's a bit too reassuring". I think our preoccupations were probably with doing our bit actually.

I think, if I was or had I been aware of this, I don't think it would have modified the text that we put in our leaflet because I think we felt our priority was trying to do whatever the available information could guide us to do to minimise the risk to patients. That was really our priority at that time.

Q. Yes. Moving on then, Dr McClelland. We can put the preliminary report down for a moment. Can we look at events around the time when this leaflet -- that is your blue leaflet -- begins to be circulated?

The first document I wanted to look at in connection with that is [SGH0026755]. I think we had better look at the bottom of this to see exactly what it is. It is from Dr Bell, it is dated 15 June 1983. We know that Dr Bell was in SHHD. It is to Dr McIntyre, who I understand to have been immediately above Dr Bell.

In short, this is a memo reporting on a meeting of you and your fellow directors, that there had been a discussion about AIDS. Indeed, some discussion about different leaflets. Dr Gunson, who we know at that time was the director in Manchester, but attending your meetings as a representative, was obviously working on

his own leaflet but he had your leaflet. I think we appreciate there was a lot of material around at the time, Dr McClelland. Then there is a paragraph beginning:

"All the directors present are now more aware of the complexity of the issues involved, particularly in relation to the views of the homosexual community, the scope for misrepresentation by the press and the public, the diplomacy required in presenting the AIDS issue in donor centres. No one is now quite sure as to whether the proposed leaflet should be for pick-up or handout, nor is the matter of possible distribution through the homosexual community resolved or even the possibility that there is a need for two leaflets, one for donor centres in general and the other slanted more specifically to the homosexual community.

"There were 18 Parliamentary questions brewing last week. It looks like SHHD are realising they will have to involve the minister. They can't rely solely on the views of the SNBTS."

Perhaps a lot one could get distracted by, looking into that, but for the moment we can see at least the perception in SHHD seems to be, as at 15 June, that there was still quite a lot of work to be done in connection with the leaflet.

A. Yes, I was interested to read this because, not surprisingly, I hadn't seen this memo until the preliminary report was published. But what I do have in front of me -- and I know it is among the papers I submitted to the Inquiry but unfortunately I did not have time to check the number, but it is a memo that -- it is actually signed by Dr Boulton. The name at the bottom of it is Dr Boulton. It is addressed to Dr A E Bell and it was dated 5 May 1983.

Basically it is the file note that I did and sent to John Cash and my director colleagues in which I had basically told Dr Bell what we were doing, and asked was that all right with the department. And I took away the understanding that the answer was yes. So we went on and did it.

Q. Yes, well, quite. Just one thing which is no doubt in a number of people's minds: all this time you are really drafting for Edinburgh and the Lothians; is that right?

A. This harks back to a point that has been made, I know, by a number of witnesses already, that at this period each of the regional transfusion centres was seen as being very much -- each director perceived at least that they had and should have a high degree of autonomy for many issues, including what they did about donor selection. I think the view that I took at the time was

that I had a responsibility to act on something which I believed was really very important for patient safety. I had, if you like, a corporate responsibility to inform the national director, as he then was, and my colleagues, my transfusion directors, what I was doing but I did not have any authority to tell them what to do.

So, yes, I was clearly, with my colleagues, doing this for the area which I understood to be my responsibility because I felt it was very important doing whatever I could to inform -- I mean, I copied all of these things basically to everybody that I thought might be able to do something about it.

Q. I think it emerges from minutes of the directors' meetings that your material was circulated among the other directors and so on, exactly as you describe?

A. It was, and it was extensively discussed by them.

Q. Yes. This memo is dated 15 June 1983 from Dr Bell. He is, I think, recording a position that there is still quite a lot of issues. There are still quite a lot of issues that are unresolved. If we can look at [SGF0010960], this is a shorter minute, also from Dr Bell, also dated 15 June 1983 but clearly written after the memo we just looked at.

He is saying that you have told him that the leaflet

has started to be circulated. There is a reference in this to misunderstanding and you said in your statement that the leaflet had been intentionally shared with the Scottish Homosexual Rights Group but I wondered perhaps if the misunderstanding was just whether it was to be shared and also distributed. It looks as though at least Dr Bell has the impression that it wasn't supposed to be distributed.

A. I really can't imagine that I would have -- I mean, I certainly gave -- they had copies of the leaflets to take away and think about and discuss of the various drafts which we have already discussed. I can't imagine, even in my youth in 1983, that it would have occurred to me that it would not be shared quite widely.

Q. Yes.

A. So I was surprised to see this reference to a misunderstanding because I don't think there was.

Q. Well, Dr McClelland --

A. Dr Bell may have had a misunderstanding of what I said to him, which is perfectly reasonable.

Q. I suppose it comes to this, Dr McClelland: even if not everybody was prepared for the leaflet to be distributed in the middle of June 1983, was it a good or a bad thing that the leaflet did begin to be circulated?

A. I think it has, from a common sense point of view, to

have been a good thing to do. It was increasing awareness among the gay community, which was probably at that time the most important single thing that we could do. I mean, I have to say that we have no objective measures directly of the extent to which that impacted the behaviour of gay men in relation to blood donors. That is still an issue which is quite difficult to establish, but I have absolutely no doubt that it was the right thing to get it out there even if it was less than perfect.

Q. I suppose if you had waited until every "t" had been crossed and every "i" dotted, you could have lost a lot of time?

A. A great deal of time.

Q. One of the things which emerged out of this obviously very active period appears to have been Scottish AIDS Monitor. I wanted to show you a letter, [PEN0020003]. I'll let you just take a moment to look at that.

(Pause)

A. Yes, I'm familiar with this letter.

Q. Right. So this is an initiative to establish a group which will be a vehicle for the distribution of information, the sharing of ideas and so on, from now on. Is that right?

A. That was the intention, yes.

Q. And did it work like that?
A. I think it worked to some extent for a period. It probably worked as well as one could reasonably have expected because this was, you know, a complex group of people with many opinions and there was never going to be a consensus, and as we have already said, there isn't today a consensus.
Q. Yes. Just on that topic, consensus, but in a different context, can I show you another document, [PEN0140098]. 7 July 1983. This is from Dr Anne Smith. You have referred to Dr Smith before?
A. Yes.
Q. What exactly was her role?
A. Dr Anne Smith was an appointment that I made in succession to the lady doctor who had been medically responsible for the blood donor programme in Edinburgh. She was Dr Elizabeth Robertson, an associate specialist, who was in her 60s when I became director. Looking at all the issues in my sort of first gallop through, as it were, the real problems were in the centre; I felt that we actually needed somebody of high professional calibre to undertake what is actually an extremely difficult role of the care and selection of blood donors. I'm sure Dr Gillon will have in his evidence brought out the fact that actually deciding when a person is healthy can

be much more difficult than deciding when they are sick. Dr Smith was an extremely capable, very well trained clinical haematologist, who took the job with BTS, and in the short time that she was there made a huge impression on this particular issue of donor selection and care in relation to AIDS. She contributed in many other ways but she unfortunately just went to a job in Canada and it was at that point that we appointed Dr Gillon.

Q. This is -- we can see from its terms -- some sort of circular letter and I think it is self-evident that it's going to doctors who have been unable to attend a meeting. So there has been a meeting. Would that be of doctors who were in charge at individual donor sessions?

A. Yes, I'm almost certain this would have been a group of what we called our sessional medical officers who tended to be part-time, many of them very capable but who would have the responsibility at a donor session of making a decision as to whether somebody would be allowed to donate; if they were allowed to donate, should some special action be taken to ensure that the blood wasn't transfused or if they should basically not be accepted for donation at that session.

The issue that was concerning Dr Smith at the time

was the emergence of the concept of homosexual men being unsuitable as donors, many sort of old attitudes emerged among the donor session staff which led to very inconsistent, sometimes rather arbitrary judgments being made about individuals, and actually Dr Smith had a pretty challenging time getting this sorted out.

This, I think, was the first of a number of interactions and there is certainly other written documentation, you know, from the time which goes into a bit more detail of the issue.

Q. I wondered, Dr McClelland, if there was a bit of a clue to some of the difficulties for Dr Smith in the first sentence of the fourth paragraph. She says:

"I should be grateful if you would adhere to the guidelines outlined even if you are not entirely in agreement with them."

Is this an issue where perhaps we are on the cusp of individual doctors feeling that they were, to a degree, autonomous or had clinical freedom at a session but on the other hand the service is trying to issue standardised guidelines and procedures? Is that the nature of the difficulty?

A. That's the nature of the issue and I think it is worth mapping that back to some of the earlier discussions -- and I'm sure there will be future discussions as well --

about the donor selection guidelines, because 1983 was shortly after the medicines inspectors had commented, certainly in the Edinburgh centre, that they felt the guidelines for selection actually really were not very specific. I can't remember the precise wording but the implication -- and it was an absolutely appropriate implication -- was that the rather general sort of in principle guidance that was contained in, for example, the very successful memoranda on the care and selection of donors, left a huge amount open to individual interpretation.

So actually confronted with the realities of trying to decide whether a person should be accepted to donate blood or not, the individual responsible, be it a doctor or nurse, had to make value judgments which inevitably were coloured by their own experience, attitudes, knowledge, et cetera.

Q. Yes.

A. And over the years enormous effort has been made -- and a large chunk of mine in the last few years of my working life was involved with attempting to develop donor selection guidelines, which reduced this sort of variability due to what is essentially inescapable in individual judgment of a particular situation. It remains a very challenging problem.

Q. Can we go back to the preliminary report, this time it's [LIT0012479]. We have mentioned this already. It is page 194. I appreciate this is going back in time but it's a passage dealing with the position in the rest of Scotland, from paragraph 8.28, a meeting of the co-ordinating group. We can see that, as far as the other areas are reflected in this passage, that the position in Glasgow, at least in May, was that there was now a question on the health questionnaire -- and I think we have already seen that several times this week -- it looks like a label or a sticker on the bottom of their leaflet. Then in Aberdeen Dr Urbaniak had decided not to do anything locally:

" ... once a donor had entered the session it was too late to make an approach and the problem was minor in northeast Scotland."

Dr McClelland, you say, very fairly, in your statement that you do not remember any specifics of the way the criteria were made available in the different centres but you recall there were differences in opinion:

"Some directors were very concerned about the risk of offending donors by giving too much prominence to the leaflet."

What do you think would be the nature of the offence

to a donor?

A. Well, I think people reacted to this in very different ways. Blood donors in general tend to be surprisingly sensible people -- perhaps unsurprisingly sensible people, and I think that the majority reaction -- and I have to say it would have been because I don't have personal recollection of donors' reactions to these leaflets and subsequently to the questionnaires, because I didn't routinely work face-to-face with donors. What I can say is that if there had been spectacular reactions, they would have found their way to my desk as the director, and I have no recollection of having to deal with major donor complaints that reached my level about any version of this leaflet or the subsequent sort of questioning process.

Some donors undoubtedly would have accepted that this was entirely sensible. If there was a risk to patients, they didn't want to -- you know, they would accept that and indeed expect it, because, you know, one of the nightmare situations for donors that occasionally happen is they discover that their blood has been responsible for causing an infection. That's usually highly distressing as one would expect.

I think the worry was very specifically about asking people if they were gay and asking them about their sex

lives. And that's good old Scottish prudery, I suppose. But that's what the concerns were about and they were very strongly voiced concerns, strongly felt.

Q. Do you think, Dr McClelland, that the leaflet -- and I suppose for the purpose of the question I'm really thinking of your blue leaflet, the June 1983 one which we saw started to be distributed quite promptly. Do you think that could be described as a leaflet which was intended to be read by some donors and make them change their mind about giving a blood donation?

A. That was its sole purpose.

Q. Yes. I just wanted briefly to glance at what was going on in the DHSS at this time. Can we look at a sequence of papers from the DHSS. First of all [DHF0019913]. it's quite a long minute or memo. If we could go down, please, to get the details of it.

It's redacted but we can see it's dated 20 July 1983 and this person is first of all recording a need to seek ministers' views about distribution of the leaflet. This person thinks it should be sent out with call-up cards. In discussing whether a leaflet should be available at donor sessions or handed out. That's the pick up or hand out dilemma. And then anticipating difficulties for donors if they are already in a session and read a leaflet and feel they shouldn't give blood,

which I can see from a lot of material around this time, Dr McClelland, was a very real concern, that in a sense -- and that's I suppose what Dr Urbaniak was saying -- once a donor walks into a session, it can, I imagine, be very difficult for them if they read something and they think they shouldn't give -- it would be difficult for them to exit again?

A. Extremely difficult. And, you know, one point in this memo which I would entirely agree with is that in the ideal world this information would be delivered to the donor before they attend to donate. That's a direction we have endeavoured to go with, not only this but other types of information over the years; progressively to try and pre-select, for all sorts of reasons including the avoidance of embarrassment at the sessions.

But the unfortunate practicality is that many donors tend to attend donor sessions spontaneously, either for the first time, in which case there is no possibility of us contacting them before, or they may be people who were on our books and have donated previously but they decide that they have time to go to a local donor session and they just turn up. That's the nature of the process.

So it's impossible to anticipate every attendance and send the information to the donor personally, as

I think we will probably come on to. Various attempts were made to deal with this problem of not putting a donor in a mortifying situation at a session, and I guess we will probably come on to that.

Q. Staying with this, there is a short chain of memos. Can we look at [DHF00019914]:

"At our meeting with the Minister of State for Health he was very keen to keep the leaflet operation very low-key."

Someone is missing, someone's memory of the meeting. He says:

"The Minister of State for Health does not want the leaflet to go out with call-up cards. The leaflet is an information leaflet and cannot be seen as a leaflet which you read and then change your mind about giving blood. The Minister of State for Health will be very irritated if we are not able to control distribution the way he wants it. He reacted very unfavourably when this was suggested at the meeting."

It doesn't look as though you had ministerial involvement of this character in Scotland?

A. Well, I certainly was not aware -- if there was ministerial discussion, it didn't reach me. We just got on and did our thing.

Q. And nobody from SHHD was saying that they wanted to

control distribution, for example?

A. No, I'm quite confident that there was never any interference. There may have been a lot of discussion within the SHHD but we were never given any direct or indirect verbal or written instructions not to do what we were doing.

Q. Yes. 9915, please. This comment that I just took you to, that the leaflet cannot be seen as a leaflet which you read and then change your mind about giving blood, seems to have provoked -- I don't think that's too strong a word -- a response with someone else saying:

"I am afraid I cannot accept that the leaflet should not be seen as a leaflet which you read and then change your mind about giving blood. To my mind this is precisely what it is intended for, although the message has had to be slightly obscured for obvious reasons. Clearly we must bow to ministers' wishes on the matter of handling the distribution. I'm not sure ministers have fully understood the pros and cons."

This person is saying:

"I'm convinced sending out a leaflet with call-up cards is the only sensible thing to do."

This is slightly cryptic to those of us who are not totally familiar with descriptions. This is somebody from Med SEB but we can put the matter beyond doubt by

looking at [SGH00026736]. If we look to the bottom of this, this is another DHSS minute from around this time. We can see that the person who seems to have been in room 108 at RSQ is a Dr Oliver. So it looks as though the person who was provoked was Dr Oliver and he was the one who was saying this is precisely what the leaflet is, it is a leaflet to read and change your mind about giving blood.

Perhaps the other thing that's interesting about this Department of Health and Social Security minute or memo is that it's addressed to somebody at the top. It is addressed to a Mr Joyce, but we can see from the bottom, certainly there is a "W", which is presumably the Welsh Office, and then "NI", Northern Ireland. "SSHD", that is Scotland, and Home Office, but there are actually thought to be 26 other people who have to be kept in the loop. I'm not going to make you count them, Dr McClelland. I have counted them. There are 26 people to be kept in the loop which on any view would seem like quite a lot of people?

A. Yes, it's impressive.

THE CHAIRMAN: Did you say it's impressive?

A. Yes.

THE CHAIRMAN: I might think of another word.

A. Yes.

MS DUNLOP: I see it is 11 o'clock, sir.

THE CHAIRMAN: Yes.

(11.00 am)

(Short break)

(11.30 am)

MS DUNLOP: Dr McClelland, before we stopped, we had looked at some of the process that took place in Scotland in the spring and summer of 1983, trying to get a leaflet out, and we had also glanced briefly at what was going on in England with all the different considerations that seem to have featured. I wanted now to move to September 1983 and look at two documents. The first is [SGH0026675]. Since we are ambitious in this regard, we could juxtapose them. The leaflet and the press release, which is [SNF0010416].

I'm not asking that we go to it but just for the record we are now on paragraph 5 of the narrative, which is a UK-wide leaflet produced and distributed from 1 September. So we can see on the left we have the leaflet, which says "National Blood Transfusion Service, 1983", and then the press release. If we can go down slightly further on the press release, I think there is a date, 1 September 1983. Then back up the press release, please:

"An information leaflet, "AIDS and how it concerns

blood donors", has been published today by the Health Departments in the UK for distribution in Scotland by SNBTS."

Then a little bit about AIDS:

"No cases of the disease have been confirmed in Scotland and the Scottish Home and Health Department emphasised today that there is no conclusive proof that the disease can be transmitted in blood or blood products. There is, however, no screening test the BTS can use to detect people with AIDS and donors are asked not to give blood if they think they may have the disease or be at risk from it".

And there is as a reference to self-sufficiency and a reference to the Council of Europe. Then if we can look at the actual leaflet, please, and go to the second page of it, we can see a question and answer format, with which we are now becoming familiar:

"What is AIDS?" "Who is at risk?"

If you go down, and then on the right-hand side, if we could go to the top again, please:

"Has AIDS occurred in the UK?

"Yes.

"Can AIDS be transmitted by transfusion of blood and blood products?

"Almost certainly, yes. There is only the most

remote chance of this happening with ordinary blood transfusions in hospital."

And then a reference to haemophilia:

"Haemophiliacs are more susceptible to AIDS because they need regular injections of a product called Factor VIII. This is made from plasma obtained from many donors. Should just one of the donors be suffering from AIDS, the Factor VIII could transmit the disease."

Then the same precaution is proposed that:

"Until more is known, donors are asked not to give blood if they think they may either have the disease or be at risk from it."

That seems to be a UK-wide initiative, Dr McClelland, launched in September 1983?

A. I'm actually absolutely confused by this document because if you just go back to the previous page, I was under the impression that this actually was not accepted because of the question and answer at the top, and although it was printed, my recollection -- and I think Dr Gillon referred to this in his paper on donor selection -- this version was actually not released because there was a strong objection to this because we actually were going to raise, you know -- maybe my recollection is wrong.

Q. The difficulty I think we have here --

A. I think my recollection is wrong actually.
Q. We will come to look at this. I don't want to get ahead of myself because it is confusing enough. Just to say that in Mrs Thornton's chronology, I suspect there may be one mistake and it may be in relation to this leaflet, because Mrs Thornton's chronology refers to this leaflet and dates it to December 1983, and I suspect that what happens is that when you and Dr Gillon have worked on this, you have taken that from the chronology but it really does look as though it was September and not December, certainly when it is accompanied by a Scottish Office press release.
A. And this is definitely the document that was -- I think my recollection may be wrong.
Q. Perhaps we can come back to this a little bit later.
THE CHAIRMAN: Could I ask one question.
Q. Yes?
THE CHAIRMAN: I know that I'm endlessly fascinated by language but what do you understand by the expression "no conclusive proof", Dr McClelland?
A. I'm not sure that I know the correct word for it but it seems to have an internal contradiction. You have proof or you don't, and proof to me is conclusive.
THE CHAIRMAN: I suppose if someone is asking whether it is established to the level of a mathematical certainty,

you yourself might have some reservations, but conclusive proof is something that worries me a little since without context, it has very little meaning.

A. Yes, I mean, I'm familiar with the problems of degrees of certainty and, you know, probability issues, but conclusive proof seems to me to have, as I say, an internal contradiction between the two words.

MS DUNLOP: I can promise you, sir, that there will be some examination of Koch's postulates in block 2. I'm told they are on this issue.

THE CHAIRMAN: Are there two versions of it: one for politicians and one for the rest of society?

MS DUNLOP: Dr McClelland, you might be relieved to hear we are not going to digress into Koch's postulate but I gather they have something to do with it.

Anyway, that's September 1983. I also wanted just to look briefly at some other press material. That was the press release. If we can look at [DHF0014689]. You can see that actually we are not looking at it to learn about the Brazilian pesticide law but if we scroll down and look at a smaller item on the right-hand side, the little piece headed "AIDS circular":

"The British Government is preparing a leaflet indicating the circumstances where blood donation should be avoided."

THE CHAIRMAN: And the date of this?

MS DUNLOP: Can we go back up to the top, please. We can see 11 August 1983. So that's actually before the official release. That's one piece headed "AIDS circular". Can we look at [DHF0014690]. That's from The Sun on 12 August 1983. Do you think that's the sort of coverage that SHRG were talking about when they referred to press coverage in their press release in May? Particularly perhaps the headline.

A. Oh, yes.

Q. Not very helpful?

A. It is not terrifically constructive, no.

Q. Right. Can we go now, please, to [SNB0143030]? We have looked at this already this week. This is the minutes of the fourth meeting of the UK working party on transfusion-associated hepatitis, and that has taken place on 27 September 1983.

In particular can we go to page 3, please. This is a little passage about the AIDS pamphlet, as it's called here. Different modes of distribution being referred to and then Dr Lane as a fractionator saying he would prefer there to be a kind of standardisation. This is a joke of sorts against fractionators perhaps:

"Dr Mitchell pointed out the problems associated with any infringements of the integrity of the donor."

That perhaps is an illustration, Dr McClelland, of a point of view we referred to earlier, that some directors were very worried about offending donors.

A. Yes, I think, my reading of the middle paragraph on the screen is actually that Dr Lane's concerns were a little different, that he wished to be able to tick all the pharmaceutical regulators' boxes, and they would have a box that said:

"Do you have a standardised donor selection procedure that applies to all the places from which you receive plasma for fractionation?"

That's purely a regulatory issue.

Q. I see. I'm obliged.

Then the next discussion of the leaflets I wanted to go to was [SNB0015188]. We can see, in fact, this is the haemophilia and blood transfusion working group discussions on 14 November 1983, and there is discussion of the leaflet at that. I haven't kept a record of which page:

"Members were asked for their views on the effectiveness of the leaflet which had been prepared by the SNBTS and DHSS. It was felt generally the leaflet had not been particularly useful."

Can you remember if that's what you thought?

A. I was interested to see this. I wasn't present at this

meeting and I don't know on what basis that statement was made or by whom. As I have said before the break, we really did not, at that time, have any objective measures of the usefulness of the leaflet because ultimately that could only be translated into behaviour and the behaviour was something that by definition would be very, very difficult to measure, ie people not coming to give blood.

But this surprised me when I read this again because I hadn't picked up from any, you know, sort of informal sources a sense that the leaflet was not useful. My impression of the general view, was, "Yes, this is something that, you know, needs to be done because this is a serious disease and we don't want people to get it".

Q. Yes. I think the next event to look at, or the next piece of correspondence at least, is probably in relation to 23 December, which is [SNB0143104]. This is you writing to Dr Cash on 23 December 1983.

A. This is helpful. That takes me -- I knew there was a problem with the wording of that leaflet. I think this is probably where we picked it up, where we did something about it, yes.

Q. Right. Rather than what you thought earlier, that you didn't distribute it, it may be that you distributed it

but with reservations?

A. I think that's probably the case. I do know that Dr Gillon made specific reference to this in his general paper on donor selection. It might be helpful to refer back to that at some point.

Q. Yes. You have added some specific references to AIDS on the questionnaire, the new donor questionnaire. You and Dr Boulton have been briefing medical staff. From the first paragraph you think the wording needs to be changed anyway.

I don't want to go to Dr Gillon's paper just at the moment, Dr McClelland, because I think we have enough bits of paper, but there certainly seems to have been an initiative to do some redrafting both in Scotland and in England.

Could we look next at [DHF0015119]? This is Dr Wagstaff in Sheffield and he is writing on 3 January 1984 to the DHSS, talking about feedback on the three months' distribution and saying:

"One or two people expressed a view there should be a revision of content. I know that [blank] the transfusion centre in Edinburgh ..."

It is one of these occasions, Dr McClelland, where perhaps rather satisfyingly one can see that blank is you because your name remains there further down the

letter. It says:

"Hopefully we may have Brian McClelland's draft to consider before then."

So we guess that blank in the transfusion centre in Edinburgh is you. You are presently rewriting the leaflet taking up-to-date views into account. It was your original draft which formed the basis of the present official leaflet and it would be wise to see your new draft. We did look, earlier this week, at a table which was sent from a number of different English centres, and actually featuring Glasgow as well, giving different responses to the leaflets in terms of how many had gone, what any adverse comments or reactions had been. I don't think we need to look at that now.

Can we follow this particular train of thought -- that is the redrafting in England -- a little bit further and look at [SNB0143185]? This is you to Dr Wagstaff on 10 January. You are enclosing a slightly reworded version, "The suggested changes are mine and mine alone". And you say you haven't had the opportunity to discuss it with a number of groups or any of the other numerous groups who appear to be concerned with this problem.

Certainly a lot of people involved in leaflet text

redrafting exercises and so on. Perhaps the proliferation of contributors or commentators wasn't always helpful?

A. It had good and bad points. I mean these things are extremely difficult to write without -- so, you know, extensive scrutiny of the thing actually could be very useful but, you know, the number of people involved risked standing in the way of actually doing anything.

Q. Yes. For a further DHSS perspective, can we look at [DHF0015266]? I think actually doing the same exercise as we did earlier with the identification of Dr Oliver, I think we can actually work out, looking at that memo that has the 26 people on it and all the room numbers, this looks to have come from Dr Diana Walford and she is saying:

"Discussed the need for the current AIDS leaflets."

Then she comments:

"In view of the published evidence of transmissibility of AIDS by blood transfusion, our current advice to donors could seem too lax."

I think that was a concern of yours around about the turn of the year 1983/1984?

A. Yes.

Q. Too lax in what respect?

A. I think it was probably too reassuring. To be honest,

I can't remember the specific concerns. I think I would need the draft in front of me just to prompt my recollection of that.

Q. Right. Well, before we do that, just a slight digression, although it is around the same time, to the NIBSC meeting on 9 February 1984. That's [SGH0010499]. Sorry, that is in fact coming to the redrafting.

I should just say, for the sake of efficiency, that you also attended -- and this is recorded in the narrative at paragraph 9 -- an NIBSC meeting on 9 February 1984 and you explain the three main strategies for minimising the risk of infection:

"Avoidance of high risk donor communities (such as prisons, known homosexual areas etc) (2) detection of clinical abnormalities by examination and careful questioning and (3) exclusion of the high risk donor, or his blood, always allowing an 'escape route' for the donor who is deemed unsuitable."

This looks to be the product of some redrafting. Can we look down to the bottom? That's your initials on the bottom right, isn't it?

A. Yes.

Q. I think we can just make out that it's your initials and then 2/84, so February 1984.

Just to try to follow what happened throughout 1984,

this is the text as at February. Can we look at the next page, please? Again, explaining what AIDS is:

"AIDS may be transmitted by blood."

Then can we go further on? Whose writing is that?

A. I don't know. I don't recognise it, actually.

Q. Right:

"Dr Cash, we are at risk if we do not send out asap."

A. I don't recognise that writing.

Q. Next page, I think, if we can. Then the usual question and answer format:

"What is AIDS, what causes AIDS and is it infectious?"

And then:

"Who is at risk?

"AIDS has occurred mainly in these groups: intravenous drug users, homosexual men, people from Haiti and some areas of Equatorial Africa, people who have had sexual contact with persons at risk in the above groups."

So it looks as though your delineation of the groups at risk is getting perhaps slightly wider?

A. Yes, I think what we were doing here -- I think where we have said AIDS has occurred would have been an attempt to identify the groups where there was actual

epidemiological evidence of transmission. That may or may not in this draft -- I can't remember -- be the same as those who we wished not to donate. There was no logical reason why the groups should be different.

Q. Can we read on, please:

"What are the symptoms?"

Then the next page, please:

"Can AIDS be transmitted by blood transfusion or blood products?

"Probably it can."

There is text about blood transfusion and then haemophilia, which is reasonably familiar from previous drafts. Then:

"How can we reduce the risk?

"Please do not give blood if you have symptoms which occur in patients with AIDS. Please do not give if you are in one of the above groups considered to be at risk."

So a little bit of a step change, perhaps. Then reassurance about there being no risk of getting AIDS from donating blood. I suppose some people at that time were worried about that?

A. Well, that's very interesting actually because we do have objective evidence here from a series of public knowledge and attitude surveys that Mrs Mairi Thornton

commissioned over several years and there was persistent finding in these studies that approximately 25 per cent of the population continued to express in the questionnaire responses the fear that they could get AIDS from giving blood. So there was just that association, AIDS-blood, which dominated over all the other information that we were attempting to put out.

Q. Of course, you don't know what percentage of that group of people might have been blood donors anyway?

A. No, absolutely not. And this was carried out by the Strathclyde market research people and they were taking what they defined as a representative population sample. So we would know that very roughly 5 per cent or so of those people might have been blood donors.

Q. Yes. Going forward to another draft, can we look at [SGF0010150], page 6? This seems to be text from June 1984. Can we perhaps scroll down, please?

A. Can you scroll up again to the top for a moment.

Q. We know, Dr McClelland, from the minutes of the directors' meeting on 12 June 1984, this text was attached to the minutes. So it appeared to us at least to be something that had been current in June 1984.

A. I'm just wondering if this could have been something that was actually intended to be sent out with donor call-up information. I think the content is very much

consistent with the previous document. It is just a rather different format.

Q. Yes. I'm trying to work out what happened in 1984. The next document is slightly odd because I think it is a jumble of different papers but if we look at [SNF0013381]. Actually we have to go to 3385, which is within this bundle but doesn't relate directly to it.

I think it is Mrs Thornton's chronology in fact. This is "Actions taken in Southeast Scotland Blood Transfusion Service to endeavour to make blood transfusion safe". If we look down we can see, firstly where it says "December 1983", the possible misapprehension that we referred to earlier and we see there is actually a question mark at December 1983 but also August 1984:

"SNBTS leaflet "important message to blood donors" published. Received 16/8/84."

So that dates important message to blood donors. Then if we look at [SGF0010932], this is "Important message to blood donors". Can we magnify the little piece on the back, please? It is upside down at the moment. I think all it says actually is 1984. There is nothing else there, I think, doctor, that tells us when in 1984, is there?

A. We were just beginning to realise that there was a thing

called document control at this time.

Q. Right. Well, actually I think we get there because we have got Mrs Thornton's chronology talking about the important message to blood donors in August 1984 and we have got "important message to blood donors". So that would seem to be it. Can we just have a look at the text, please? I think it will be the next page:

"Please read this leaflet to help us keep blood transfusion safe."

Then description of AIDS. Description of groups:

"If you think you might belong to any of these groups, please do not donate blood at present."

And then:

"Please remember there is no risk of getting any of the above illnesses from giving blood."

That's obviously targeted at the sort of misapprehension that you described.

So that's the revision the need for which seems to have been identified towards the end of 1983. This is emerging in August 1984. If we look at [SNB0125017] -- and this is a retrospective view because it is a letter dated 14 December 1990. Can we look at the bottom, please? We can see it's a letter from Professor Cash, national medical and scientific director. Can we flick back to the first page again, please, and look at the

text. Just perhaps as a retrospective look at the whole issue. I should give you a minute to read it. (Pause)

A. I think the first paragraph is a pretty good summary of what we have been discussing actually.

Q. Yes. The third paragraph, a reference to lawyers. In general this looks to be Professor Cash recording a sort of positive sentiment about the fact that the drafting and issuing of leaflets in Scotland has been possible without detailed involvement of SHHD. Is that a reasonable summary?

A. Yes, I think, you know, the implication of what he is saying in the first two paragraphs is that actually the process south of the border was, on occasions, very slow and I think we did break ranks on a few occasions and introduce some changes because we felt it was important to do so.

Q. Yes.

THE CHAIRMAN: This reads as if it is some sort of briefing note to the Scottish chief medical officer, Sir Kenneth as he became.

A. I think it is probably clear if we read on but I think Professor Cash was probably just expressing some concern that, you know, the whole thing was becoming much more sort of, subject to legal scrutiny and there were dangers in having inconsistencies across the

United Kingdom.

MS DUNLOP: Yes, let's look at the second page again, please.

So Professor Cash really hoping perhaps for greater cooperation and more uniformity north and south of the border?

A. Yes, hoping also for a slightly quicker process south of the border which was probably rather optimistic.

Q. Aspirational?

A. Aspirational is the word.

Q. I would like to go back to your statement at this point and the particular page of it is WIT0030044. You were asked question 9:

"The leaflet was revised in 1984 to change the first category of donors who were declined to sexually active homosexual men."

You say:

"The reasons for these changes were put forward in my letter to Dr Cash dated 17 December 1984."

If we have a look at that letter, [SGH0010343], that is your letter to Dr Cash of that date, 17 December 1984, and you are talking about really a further need for change, wanting to state that AIDS is caused by a virus, specifying geographical areas from which residents or visitors shouldn't donate, and then

saying about the line:

"'Sexually active homosexual men' should probably be changed to read 'homosexual or bisexual men'."

The question was: what in particular had led to the change? You perhaps don't completely spell it out in your letter, Dr McClelland, but I wondered if we could just deduce that you were feeling that the text, even as it stood in December 1984, wasn't yet quite clear enough.

A. I think if we were to go back and line up the relevant bits of text in a tabular form, I suspect that what was happening was that the phrasing relating to gay men had probably been a bit diluted and we were trying to perhaps tighten it up again. I really can't remember. You see, we have been going round in circles with this, you can see, because the term "homosexual" has come back again. It later then morphed into men who have sex with men, MSM, which is the current jargon, men who have sex with men.

We have been grappling with this problem all along and I really can't remember, in terms of line 3, what lay behind that change. It looks a bit like tinkering to me, quite honestly, looking at it now. The other two are important because this was reflecting the fact that by this time we had seen the Montagnier and Gallo

evidence, and we were 99 per cent certain it was a virus.

I think I have already touched, before the break, on the question of geographical areas and this is kind of just sort of presaging something that occupied us for years and years and years and is still a problem because there is a huge geographical range of prevalences, and indeed, incidences of HIV, and it is exceedingly difficult to factor those into the donor selection criteria in a way that one feels totally comfortable with, and it is not for want of trying.

Q. Yes. We put to you, Dr McClelland, another newspaper article. This is [DHF0016009], which we could perhaps look at. This is again from around this time. It is actually November 1984?

A. Oh, yes.

Q. Yes, you have seen this?

A. Yes.

Q. And you were asked if you agree with what Dr Seale had said. He is speaking as a former STD consultant at the Middlesex in London. You were asked if you agreed with what he said and you have said you don't agree. Just to let everyone have a look at it. (Pause)

The picture that's painted by this is really that there was no effort to try to identify higher risk

groups 18 months ago -- so that would take us back to the middle of 1983, that seems to be the position being adopted as a basis for critical comment. If we can go back to your statement, your answer at number 10, you do not agree with that. Is that right?

A. No, I really don't agree with that. I mean, the image you have just showed doesn't have the date on it, but I saw a copy that has a date stamp of November. So I assume ...

Q. I think it is on there somewhere?

A. I think that's approximately the date at which the thing was published and my response to that was that the time that elapsed between the very first, as it were, suspicion -- and this emerged at an academic meeting in the middle of 1982 -- that AIDS could occur in patients with haemophilia might reasonably therefore be attributable to transfusion. From that time onwards the first guidance issued by the US public health services was in March, I think --

Q. March 1983, yes?

A. -- 1983, and we had drafted our first donor leaflet in May 1983. We had done numerous drafts by May 1983 and it was out and on the newsstands, as it were, in June or July -- is that right? -- June, I think.

Q. June?

A. June. So I think in terms of, you know, technology transfer, that's actually not bad.

Q. Perhaps the other similarity between the American approach and your initial material from June 1983 would be the terms in which -- and I'm not going to go back to this just now -- the groups were described in your June 1983 leaflet, and you accepted that it was, to an extent, a compromise leaflet. But the reference to multiple partners and so on does appear, if one looks at the American material, very similar to what had been said in March 1983 in America, and you would agree with that?

A. Yes, absolutely. I mean, I think initially, and quite explicitly, we followed slavishly because we had no local data and we did it as quickly as we could and I think actually we delivered pretty quickly. So I just completely reject that comment. I think it is ill-informed.

Q. Another measure that was taken towards the end of 1984 was to ask donors to sign a statement that they were not in a risk group. I wanted to ask you about that. So if we look at question 11:

"Is the introduction of the signing by donors of a statement that they were not in a risk group in response to the discovery of the Edinburgh cohort?"

That is the group of people who were discovered to be positive for HTLV-III, as it was then known, in the autumn of 1984?

A. Correct.

Q. You do say, Dr McClelland, they both happened around November 1983. I think that's just a typo, it should be 1984?

A. Yes.

Q. Can we look in this connection at another letter, [SGF0010908]? This is Professor Cash to all the directors; yes, and Dr Perry?

A. Yes.

Q. He is saying, on 29 November 1984, the leaflet is to be enclosed in every call-up letter sent to the home address of known donors not normally individually called. You had a leaflet at the session and there is to be monitoring. Then if we could go down the letter:

"The health questionnaire. Each donor, prior to blood withdrawal, will be asked to sign a statement which will read:

"I have read the SNBTS AIDS leaflet 'Important message to blood donors' and confirm that, to the best of my knowledge, I'm not in one of the defined transfusion-related risk groups."

So really quite a bit more proactive in terms of

what you were asking donors to do?

A. Yes, absolutely. The question that you asked me was: was this related to the identification of HTLV-III infection in some Edinburgh haemophiliacs? I'm fairly sure it was.

Q. Yes. I should have said, of course, this is the discovery of positive test results in a group of people who have been treated exclusively with NHS product.

A. Well, we worked on the basis that they had been treated exclusively with NHS product. I think it is the subject of another chunk.

Q. Yes, we are coming to that later too.

We have also referred in our narrative -- I don't think it is really necessary to go to this -- to a leaflet from the Terrence Higgins Trust, which you discussed at a directors' meeting on 11 December 1984. The Terrence Higgins Trust were based in London, I think, is that right?

A. Yes, Terrence Higgins was one of the earliest of the deaths from AIDS in London and the Terrence Higgins Trust became a very constructive organisation actually, and I think my recollection is, having revisited their leaflet, that we felt it was in general sensible, useful and you know, we were happy for it to be made available.

Q. Perhaps we should just look at it. It is [SGH0010346]. "AIDS, more facts for gay men", it is called. There are some specific paragraphs of advice and again a question and answer format. Can we turn over, please, and look at the inside? Information about transmission, symptoms, prevalence, advice and also advice to people with haemophilia, towards the end:

"Haemophiliacs requiring further information."

Can we go back to the page before? In bold on what must have been the front of the leaflet it says:

"Until we know more you should not give blood or carry an organ donor card."

It is actually quite succinct and unambiguous.

A. Yes, and in the right place, it is on the front page. This has been, broadly speaking, the position that Terrence Higgins has adopted throughout.

Q. Something obviously, as I said, that you and your fellow directors have looked at?

A. The medical director of the Terrence Higgins Foundation, Dr Nicholas Partridge, was a very constructive member of the expert advisory group on AIDS for some considerable time. So he was fairly, sort of, mainstream.

Q. Which you yourself also joined from its inception?

A. Yes.

Q. Sorry, sir, from now on there is a bit of jumping about

in terms of chronology but just to cover the remaining matters, can we go back to the statement?

We are now at WIT0030044? What led to the flash card. The flash card is actually described in the narrative. It should be at [PEN0010001], page 8, if we can go on to that, please. Yes, there is the reference to the flash card. Actually that comes in 1986 but just to follow your statement through. What was the thinking here, doctor? Was it just that a flash card is even more attention grabbing than a leaflet?

A. I think we were moving -- as I said this morning, we had concerns right from the start that simply having a leaflet available, posting it to people, handing it to them, even asking them if they had read it, we couldn't be confident how much they had internalised.

The flash card was an attempt to move on a little bit from that and this was administered at the time when the donor was actually face-to-face with the member of the donor selection staff. You know, it went with the question, "Have you clocked this?" "Have you read this?" And, you know, "Are you in any of those categories?"

So it was a attempt to be a bit more up front about it and there were, of course, later on, further attempts at introducing sort of questionnaires with tick boxes,

as Dr Gillon has mentioned, experiments with, you know, computerised interviewing of donors which probably would have been the way to go actually.

This was trying to escalate a little bit the attention and give us a bit more confidence that people had at least read and responded to the critical information.

Q. Yes. We discussed the flash card, I think, in your narrative. If we go to page 9 of the right-hand document, please, this is paragraph 16. You were developing the flash card further. Dr Gillon being asked to work on his draft, to get it more succinct. Then question we have asked you, about a reference to withdrawal of leaflets, I think you have explained that that would just be an administrative matter. It wouldn't be that suddenly there would be no leaflets?

A. No, it was a withdrawal to replace with the new edition.

Q. Yes. Then in your narrative, paragraph 20, we notice that there were posters produced by the Blood Transfusion Services. There is the suggestion in January 1985 that posters would be useful. We have only managed to find one undated and unattributed poster but it seems perhaps slightly late to be thinking about posters, or was that just all back to the initial perception about not wanting to cause offence?

A. I don't recall that we actually considered posters and I certainly don't recall that we ever used them. I think we may have felt that posters possibly weren't quite the most appropriate way to deal with this, that something that people could read themselves was --

Q. Rather than marching up to a notice-board and being seen --

A. "Are you gay?"

Q. Yes.

I have referred already to the chronology and we have looked at it. I think we say in our narrative, and this is just repetition for which I apologise, but if we look at paragraph 22, so over the page on the right-hand, we suggested that the September/December 1983 might be a bit of a confusion, and in fact, given the question mark against the December, we have perhaps arrived at what seems the likeliest explanation?

A. I think we have deduced the correct date.

Q. Yes, I hope so. Just one or two other points, Dr McClelland, which arise from your statement. If we could look at [SNB0143110], this is a letter from a Dr Patricia Hewitt.

A. Oh, yes.

Q. And you mention this in your chronology. This is

liaison with the blood transfusion centre in Edgware?

A. Yes. That was a centre that was very proactive and tended to get on and do things. Dr Hewitt was a very able young consultant at this time, and the idea that is reflected in the letter had originated in the United States; they called it "confidential unit exclusion" or "CUE".

It was merely a way to try and provide a donor who had attended a session and suddenly thought, "Whoops, I shouldn't be donating", with a way to escape endorsement. This particular approach to it was to allow the donor to continue to donate but to mark on a questionnaire the fact that he or she did not wish their blood to be used for transfusion. Other variants were "Please use only for research purposes".

But it was to provide a sort of useful escape route. As I recall, our experience with a version of this, which we did implement in Edinburgh, was that we seemed to have an extremely low yield. There were actually very few people who utilised the option. I think we eventually dropped it, actually.

Q. Right. We didn't mention this earlier but one context in which it was presumably very difficult for people was sessions in workplaces?

A. That was a particular example but also communities.

Some community sessions, you know, some of our strongest sessions were, and remain, in small communities in the borders, where everybody knows everybody else and if you suddenly go to the donor session, pick up a leaflet and read it and then walk out, there will be 57 people who will be talking about it in the Women's Institute within the day. So this was a real issue.

Q. Can I ask you also to look at [SNB01143119]? This is from within your own organisation and this is the same sort of idea. You say in your statement that you had, in your pilot donor questionnaire at this time -- and this is 18 January 1985 -- added text:

"If you think there is any reason why your blood should not be used for transfusion, please tick."

We see you have mentioned that:

"If the donor indicates his or her blood is not for transfusion what to do with the lab sheet?"

Can we also go through this, please. If we go to the next page, we can see there is a health check with tick boxes. If we look down, on the next page, please:

"I have read the SNBTS leaflet, 'Important message to blood donors' and consider that I am not in one of the AIDS risk groups."

"If you think there is any reason why your blood should not be used for transfusion, please tick."

So this is you trying to implement that sort of thinking?

A. Yes. And this is obviously a bit of a lash up because we had large quantities of these printed documents and to implement it quickly I think we just had to overprint them or overstick them or something, but this or variants of this declaration by the donor has remained a fixed feature of our procedures from that date onwards.

Q. But you say not a particularly high take-up?

A. Oh, no, no, sorry. There is two elements to this. I have read the leaflet --

Q. Sorry, it was the second --

A. Yes -- and signed. So the second one, my recollection -- I think Dr Gillon would have much more detailed information about this -- we found the yield of that was actually pretty small. I'm sorry, my previous remark was referring to the declaration.

Q. Yes. Sorry, it is my mistake. I think I understood that when you said the yield was low, it was the segregated paragraph that --

A. Yes, that is correct.

Q. -- you were highlighting.

A. I certainly had no doubt that the addition of a signed declaration with, you know, all the donors' details

below it was probably one of the more important measures that we could take to, as it were, concentrate the mind on, "Have I really read this and am I signing for the truth here?"

Again I have no evidence of that but intuitively I feel that was probably one of the more important, you know, developments in this procedure.

Q. Can we go back to your statement, please: WIT0030046? You chart for us some other developments in 1985, 29 January, a memo saying:

"Since the introduction of the opt-out system in December, four donations have been withdrawn."

And asking Mrs Thornton to send the leaflet to those that you didn't routinely call up. What was the difference between donors you routinely called up and other donors?

A. Well, as I said this morning, there were donors who attended spontaneously for the first time or on a repeat occasion, but donors who were registered and whose details were in the system -- which was originally a card based system and then was computerised -- basically all donors, the default was that a donor would be called up at an appropriate interval after their previous donation, the base position was six months, not less than six months. But there were a number of

exceptions to that which would be based on the health information that was obtained at the previous attendance.

So, just to give you one example, if an individual reported that they had travelled to an area of the world where malaria was endemic, then they would automatically be excluded from call-up until at least one year had elapsed and quite a detailed structure of deferral periods related to particular reasons for deferring the donor.

Q. Yes. I think it was just really background. I was interested in a category of people who were obviously, as it were, on your books. You had their names and addresses but you didn't routinely call them up, but you are saying that may be for reasons specific to individuals, or might it just be that they don't turn up very reliably?

A. No, I think that -- I don't recall that (a), there was such a category of people. There may have been -- certainly later there was -- some donors who were sort of held in a kind of special panel, which was basically donors of particular blood groups, where we know from experience that there are unpredictable urgent demands. And rather than calling them routinely and, as it were, inactivating them from a further donation for six

months, we would keep them there for emergencies.

But as I say, the default position was if we had information from a donor and their attendance pattern was such that we had reasonable reason to expect that they would re-attend, they would be called. If they had failed to respond to a specific number of calls, which changed over a time, I guess, then they would be put into a separate category, which was called off-service and we would not continue to call them because clearly there was possibly a problem with the address information or something being incorrect. But we would retain their records so if they did return and present their identification information, we would have all the data and we could reactivate their record.

Q. I think perhaps the only other matter that you refer to in your chronology that we should note at this stage is on the next page, 0047. You say, autumn 1985, a new leaflet, "AIDS information to all blood donors", about information about the commencement of routine HTLV-III testing.

I'm not going to go into that because that too is another topic to which we intend to return but, just in a nutshell, the advent of screening of donated blood called for a new leaflet?

A. It was a step change, obviously, and the particular

issue that was of great concern to us was the donors -- well, first of all there was an extensive debate, which had the correct, in my view, resolution, as to whether donors must be informed of the result, and the answer was, yes, they must be informed of a positive test result. We already knew that that could have very damaging consequences for the donor in terms of very practical issues like life insurance, as well as psychological issues, relationship issues and so on. So it was a big event.

Therefore, we felt it was absolutely essential to say to donors, "You will be tested. If you give blood, you will be tested, you will be given the result," and the implication, if it turns out to be positive, that's a one-way change in your -- it's a step converting from being a healthy person to being a patient.

So we were trying to make sure that donors were aware of the implications of that and if they didn't want to have a test, didn't want to find out, then please don't donate.

We did other practical things to try and divert as many people as possible to the appropriate sort of clinical set-up for testing.

Q. At the end of your statement, Dr McClelland, you have included an extract from Dr Gillon's paper. Just to

clarify -- I think I slightly misunderstood this the first time I read it -- this first leaflet, he says:

"The SEBTS June 1983 leaflet was widely circulated within the UK transfusion services."

But I think what he is meaning by that is he showed it to other directors in other parts of the country, rather than that the southeast leaflet became something distributed to all blood donors across Britain?

A. It was circulated among, if you like, the management of the other services, absolutely.

Q. Yes. I think we can read for ourselves that section from Dr Gillon's paper.

I did want, just in conclusion, Dr McClelland, to ask you a little bit about the shape of, I don't know, should one call it an epidemic in Scotland, the AIDS epidemic?

A. I think it probably ticks the boxes, yes.

Q. Can I ask you to have a look at [SNF0010284], page 13, just to say that this comes from a report of a working group convened by the chief medical officer SHHD, which reported in March 1993. Just to look at these tables, these are statistics to the end of 1991. The first table, obviously, table 3a, is the material organised by the year of first positive specimen and then broken down into different transmission groups.

We can see that consistently -- apart from 1990, but consistently at least until then -- intravenous drug users are the largest transmission group. We can see a column for blood groups. I was also interested in 3b, which gives a breakdown of transmission groups for Greater Glasgow, Lothian and Tayside health boards. At least at that time that shows really quite a difference between, I suppose, Glasgow and Edinburgh, doesn't it?

A. Oh, yes. I think the other thing that one needs to pick up in the top table is the IDU column. These are year of first positive specimen. So what you are actually seeing there is the effect to a very large extent in those years up to the start of testing, page 6, of what was called the "Muirhouse outbreak", which involved, I think -- when initially identified, it was 100 or so people with a history of injecting drug abuse tested and 50 per cent of them were positive, which was a shattering finding, totally unexpected.

So the figures for IDU in Scotland are heavily biased by one rather dramatic, highly localised outbreak in the Muirhouse area of Edinburgh, which has been extensively documented by Dr Roy Robertson and his colleague.

But, in answer to your other point, there are striking differences between the regions in the make-up

of transmission routes.

Q. Plainly, the topic of AIDS in Muirhouse and how infection was transmitted amongst a group of people who were intravenous drug users is another very large topic, and we could spend a lot of time on that. It is perhaps a mistake to try to extract some brief propositions but would it be reasonable to say that that outbreak was predominantly associated with heroin use amongst a group of people who are poor and socially deprived?

A. Absolutely, absolutely.

Q. And perhaps, although this is speculation, not a group of people who would be represented in your group of blood donors?

A. I think highly unlikely that we would have had individuals who were, as it were, active participants in an outbreak presenting as blood donors.

Q. Yes. Thank you very much, Dr McClelland.

A. Thank you.

THE CHAIRMAN: Is Mrs Thornton coming as a witness?

MS DUNLOP: No, sir.

THE CHAIRMAN: No, I didn't think she was.

You have relied very heavily on Mrs Thornton for a lot of this data, I think; it comes through. Are you content that she was the right person to produce the material, Dr McClelland?

A. I'm not sure that I quite understand your question.
THE CHAIRMAN: If I'm going to rely on the evidence, I have to rely on Mrs Thornton and I obviously can't rely on my personal knowledge of her.
A. I would say from my extensive personal knowledge of her, having worked with her for many years, any information provided by her would be highly reliable.
THE CHAIRMAN: Thank you.
Mr Di Rollo?
MR DI ROLLO: Sir, Ms Van der Westhuizen is going to ask the questions in relation to this topic.
Questions by MS VAN DER WESTHUIZEN
MS VAN DER WESTHUIZEN: Just a question about the leaflet that you mentioned was available for distribution in June 1983, the leaflet that you developed.
THE CHAIRMAN: I'm sorry, could you make sure you speak into the microphone.
MS VAN DER WESTHUIZEN: Dr McClelland, in relation to the leaflet that you mentioned was available and was distributed in June 2003 --
A. 1983.
Q. -- June 1983, the area of distribution of that, was that just within Edinburgh and the southeast or was that distributed throughout Scotland?
A. It was, if you like, deployed as part of our operating

processes in the Edinburgh and Southeast Scotland region, which was not entirely restricted to Edinburgh. So the blood donor community, in sessions that our centre was responsible for, utilised the leaflet as part of our processes from June 1983 on. It was provided to, if you like, the management, the directors, my colleagues, of the other centres, both in Scotland -- and I'm sure that all the other centres in England and Wales will have received copies of it by various routes, but it was entirely up to the management of those centres to determine what, if anything, they did with it.

Q. Do you know whether, until the time the national leaflet became available for distribution in September 1983, there were regions in Scotland that were doing nothing then about deterring high risk groups?

A. Well, the documentary evidence that we have seen seems to indicate that one of the Scottish centres had expressed -- the director, I think, is on record as saying he did not feel it should be distributed at sessions. He took the view, which actually has quite lot to commend it from a logical point of view, that really providing information about not giving blood at the time the donor attended the session was too late and it should go out in advance.

I'm really not able to say what was done in relation to distribution of either this leaflet or of the content of it presented in some other form. In the other centres, other than that, as we have heard this morning, the -- we have seen a document from the Glasgow and West of Scotland service which drew attention to the risk groups for HIV. Unfortunately, I cannot give you more detail than that.

Q. Thank you. The decision to use print material in the form of a leaflet, that was based, presumably, on an assumption of literacy. It seems that there was a problem with people either not reading or possibly being incapable of reading or understanding the content of the leaflets and questionnaires that were distributed. Are you aware of what systems, if any, were in place in the various regions, or certainly within your own, to accommodate that issue?

A. The problem is a serious one and we were concerned about all of those issues. And, of course, there is another issue, which is language -- I mean mother tongue. In 1983 I'm pretty confident that we did not at that stage address those issues. I think we were doing something that was really completely new. It doesn't look very revolutionary now but it was quite revolutionary then and, as you have heard, there were considerable

misgivings among many of my colleagues about whether it was actually a good or proper or safe thing to do.

Our concern primarily was, as I say, not so much about literacy in the first instance but basically about whether, by just providing the information, people would read and internalise and critically act on it. That is a hugely challenging problem for any exercise of this kind.

The issues of access, which I think is essentially what you are talking about, access to the information, have been progressively, not just in terms of blood donor leaflets but across the whole of our society, given much more attention and I think are dealt with rather better now than they were in the early 80s.

What we did attempt to do, which may be of interest to you, was quite early on, and I can tell you that it involved the use of a BBC microcomputer, and some may be old enough to remember one of those strange objects. Dr Gillon and I and a psychologist from the Edinburgh University psychology department did establish a prototype computer-based donor interview, which was actually remarkably well received by the donors, even though it was, in those days, pre-mouse; everything was keyboard responses. We sought funding from various research bodies to try and extend that study and

actually evaluate it formally but unfortunately -- I think we were a bit early -- we didn't succeed.

It is an issue that has only really now, in the last two or three years -- the technology has caught up and people are actively interested in using that approach.

Q. In light of your concerns about donors possibly not internalising the content of the material, were any alternatives, such as direct oral sessions, considered in the 1980s?

A. They were. Dr Gillon again will have given details of how this developed, I'm sure, in his evidence or, if not, he will.

Yes, we did move on to introducing -- don't try me for the dates because I'm very bad on dates, but some time probably towards the end of the 1980s, we started the programme of personal donor interviews, initially with new donors, on the logical basis that, once the donor has been through it once, most of the information is actually unlikely to change, although we did later progress to personal interviews with all donors.

That was pioneered in the southeast centre. It was quite a battle to introduce it because it considerably increased the man- and womanpower requirement for our donor sessions and that involved money and change and therefore opposition. So we had quite a fight to do

that.

Q. Thank you, doctor.

A. Thank you.

Q. Thank you, sir.

THE CHAIRMAN: Mr Anderson, it is getting very near to lunchtime and I don't want to rush you.

I think also, Dr McClelland, I might want to look at one or two things myself to see if I want any questions. So I think it might be better to return after lunch.

MR ANDERSON: I'm not going to take up any time because I have no questions.

THE CHAIRMAN: Mr Sheldon?

MR SHELDON: I do have one or two questions.

THE CHAIRMAN: We will have them after lunch.

(12.58 pm)

(The short adjournment)

(2.00 pm)

THE CHAIRMAN: Yes, Mr Sheldon?

MR SHELDON: Thank you, sir.

Questions by MR SHELDON

MR SHELDON: Doctor, I wonder if you would look, again, please, at an extract from the preliminary report. It is [LIT0012486].

This is the passage that I think Ms Dunlop took you to earlier on. A letter provided by Professor Bloom of

the Haemophilia Society, where he says:

"The cause of AIDS is quite unknown and it has not been proven to result from transmission of a specific infective agent in blood products."

I think at that time that was perfectly true, that there was no proof -- no conclusive proof, if you will -- that AIDS was transmitted by means of a virus and transmitted by means of blood products. Is that right?

A. That's correct, it had not fulfilled the Koch's postulates, to hark back to this morning.

Q. Indeed. It was suspected that that might be the case?

A. It was strongly suspected that because of the appearance of the syndrome in a group of people who had none of the predisposing factors and who shared the common factor of having had multi-donor blood products, this was taken as very strong evidence. And in fact by May 1983 there was at least one case, a case reported by one of my colleagues from California, of a child who had been transfused with platelets and developed AIDS, and the platelets had been established to have been donated by an individual who by that time had clinical features of AIDS. So it was looking pretty strong in May 1983.

Q. Professor Bloom is a pretty experienced and at that time fairly eminent haemophilia physician. He is chairman of

the Haemophilia Centre directors; is that right?

A. He was at the time, yes.

Q. And here he is giving advice which you described earlier as extraordinarily reassuring.

A. Perhaps I should have said, in my opinion inappropriately reassuring.

Q. Well, I think that's where I'm going next, that following on from what you said, that there may have been a tendency at that time to issue advice that, certainly with hindsight, looks as if it was too reassuring, that it was unduly reassuring. Do you have any sense of why that was, of why people were seeking to be reassuring, for example, looking at Professor Bloom of the Haemophilia Society?

A. I think there were probably at least two different reasons for people -- one was a sort of general wish to avoid alarm among the public but there was a very specific concern for anyone who had to treat haemophilia patients, or indeed anyone who was a haemophilia patient or was the parent of a haemophilia patient, because the implication of accepting that AIDS could be transmitted by Factor VIII concentrates threatened the continued security of treatment, which really had transformed the lives of these patients.

So there was a huge balancing concern there, that if

you really took seriously the risk of contracting AIDS from Factor VIII treatment, the implication was that that treatment might not be available and one would be sort of seeing this spectre of a return to the era when these patients were crippled and had a frankly dreadful life.

Q. And that concern appears to have gone to the length that the Haemophilia Society lobbied the government to maintain the supply of concentrates from, among other places, the United States. Is that right?

A. That's correct, yes.

Q. I want to turn to a really very different issue and leads from this, that as usual, through 1983 there were SHHD representatives present at the SNBTS meetings. Is that right?

A. Yes. But specifically at the directors' meetings.

Q. Yes, indeed, and I think there would normally be four meetings through the year. Is that right?

A. There were four meetings which were designated directors' meetings and they were interspersed with what I think at that time were called co-ordinating group meetings, which actually involved essentially the same players, and it was actually sometimes difficult to distinguish which business belonged in which box. But as I recall, the department representatives and the

representatives from the UK, from the National Blood Transfusion Service, did not generally attend the co-ordinating group meetings, but I stand to be corrected.

Q. All right. You may not have a specific recollection of this but if you do, please tell me, but I think it was Dr Bell who attended all those meetings in 1983. Do you recall that?

A. Well, certainly Dr Bell was, as I recall, our sort of prime medical contact within the Scottish Home and Health Department at the time. So I imagine, unless there is evidence that he was unable to attend for some reason, he would have been the normal attendee.

Q. I take it that Dr Bell was really your main contact, for example in relation to the AIDS leaflet issued in 1983?

A. Well, he was certainly the person that as the regional director, as opposed to the national director, I would sort of communicate with. Although it was relatively unusual, actually, for me to communicate with him directly. That sort of communication would normally go through Dr Cash, as he then was.

Q. I see. Yes. What did you understand the task of medical officer, such as Dr Bell, to be in relation to health service bodies such as SNBTS?

A. I am not sure that I did understand actually. It's not

an issue that I think I gave a huge amount of thought to. Dr Bell was a very experienced, sensible and, I would say, wise individual. So I think I would be happy to discuss an issue with him and, you know, value the advice I got. But in terms of sort of having a clear understanding of what the role of a medical officer at his level in the department was in any sort of formal sense, I don't think it is a matter I had given very much thought to actually.

Q. I mean, you said that you would be happy to chat to him and value advice that you got from him; what sort of advice would you seek and get from him?

A. Well, I mean, just to be specific, I commented this morning, and it is in the papers somewhere, but as I say -- I don't actually have the reference in my head -- on the specific issue of the AIDS leaflet, I think on this particular occasion it may well have been that Dr Cash was actually away or tied up in a meeting or something like that, but I obviously felt it was appropriate first of all to phone Bert Bell and tell him what we felt we needed to do in relation to developing the AIDS leaflet and deliver it. And that, I think, would have felt quite a natural thing to do. And in doing so I would feel comfortable that (a), I would get his initial reaction as to does this sound

like a completely crazy idea or did it seem a sensible thing to do, and I would also rely on the fact that he would communicate that to appropriate colleagues in the department.

You know, that was a very useful function. As I say, it is one that normally, I think, would have resulted from an interaction between the national director and the medical officer -- the personnel in the department rather than myself as a regional director.

Q. We have heard some evidence, and in particular yesterday, about, as it were, the province or provinces of clinicians on the one hand and SHHD on the other. I think you have talked a little bit about the autonomy of regional directors, the principle of clinical freedom and so on, and I really just want to try to get a feel from you, if that's possible, as to the question of whether there were provinces beyond which you, as a clinician, might not stray and beyond which SHHD advisers might not stray in dealing with clinical issues?

A. Well, I mean, there was one very large and important province which was anything to do with money, which affected a lot of things.

Q. Yes. So clearly funding and perhaps overarching policy issues might be a matter for government. Is that a fair

way of putting it?

A. Well, funding clearly was because, I mean, we had very clear lines of control over, you know, authorisation as it were, for what money could be spent and what couldn't. That operated through the Common Services Agency. But in fact it was not, you know, at all unusual -- and I think Professor Cash would be able to give you much more detail of this -- for discussions to take place directly between the management of the SNBTS, primarily the national director, and the department. I know that from time to time that was a bit of a cause of friction in relationships with the Common Services Agency.

Q. That might perhaps be one example of an area or an example of the demarcation line from your point of view. From the point of view of medical advisers within SHHD and SHHD generally, were there matters on which you would not expect to be being told what to do, getting advice about or whatever?

A. Probably the first specific example -- and it is not separated from the issue of funding -- I think I always accepted, and I think it was generally accepted by the time I became a director in the SNBTS, that a major issue, such as the introduction of the testing for what was then HTLV-III antibody, which was a systemic

national programme which had a high annual cost and which also, one could foresee, once entered into, it would be virtually impossible ever to escape from the cost of running that programme; I think we all -- I mean, I certainly would never have any difficulty in acknowledging that an issue such as that had to be dealt with at quite a high level because this becomes an issue of, you know, choices about the spending of very substantial and recurring quantities of government funds.

It would be completely inappropriate for someone in the position that I was as a medical director to view that as a matter purely of clinical freedom. It is very different from defending the right to give a particular treatment to a particular individual patient.

Q. But should we take it from that answer that there was a graduation in the issues which might arise, between issues which were, for example, at one extreme perhaps, relating to a particular patient, a particular treatment for a particular patient at the most particular, and issues of funding national programmes at the other. That in between there may be issues which involved what might be described as a grey area, I suppose, between what was properly a matter for clinical judgment and what was properly a matter for policy?

A. I'm not sure that "grey area" quite describes it. There were a lot of things that were of no interest, as it were, at a departmental or a policy level. At least they would be of no interest until something happened and they suddenly developed a profile, and then they could transform into being extremely interesting.

I mean, coming back to the issue of the AIDS leaflet. I was aware that, you know, that was potentially quite a sensitive issue in that there were matters that could be of concern to people who took a political view of things with anything that could be seen as introducing a degree of discrimination against some group of the population.

I think, probably because a political interest emerged, and quite a lively political interest, particularly as we have seen south of the border, that became a department issue. There is not any nice easy measuring scale that you could look at and be theoretical and say, "That's one where the department has a role and that's one where it doesn't". You can say unequivocally, anything that involves substantial amounts of money, yes, beyond that I think it would be difficult to generalise and could be somewhat unpredictable.

Q. I want to come back to that in a moment, but do you

recall whether the directors meeting of 29 March 1983, was that the first occasion that the issue of prison donations from prisoners had been raised at a directors' meeting?

A. As far as I know. In terms of the period that I had been attending the meetings with the directors, I don't have a recollection of it being raised before, and I don't think that any of the minutes that I have sort of read indicated that prison donations had been discussed before that.

But, of course, they may well have been discussed because clearly there was, as we know from the other day's evidence, interest, and there were discussions among the transfusion directors in England about this somewhat earlier, considerably earlier. It was a small community. You know, there are only a couple of dozen people in that position in the whole country. So I think it would not be unreasonable to think -- it is quite possible that information would have reached the Scottish transfusion establishment that this matter was being discussed in England but I have absolutely no evidence of it.

Q. Just a couple of particular matters then, if I may.

Could you look, first of all, please, at [PEN0020001]? This is your note or memo about

a telephone conversation with Dr Bell. It is 11 May 1983.

A. Well -- yes.

Q. You say:

"[You] spoke to Dr Bell and informed him of our intention to do the following."

That suggests that you were speaking to Dr Bell really as a courtesy, and this is what you were going to do. Is that right or is that not a correct interpretation of that?

A. There is another slightly fuller memo which I would have sent, I guess, to Dr Cash following this conversation but, yes, basically it was a courtesy. I was informing him that we felt we had to do this and, as I said, I respected his experience and wisdom. If he had said, "Wow, that is going to be a monster problem", I would have taken that seriously, but my clear recollection is -- well, as I said there:

"Dr Bell clearly cannot agree to this as official SSHD policy but he endorsed this as a sensible course of action and said 'get on with it'."

And I was happy with that.

Q. That's what I wanted to ask you briefly about.

Dr Bell says he can't agree to this as official SHHD policy. Did you have a sense of why that was?

A. I didn't really expect him as one individual in, I suppose, the middle ranks, as it were, to be in a position to agree it as a department policy. It never occurred to me that he would do that. But I was fairly clear and it was part of the reason that I chose to have this conversation with him, that as I have already said, if he had felt immediately that there was something hugely problematical about this, he would have said so and I would have taken that seriously.

It's hard to say hypothetically what I would have done. I took this conversation to represent essentially encouragement to get on with it. So we did.

Q. But you were clear that the reason why he couldn't agree to that himself was because he was answering to his, as it were, political masters or masters in the Civil Service?

A. That's I think putting --

Q. Is that putting it too strongly?

A. -- words that I didn't say. I simply said I did not have any expectation that somebody in his position would, you know, endorse this as official government policy.

Q. And if you could look, please, at [SGH0026755], I think this is Dr Bell's memo to Dr McIntyre of 15 June 1983. We can see that it's a report of yesterday's meeting of

the Scottish transfusion directors. Dr Gunson had attended and explained the involvement of DHSS. Perhaps just taking matters short, it is clear, certainly by that stage, that there is quite strong involvement and interest by DHSS in the whole issue. Is that correct?

A. That's what it says in the letter. I wasn't aware of that at this stage at all.

Q. All right. If we could just scroll down, I think it's the third paragraph:

"We will try to ensure that DHSS ..."

This is the end of the third paragraph, I think:

"He, Dr Gunson, will try to ensure that DHSS consult SHHD in good time before there is ministerial involvement in going public on this subject."

Were you aware of that sort of aspect, that Dr Gunson appears to have been liaising with DHSS so as to consult with SHHD?

A. I probably was aware of it. I mean, I certainly was aware that Dr Gunson -- I think by this time he was national -- I can't remember his precise position at this time but my recollection is that he was representing all the National Blood Transfusion Service in his discussions with Scotland and also that he was, in whatever capacity, the senior medic that talked to the department about policy issues for the transfusion.

So it doesn't surprise me that he was in discussions with the Department of Health in London.

Q. The next paragraph goes on to say:

"All the directors ..."

Which I take to mean the transfusion directors:

"... present are now more aware of the complexity of the issues involved, particularly in relation to the views of the homosexual community ..."

And so on. Were the directors in some sense unaware of those complexities, those particular complexities, prior to the meeting?

A. Well, I have to say, first of all I don't have a recollection of this meeting. There is a lot of things 20-odd years ago that I don't remember all that accurately and this is one of them.

Q. Of course.

A. Secondly, I can't really answer for, as it were, the degree of understanding of the complexities of the individual directors. What I can say, because there is plenty of documentary evidence, there were very different attitudes among the directors as to the extent to which they were comfortable about addressing some of these issues of sexual behaviour of volunteer blood donors, but I really couldn't say -- I was very surprised to read this. It did make me wonder if what

was sort of between the lines of this actually was saying, we really didn't understand how complicated this was. If that was the intention, I felt slightly irritated by it because actually we pretty well did understand. Speaking for me and my colleagues, and I can really only speak for myself and the people I had regular discussions with, we were acutely aware of the complexity of the issues.

Q. I'm really just trying to explore with you the extent of the involvement of SHHD at that time and certainly the way in which the SHHD representatives would interact with the directors at a meeting like this.

A. I think the most useful thing I can do is repeat what I said this morning, that my clear recollection is that whatever discussions may have taken place within the department that I actually wasn't party to. I don't have any sense, looking back, that in relation to the issue of the AIDS leaflet specifically, in this period, 1983/84-ish, there was interference, or inhibition, or undue influence or indeed any influence really exerted on what we were endeavouring to do in the Scottish Home and Health Department.

I was very much aware that progress was slower and agreement more difficult to achieve in the National Blood Transfusion Service and its relationships with the

department in England. They obviously were having more difficulty moving ahead with this.

Q. But you didn't feel that that difficulty inhibited the Scottish service in its efforts to produce and distribute --

A. As I say, over this period I can't recall any incidence in which I felt that actions taken or instructions given or even, you know, nods and winks given by the Scottish Home and Health Department personnel, that I was aware of, had forced us to do anything that we didn't feel was appropriate, you know, follow our best judgment as to what we must do in respect of this particular issue.

Q. Thank you, sir, I have nothing further.

Questions by THE CHAIRMAN

THE CHAIRMAN: Dr McClelland, could I ask you first of all a little about the European background. Would you look at [DHF0014550] please? That's a recommendation from the committee of ministers of the Council of Europe on 23 June 1983. Are you familiar with that?

A. Yes.

THE CHAIRMAN: If you look at page 2, I think we can see clearly what the recommendation was at that stage. The general recommendation to take all necessary steps, but the third particular recommendation was to provide all blood donors with information on AIDS so that the risk

groups will refrain from donating blood and a leaflet is appended as an example. And do we see that that was the leaflet from the American Red Cross?

A. That's right.

THE CHAIRMAN: By this stage, of course, as I understand it, you were already following that advice in anticipation.

A. Yes, I can't remember the precise date of this but I think we were certainly going down the same track. I do not recall seeing the American Red Cross leaflet but we may well have seen it at the time. Dr Gunson attended the meetings which prepared the documents that were approved by the Council of Ministers, and he was scrupulous about sharing information that he obtained at those meetings. So it may well be that we actually did receive a copy of that leaflet but I couldn't remember it and I couldn't find it in our files.

THE CHAIRMAN: If I give you just a little bit of additional background information. There was a meeting with the Minister of State, lord Glenarthur, on 6 July, at which the question of a leaflet was discussed. Before that we know that your draft was in circulation quite widely and I would like you to look at a document that refers to that, [SNB00013500]. This is a minute of the English Blood Transfusion Service directors' meeting on 18 May 1983. Is this something you will have seen

before?

A. I have. And I'm not absolutely certain that it is actually a minute, although it says it is because if you look at the top right-hand right-hand corner, "RM" I think is Ruthven Mitchell, and I think this may be a note that was prepared by Dr Mitchell for Dr Cash and his colleagues, because he had attended that meeting on behalf of SNBTS. It doesn't look like a minute from that committee.

THE CHAIRMAN: No, I can see that, looking at it now. But it would indicate that Dr Mitchell had attended this meeting then.

A. Yes.

THE CHAIRMAN: If we look down it a little bit, I think we come to a report on the preparation of a leaflet, maybe on the next page. One of the items, 4, is:

"Publication of an information pamphlet by DHSS on a take-it-if-you-wish basis to be made available to donors."

Then if we go further down, I think we find comments on it about your draft. Go on to the next page, please. Yes, about ten lines down or less:

"Literature had been circulated through the Haemophilia Society newsletter, Edgware were drawing up a simple leaflet which would be ready at the end

of June. Copies of the Edinburgh document on AIDS were distributed and discussed. The general feeling was that the document was useful but that it should be toned down in its content."

Then we go on to see that Dr Gunson's working party were asked to draft a leaflet with some urgency, a simple document. Do you remember seeing this material?

A. Oh, yes, I'm familiar with it.

THE CHAIRMAN: You are familiar with it?

A. Yes.

THE CHAIRMAN: Does this reflect what happened when your draft was circulated widely in England at this time?

A. I can't really give a definitive response to that because I had no direct or reasonably direct feedback from colleagues in the National Blood Transfusion Service as to how they reacted to this particular leaflet.

THE CHAIRMAN: I think we do understand that when a draft did come out from DHSS it was based roughly on yours.

A. I think so, yes. I mean, they were all based more than roughly on the American -- the original drafts which emanated all from the same source. So there is a high degree of commonality, I think.

THE CHAIRMAN: You have gone through, this morning, quite

a lot of material showing the response in Scotland itself. I may have missed it but there is one minute that I would like you to look at. If I have simply missed it out I am sorry for that. It is a document SGF0010156. Try [SNF0010072], if I have given you a wrong reference.

That's a minute, I think, of the SNBTS directors on 13 September 1983. If we look down through that to obviously the next page. I don't have a hard copy of it to help you. "AIDS 4", yes. You see there:

"It was noted that since the last meeting the UK leaflet had been produced and the Minister of Health made statements on the matter, the leaflets were being distributed."

Then we get a note that the method of distribution had been left to the directors and they reported in. Do we see that by this stage, in the North, the leaflets were on display with other publicity leaflets at donor sessions and in plasmapheresis rooms, and it was noted that there had been no reaction to them. In the Northeast the leaflets were available at all mobile and fixed-site sessions. Very little reaction is noted.

Then over the page. The East were displaying them at the clerking desk and anyone requesting information was referred to the medical offer on duty. You weren't

present so Miss Corrie was to ask you, but I think we know from you yourself what the reality was.

In Northern Ireland, Dr McClelland there had not received the leaflets but would be making them available at donor sessions when he got them. Then we have Dr Mitchell reporting that he had incorporated in his health notice, the question:

"Have you heard about AIDS?"

The rest of the stick-on label is quoted. It says that the leaflets were available on request with the medical officer at sessions and:

"Dr Mitchell wished to retain medical confidentiality. He had had one query from Radio Clyde. He was reviewing the success of his approach."

Leaving aside Dr Mitchell's wish, which appears to keep matters in confidence, does it appear that by September there was fairly wide use one way or another of the leaflet?

A. I think there is fairly wide availability.

Q. Does that accord with your recollection?

A. Yes, this is more specific than my recollection, I have to admit.

THE CHAIRMAN: Do you remember at all whether they were put into general circulation in Glasgow and the West of Scotland at this time?

A. I don't know.
THE CHAIRMAN: You don't?
A. I don't know, sir.
THE CHAIRMAN: Really very little else. I think that I have got a note that when the general UK leaflet became available, your particular leaflet in the Edinburgh and the Southeast was withdrawn.
A. Yes, we were, right from the start, very keen and I think all parties were keen to try and have a common document because donors do cross the England/Scotland border and the less confusion for them the better.
THE CHAIRMAN: I think as time went on after that, it was the UK leaflet that was used generally.
A. Oh, yes.
THE CHAIRMAN: In its various developments.
A. I mean there is no question that the AIDS event did trigger a strong move towards convergence and commonality which had not been present before.
THE CHAIRMAN: Thank you very much. I could go on much longer filling in details, Dr McClelland, but I think the story is fairly consistent. So there is little need to do that. Thank you very much indeed.
A. Thank you.
THE CHAIRMAN: Yes Ms Dunlop?
MS DUNLOP: There are no further witnesses for today, sir.

THE CHAIRMAN: Thank you very much. So we come back on Tuesday?

MS DUNLOP: Yes.

(2.48 pm)

(The Inquiry adjourned until Tuesday, 29 March 2011 at 9.30 am)