Wednesday, 27 April 2011

(9.30 am)

DR MARK WINTER (continued)

Questions by MS DUNLOP (continued)

THE CHAIRMAN: Good morning.

MS DUNLOP: Dr Winter, when we finished yesterday, I said that we would be beginning today in 1983. That isn't quite right, it is the tail end of 1982 but I thought I would just ask you when in 1983 you became centre director?

A. On 12 December.

Q. Right. So the very end of 1983. Yes. Right, thank you. That gives us some context.

I thought we would start while we are fresh, with Koch's Postulates, and perhaps if we could look firstly at a page in the preliminary report, which is page 5 of [LIT0012479] or page 190 in the hard copy.

The part I wanted to look at is actually in footnote 16:

"There were further significant reports from the United States of America in the MMWR of 10 December 1982. The three haemophiliacs referred to in the July publication had died. Children with haemophilia must now be considered at risk. The illness may pose a significant risk for patients with

haemophilia.

"At pages 652 to 4, the same edition reported that a 20-month old infant appeared to have developed the syndrome after transfusions which had included platelets from a male subsequently found to have AIDS. It is commented that these reports raise serious questions about the possible transmission of AIDS through blood and blood products."

In fact that reference doesn't include the second part of the quote. So to look at pages 652 to 654, we need to go to [SGH0085105]. That is the publication, and in particular if we could look at 5108, and this is it:

"Possible transfusion-associated Acquired Immunodeficiency Syndrome, California."

Obviously this is going into that episode in greater detail than our footnote:

"... a 20-month old infant from the San Francisco area who developed unexplained cellular immuno-deficiency and opportunistic infection. This occurred after multiple transfusions, including a transfusion of platelets derived from the blood of a male subsequently found to have ... (AIDS)."

Perhaps just to give everybody a chance to look at some of that. Then can we go on to the next page,

please? So this is a baby, and perhaps in particular one should highlight that paragraph beginning:

"Investigation of the blood products received by the infant during his first month of life has revealed that one of the 19 donors was subsequently reported to have AIDS.

"He was in apparently in good health when he donated blood on March 10, 1981. Platelets derived from his blood were given to the infant on March 11 and then eight months later, he, the donor, developed symptoms."

In fact he ended up with pneumocystis pneumonia. The editorial note points out at the end of the first paragraph that:

"If the infant's illness described in this report is AIDS, its occurrence following receipt of blood products from a known AIDS case adds support to the infectious agent hypothesis."

Perhaps we should just look at the next page as well. The very last part:

"This report and continuing reports of AIDS among persons with haemophilia A raise serious questions about the possible transmission of AIDS through blood and blood products. The Assistant Secretary for Health is convening an advisory committee ..."

Can we go on next, please, to the statement you

provided for this Inquiry, which is [PEN0150292] but at 297. Dr Winter, you mentioned Koch's Postulates to us and we asked if you could -- and I appreciate this is actually looking at a different issue, question 1.14 that we can see there, but if we can perhaps decouple the first part about something Kenneth Clarke said in November 1983, and we will be coming to that, but all I wanted you to talk about at the moment, please, is Koch's Postulates and you have set out an explanation there but perhaps you could just explain it to us here today.

THE CHAIRMAN: I think you are expected to do it briefly and succinctly.

MS DUNLOP: For those of us who are not familiar with Koch's Postulates, they were mentioned in our first block of hearings but the basic thrust of the idea of Koch's Postulates if you could, please.

A. You sent me correspondence from The Journal of Thrombosis and Haemostasis, quite recently published, last year, the reminiscences of Dr Bruce Evatt, and I just wanted to point out in the response to that correspondence that one of the doctors responding makes the same point that I do, that at this stage of the epidemic, prior to this, the aetiology of the disease remained unknown because the Koch's Postulates had not

been fulfilled.

Q. We are going to come on to that as well.

A. It is not only I that speaks of Koch's Postulates. Koch, I believe, was a 19th century German physician who set out criteria to prove that an infectious condition was the cause of a particular illness when transmitted from one person to another. So if you were trying to prove, as at this time, that AIDS was a transmissible agent, and if you were relating that to Koch's Postulates, you would have to have a situation where somebody had acquired the disease of AIDS with all its characteristic clinical features, and ideally -- let's talk about blood tests in a minute, but certainly they had the characteristic clinical features -- that it could be traced and proven that they had had, in the case of blood, some form of blood transfusion or blood product given from a blood donor who either at that time or subsequently proved to have the same clinical condition.

As I say, ideally that would be accompanied by stronger evidence in the format of a definable and detectable virus. But that essentially is how Koch's Postulates would relate to this particular situation. Here was a situation where a recipient of blood had developed AIDS and it could be traced that one of the

blood -- or in this case platelets, I think -- concentrates that they had received had come from a blood donor who had subsequently developed that selfsame condition.

So from that point of view, because you had the three parts of the equation -- the donor, the recipient and the blood transfusion -- it could have been said to have fulfilled Koch's Postulates.

Q. Yes.

THE CHAIRMAN: So Koch's Postulates demands a series of particular propositions to be established positively. Does it require the exclusion of alternative explanations?

A. Not as originally set out. I believe it is really just establishing that link, from one person to another person via another medium that can be traced to have had that agent.

THE CHAIRMAN: So it is a level of probability established by the positive factors?

A. Yes.

MS DUNLOP: The first thing about Koch's Postulates which might strike a layperson, Dr Winter, is whether doctors would ever take action even if not all three of the links in the chain have been established. So if we think of the three links in the chain, and I'm looking

at how you have set it out in fact in the context of AIDS in your answer 1.14, which we have in front of us; the three links in the chain are: one, that a blood donor who had contributed to a batch of concentrate had either developed AIDS or been shown to be HIV positive; two, that HIV had been identified in the suspected batch; and three, that the patient had developed AIDS or been shown to have HIV.

If we think of this report about the infant, would it be the case that propositions one and three were satisfied by that episode?

A. Well, it would because the virus at that stage had not been discovered and there was no blood test.

Q. Yes.

A. But if I can make some other comments around this whole situation, if I may at this time.

Q. Yes.

A. Because, as one looks back at the whole epidemic of AIDS infection in people with haemophilia, it seems to me that there are three or four absolutely critical times and here was one of them. As we were discussing previously, by, shall we say, the early autumn of 1982 British doctors had doubts as to whether AIDS could be transmitted by blood products. There were a small number of cases, there were no German cases, there were

no British cases, there were other theories as to the aetiology of AIDS. American doctors, we know, from the statements of MASAC, the Medical Advisory Panel of the National Haemophilia Association, we know that they had major doubts because of the rather inconclusive recommendations that they made at that time, and that is also set out in the correspondence of Dr Bruce Evatt, who clearly documents the disagreement among American doctors.

So shall we say September 1982 there is uncertainty. There is this very small number of cases. We don't have an agent. What does it mean? There are other theories. Most of the patients are gay.

By December 1982 that theory is no longer tenable because you have now ten patients with haemophilia but most particularly you have this case. Any clinician looking at this data would have to believe that AIDS was a transmissible disorder and that it could be transmitted by blood and blood products. It was the only clinical interpretation of the data that was available. There was no other way that this child could have acquired this very unusual condition; very unusual for a baby to have these series of opportunistic infections. So it was very highly likely that it must be AIDS and must have been caused by the blood

transfusion from the donor who subsequently developed AIDS.

So here is a really critical moment. Doctors everywhere now have to believe that AIDS is a transmissible disorder. In America that leads them on to, as haemophilia doctors, just trying to decide how to cope with it in a country where they have commercial concentrate.

In Britain, as we shall doubtless see in great detail, the theme changed. Doctors said, if you like, it really does look as if this is an infectious disorder transmitted by blood, transmitted by commercial concentrate, but maybe this virus, if that's what it is, might not be present in British concentrate. So that became the major dynamic for British haemophilia treaters from that moment in time: an acceptance that it was a transmissible disorder, presumably a virus, and it was in commercial concentrate.

Would it prove to be in British concentrate? There was immediately a major split, as we shall see, between some haemophilia treaters in Britain who thought, as the patients did, as we heard in previous evidence, that British blood was essentially likely to be very safe of viruses and that British Factor VIII was extremely unlikely to transmit this disorder, and there were other

doctors who were really greatly concerned, given the vulnerability of the concentrate system, with 20,000 donors, that maybe this virus could be present also in the British blood supply, albeit to a minor degree.

This was a very major time and I'm sure we shall discuss this in more detail in due course.

Q. Yes. Thank you, doctor Dr Winter.

The next publication I wanted to ask you to look at it actually a cutting from The Observer. That's [DHF0017108]. There is a document that goes with it, which is [DHF0017111]. If we look at The Observer first.

This is 16 January 1983 and it's from a reporter in Washington:

"Commercial blood product imported into Britain from the United States, may pose a grave threat to the health of haemophiliacs who inject it to encourage clotting."

Then saying:

"It has been linked in America with a devastating and mystifying disease previously associated with homosexuals, which causes a serious breakdown in the body's immunity system. Officials at the CDC have described the spread of the disease as an impending epidemic among haemophiliacs."

Then some more discussion about what has been

happening, the fact that 50 to 60 per cent of Factor VIII in Britain is from the United States. Then looking at the column on the right:

"In the past ten months the disease has spread from the homosexual community to include haemophiliacs, Asian immigrants, drug abusers, a handful of heterosexuals and some children. The cause remains baffling. One theory is that an infection agent is transmitted directly, either sexually or through contaminated blood products, in a similar manner to Hepatitis B."

Then there is a highlighted passage, which I'll just read out:

"Although no cases of AIDS have been reported from British haemophiliacs, the deaths of at least ten American haemophiliacs, are now known to be caused by the disease following a survey of nearly 6,000 haemophiliacs."

Then there is a quote at the end from Dr Peter Kernoff, who I think is another very well-known name in the treatment of haemophilia in Britain:

"'Assessing the risk is not a straightforward matter. We need much more hard evidence', he said, 'Factorate VIII is a very valuable product and the advantages far outweigh the disadvantages'."

That found its way to the desk of somebody in the

Department of Health and Social Security, and if we look at the other document, [DHF0017111], we can see that on 18 January there is an internal communication about The Observer article. Somebody has confirmed that:

"... the value to severe haemophiliacs of clotting Factors VIII and IX far outweigh the possible and as yet unproven hazards of the transmission of Acquired Immunodeficiency Syndrome."

There is a reference at the end of that to a draft. I'm not quite sure what the draft was but somebody had obviously drafted something and was wondering if they needed to change it.

So the first thing perhaps I should record, sir, is that we have asked for the names of the people in this memo. We have asked for the blank in the first line and we have asked for the signatory, but we were then asked in turn to explain why it was we wanted to know and that's the way matters rest.

THE CHAIRMAN: I think that I can help you by saying that these names seem to me to be very important, having regard to Dr Winter's evidence generally and the significance of this period in the development of knowledge and of policy and response to knowledge. To know precisely who had confirmed the value of clotting factors in this relative way and to find out who was

passing the information on seems to me to be of vital importance.

MS DUNLOP: Yes, thank you, sir. The position obviously may change. We have tried to explain why it is we are asking but at the moment I'm not able to say who it is.

THE CHAIRMAN: I have no wish to ask for all of the redactions to be reversed and we know that there has been a change of policy since these documents were originally prepared for Freedom of Information Act purposes. However, where a document clearly has a significant part to play in the developing history, we ought to get the names.

MS DUNLOP: Yes.

THE CHAIRMAN: I hope that assists in your efforts.

MS DUNLOP: Thank you, sir.

Dr Winter, I don't think I really need to ask you very much about this. Perhaps save to say that it doesn't look as though much is changing within the Department of Health, at least in response to all the information that's coming in.

A. I think Dr Kernoff's comments exactly encompass what I was trying to get across to you and the situation at this time. He is a very respected figure looking at this data saying it is of concern, but we are talking about a product which has revolutionised the lives of

patients and there is major obvious benefit to this treatment. We will have to look at the risk that appears to be evolving. That was the situation of the day.

Q. So back to the balance of which we spoke yesterday.

The next document I would like to put to you is an article from Science, which I think is an American publication rather than a British publication, but it is dated 21 January 1983, and the reference for it is [LIT0011589]. This concerns a workshop which had taken place on 4 January 1983 in Atlanta. The main topic of discussion had been the possibility that the disease -- and this is the first paragraph:

"... might be spread in blood and blood products."

You know about this gathering, I think, Dr Winter, do you not?

A. No, I was not aware of this.

Q. Oh, right.

A. I think it was one of a series of meetings that CDC held around this time.

Q. Right. CDC had recently reported that:

"Haemophiliacs are at high risk of contracting AIDS. Bruce Evatt told the workshop that AIDS was the second leading cause of death for haemophiliacs in 1982, even though the disease was first discovered in haemophiliacs

in the summer of that year ... Eight other people who had none of the other known risk factors had died from AIDS compared to 40 who died of bleeding."

James Curran says:

"The sense of urgency is greatest for haemophiliacs. The risk for others who receive blood products now appears small but is unknown."

Then there is a reference in the next paragraph to the case that we looked at about the infant who had contracted AIDS. From the middle column, perhaps if we could go up a little bit, we can see:

"The workshop participants easily reached agreement on some measures."

But looking further down the middle column to the last full paragraph:

"The seriousness of the threat of AIDS transmission and what, if anything, ought to be done in the current state of uncertainty, remained thorny issues for the workshop participants. Not everyone agrees with the conclusion accepted by CDC officials and many other investigators that AIDS is caused by an infectious agent, presumably a virus, which could contaminate blood products."

I suppose because he is American, it is Louis Aledort, is it?

A. Yes. He was director of the centre in New York.
Q. Right. And he is the medical director the National Haemophilia Foundation as well. He says:

"It is too easily concluded that there is a transmissible agent. I cannot rule it out but the data are not there yet."

Then he goes on to say:

"Aledort favours the idea that haemophiliacs, because they are exposed to a great number of foreign antigens, experience a high degree of antigenic stimulation that effectively wears out their immune systems."

Dr Winter, I think we all understand, from having read a lot of the material from this period, that that was, in a sense, a competing theory, but it doesn't appear to be particularly reassuring because even if that were right, it is still causing a very serious illness in people with haemophilia. Is that not the case?
A. Yes, I mean, I think it is valid to stress that there was this alternative theory. You know, the commonest theory, we spoke about previously, was that the gay patients had immune function that was defective because of some lifestyle-related factor and maybe that's why haemophiliacs were getting this disease as well, because

there had been previous evidence, and I think Professor Ludlam has published on this, that you could demonstrate that the immune function of patients with haemophilia was not completely normal. Presumably it was thought because of the many, many proteins that their immune system was being exposed to through the use of concentrates. So there was this alternative theory, which was much in vogue at the time in the months leading up to the discovery of the virus by the French team.

There was talk, therefore, if you followed that alternative theory, that maybe the manufacturers ought to look at making the Factor VIII more pure, and for several years from this point there was great talk about the type of purity of coagulation factor concentrates.

Indeed, the concentrates being used at this time were then traditionally described as being intermediate purity. That's to say, they had plenty of Factor VIII and Factor IX but they also had quite a significant number of other proteins, and discussions would then take place from this time about whether the manufacturers ought to be making concentrates of high purity, which consisted more or less exclusively of Factor VIII and Factor IX. Very eventually these concentrates were produced. But for those doctors who

believed in the alternative theory of immune suppression, that was the logical way forward, to look to purify the concentrates.

THE CHAIRMAN: Dr Winter, one of the things that has concerned me here is how to approach these competing theories once it had become clear that children had been affected. If one takes the thesis that Dr Ludlam had developed, which did take progressive deterioration of the immune system after long periods of exposure as one of its central planks, one can see, I think, the argument in the case of haemophiliac patients who had been treated over a long period of time.

But once one had an child, particularly as young as the children referred to in the American literature, it doesn't seem that that explanation has quite the same strength. Can you tell me how this information about the child was disseminated at the time and whether it did make an impact. I can see that looking back in retrospect you might say that it should have done but can you tell me whether it did make the impact at the time that it might have?

A. Well, I think that, as I have stated, my recollection is that it did have a very significant impact because it did so much to move the aetiologies towards that of a transmissible agent. So from that point of view it

was a very seminal case and hugely influenced, I think, the way that haemophilia clinicians in Britain and the US were thinking.

I mean, there had been data about immune function not being normal in patients with haemophilia but the way in which these tests are done are quite research-based. They are quite complex. The methodology is open to interpretation. So I think that there was quite a good deal of discussion in any case about what the implications of these in vitro findings might be.

Yes, you could demonstrate in a laboratory test tube that the white blood cells of people with haemophilia didn't respond very well to stimulants, but was that in any case relevant to what was happening in vivo. I think the data, such as it was, about perturbed immune function seemed to be related to those patients who had been most heavily treated. I'm not sure that that data was ever done on children, and in any case the methodology was complex and research-based and there was some reservation about what the data actually might mean.

THE CHAIRMAN: Yes. On any view, the data about the homosexual community involving cytomegalovirus, Epstein-Barr virus and all the other factors that might

cause a deterioration in the immune system, would be different in the case of haemophilia patients.

A. The comparison is between doing these tests on haemophilia patients who were completely well and healthy and finding that these in vitro tests were not completely normal as compared with a control population. Obviously, the first tranche of AIDS patients, the immune function was much more profound than that, and it was so profound that they had then gone on to develop this new clinical syndrome and these very characteristic clinical illnesses like pneumocystis and Kaposi's sarcoma.

THE CHAIRMAN: Yes, thank you. It is a difficult area and I'm going to have to be very careful about how I eventually form views about the contemporary situation.

A. Yes, but I stress, to me this was a highly critical time and any regulatory body looking at this data should have been saying, "We must believe that blood can transmit this disorder," and they should have therefore been really looking very hard at their practices from this moment in time to see whether the blood or blood product that they were producing might be transmitting the disorder.

MS DUNLOP: Just to finish looking at the article,

Dr Winter, can we perhaps move to the next page. The writer says:

"Meanwhile, haemophiliacs who need clotting factor face an uneasy situation."

There is a reference to Dr Oscar Ratnoff and his proposal about using cryo instead of concentrate; pointing out that cryo might not be potent enough for some patients, and then a suggestion from the Haemophilia Foundation that new patients be given cryo as long as possible.

So it does look, Dr Winter, as though, within the haemophilia clinician community in the United States, there was a considerable divergence of view. We have looked at what Dr Aledort was saying, and here is someone else presumably taking a slightly different line?

A. Yes, and also Dr Evatt says that in his published correspondence. Dr Ratnoff was a particularly interesting figure. He was a very important figure in the history of coagulation research and he was, I think, to my knowledge, the only American clinician who made this decision that he was not going to use any more concentrate from this period of time -- and he was criticised significantly by his colleagues -- and for all the reasons we have discussed previously: that was

the patients weren't very happy about going back to cryoprecipitate because it meant going back into hospital. But when the AIDS blood test was eventually developed and introduced, in his centre there were remarkably few people who had HIV. So you could construct a view that he was remarkably astute in making that change, even though it had practical implications.

Q. Yes. Just before we finish referring to the gathering in America on 4 January 1983, can we look at Douglas Starr's account. This is page 268 of the Douglas Starr book, Blood, and the reference for that is [LIT0012936] at page 2938. It is rather vivid, Dr Winter, to read from that paragraph beginning:

"Throughout the fall of 1982, Evatt and his colleagues embarked on a campaign to warn the nation's medical establishment. The CDC was undergoing budgetary cutbacks so Evatt used his own money for the travel ... received mixed responses."

Then on the following page, we see a reference to Dr Aledort and his reluctance to abandon concentrate therapy. And then others in the National Haemophilia Foundation could not ignore Evatt's findings. It comes across, Dr Winter, that Dr Evatt is a really key figure in the American part of the story. He had a background, before he went into CDC, in haemophilia care as well,

did he?

A. I believe he did, but anyway he is, you know, a heroic figure in this epidemic because he is the one who has identified, through requests for pentamidine, that haemophilia patients were getting pneumocystis and therefore were getting AIDS, and here he is working for an organisation that does not have a mandate to provide clinical advice. Clinical advice in the US for haemophilia patients comes from MASAC. So here he is, gone off on a campaign to try and persuade the doctors of MASAC to consider that they might be on the edge of a major epidemic and this is the response that he is getting.

Q. Yes. Then perhaps also worthy of note:

"Ironically, the most cooperative early response came from the profit-oriented drug companies, although some would later try to stall. Tom Drees, president of Alpha at the time, said he was knocked off his chair when Evatt addressed a group of fractionators."

Then perhaps, as lawyers, certainly we would be able to think of this ourselves, that:

"The companies did not react solely out of altruism. Living in the worlds of medicine regulation, public relations and the law, they recognised certain hard, even cynical realities."

There are some fairly clear reflections from that source. If we look on to the next page it says that:

"A Cutter official concluded that Cutter should agree ..."

And this is to exclude higher risk donors:

"... for political, moral and liability reasons."

Then, page 270, there is a day-long session at CDC on 4 January:

"Evatt laid out his most recent data."

Then a description of what happened on 271, that Evatt thought that they had presented a complete package. They thought it was a no-brainer but that turned out not to be an accurate perception.

We can all read this for ourselves but there is also mention of Dr Ratnoff on 272. Quite a full account, up to page 274, of the events at that particular meeting.

You yourself mention an editorial in the New England Journal, which I gather is a very prestigious medical publication. Would that be correct?

A. I think you could probably argue it is the most prestigious.

Q. This is the editorial that appeared on January 13, [LIT0010040]. Most of the data summarised in the editorial is material with which we are now more familiar. I really just wanted to ask you, Dr Winter,

about what's said towards the end, on the next page; so on 0041. If we go down towards the bottom, this is Jane Desforges. Do you know who she was?

A. She was an American clinician of the time, I believe.

Q. Right. I'm just interested in that pair of sentences at the end of the penultimate paragraph:

"The present programme has been extremely successful and been given up by physicians and patients only with great reluctance. Yet it is time to consider doing so even though we may not have enough evidence to demand such a radical change."

In some ways, Dr Winter, the second sentence is slightly puzzling. I think perhaps one needs to know where the emphasis is meant to go but, even though we may not have enough evidence to demand, we should consider changing treatment. If you didn't have enough evidence, why would you change course?

A. I think she is just setting out theoretical options, isn't she, as to how to respond to the data that they have. They can either bash on as they are or they can consider a switch, but in terms of practicalities, she herself says, you know -- and I previously set out to you -- it wasn't practical to give people cryoprecipitate at home because of the requirement for freezing.

Another major factor was that there was only a limited supply of cryoprecipitate and, as we shall see, when there were suggestions that we might move back to cryoprecipitate in England, the blood transfusion companies or the blood transfusion services very quickly said to us, "We just don't have the supply". So those were the two particular problems about a potential response to this crisis by moving back to cryoprecipitate. You couldn't use it at home realistically and there wasn't enough of it in any case.

Q. I wondered perhaps if the key word is "demand". She is really saying that it is something that one should consider but it's not so clearcut that one could demand the change of course. I don't know, we would really need to ask her, I suppose.

THE CHAIRMAN: Was Jane Desforgess a haemophilia clinician?

A. I believe she was. I don't, I have to say, recall her but I assume she must be a haemophilia treater.

THE CHAIRMAN: I suppose it is possible that at this time different specialists would have different emphases in their analysis of the problem. Were the haemophilia clinicians particular in having to have regard to the benefits associated with factor concentrate use? Or was that recognised more generally?

A. Sorry, can I just ask you to repeat the last part?

THE CHAIRMAN: Yes. Were the haemophilia clinicians particular in having special regard to the implications for patients of giving up factor concentrate treatment or was that recognised more generally across the medical profession?

A. I think these matters were really solely in the province of haemophilia treaters. It is such a specialised disorder that even other haematologists would probably -- actually might not even have been aware of these developments. Medicine is so specialised these days.

So, no, as editorials would have been commissioned by the journal, it must be the case, I'm sure, that Dr Desforgess was a haemophilia treater because it would have been very strange if they had commissioned an editorial from a doctor who was not a haemophilia treater.

THE CHAIRMAN: You see, on one view of some of the documentary material from around this period, one might form the view that there was particular resistance on the part of some, at least, of the haemophilia clinicians in this country to take on board the implications of the American experience, in particular because of the advantages that had been experienced in using concentrates. So they were perhaps resisting

responding to the science that was emerging.

A. I think, as I set out in my evidence, that was the case. The initial -- if you like, the clinicians didn't want to believe any of this data, because we have just been through such a very major advancement in healthcare. So that would have been the mindset originally and then they are looking at this American data and the next thing is, okay, these patients -- they are a very small number and there were no British ones and there were no German ones, so I'm just going to keep on looking at the situation, and now you have a situation, December 1982/January 1983, I can't ignore this any more. These patients must have a disorder that's caused by blood transfusion in the forms of the concentrates. So maybe in Britain things will be fine if we now just switch or do all we can to use British concentrate.

In America it was the same, as we have already seen from Evatt's correspondence, Aledort's correspondence, the MASAC recommendations: the clinicians didn't want to believe it, the commercial companies didn't want to believe it, the blood transfusion services didn't want to believe it because they were particularly sensitive about excluding certain risk groups as donors. There were lots of political issues around that. So none of

the related agencies wanted to know this. That's why, if you like, I'm sure, this data took some time to really hit home.

THE CHAIRMAN: On one view, thinking that the United Kingdom position might be different could be said to reflect wishful thinking since the supply of concentrates depended on importation from America, and one might say in retrospect that the potential for risk associated with collection practices in America had to be the same when the blood product was used here or in Germany as it was in America.

A. Yes, remember, this is a group of doctors who several years previously had made representation to the DOH along the lines of the World in Action documentary, along the lines of saying, "As a country, we shall not be importing blood from commercial sources, let alone the cost of it, it is the safety of it".

So deeply engrained in the psyche of haemophilia clinicians, as in the patients, as we have discussed, was this concept that British blood was likely to be much freer from viruses than American blood. So here we were in 1982, we already knew about the hepatitis, we already knew about the increased risk from commercial donors. Here was now what looked like a transmissible disease that also appeared to be occurring in these same

unsavoury American blood donors. This reaffirmed the view that these things weren't likely to happen in British blood donors.

THE CHAIRMAN: Perhaps a strange view of these unsavoury donors, as you refer to them, that they were confined to people resident in America and excluded people visiting America from this country.

A. This theory was wrong, of course. All the things that those group of British doctors were saying proved to be incorrect, as we shall see.

THE CHAIRMAN: Thank you. I think the only one thing that I would ask generally at this stage is that we try very carefully to distinguish what would have been understood at the time from what can be seen in retrospect. This is an area in which it could be very, very dangerous to allow hindsight to dictate the formation of views.

A. I think that's why it is so helpful to see these documents, because everything that I have said to you, the other clinicians who you are demonstrating in these documents, the other groups, they are all making the same sentiment, aren't they? They are all saying, "Yes, we are looking at this data very hard. We don't know what it exactly means, we are concerned about it, but we couldn't possibly change our practice because look at all the benefits of the new treatment." All of these

articles are saying the same thing, whether they are American or British, and that was exactly what was happening at that time.

THE CHAIRMAN: Thank you. Yes.

MS DUNLOP: Dr Winter, just before we leave the United States for just now, there was another article I wanted to mention briefly in the Annals of Internal Medicine. Where does it stand as a publication?

A. Rather more in the Championship than the Premier League.

Q. Right, thank you.

THE CHAIRMAN: You might have to explain that to me. I'm not a football fan.

A. Not quite of the same rank as the New England Journal. It is also an American publication, related, as its name suggests, to general medical science.

MS DUNLOP: Does it tend to be read in this country? Perhaps I should ask: in the 1980s would it tend to have been looked at in this country?

A. Yes, the post-graduate centres in Britain would be sure to stock that on their shelves.

Q. There is an article from March 1983 and its reference is [LIT0010047]. This seems to be a reasonably full summary as at that time of the nature of the difficulty, starting, as most accounts start, in June 1981.

Then we can see that that issue actually contained

a further six articles, which the writer says lend further support to the transmissible agent hypothesis, and talking a bit more about clotting factor concentrates.

It is interesting to see that the figures given there are really getting very large. We can see on the screen, about ten lines up, that:

"Each lot contains material pooled from 2,500 to 22,500 individual donations and contains approximately 500,000 U of anti-haemophilic factor. The average patient with severe haemophilia needs 30,000 to 50,000 U/yr, which is obtained from five to ten separate lots."

Actually, if you do the arithmetic on this, their statement that a person with severe haemophilia is potentially exposed to tens of thousands of donors per year, in fact even on these figures it could be hundreds of thousands for some people, which is really quite a dramatic exposure to all the different problems that might come from receiving products made from the blood of other people.

Then, if we look at the following page, I think perhaps just to record that this editorial also mentions what I think you have already agreed was a very significant development -- this is at the bottom of the left-hand column; that is, the transmission in the

infant:

"Patients receiving blood products, those with haemophilia, will continue to be at highest risk. However, one case has been reported in an infant."

Then some recommendations, and we can see the name of Dr Evatt there too.

To return to Britain, Dr Winter, the UKHCDO hepatitis working party, you told us yesterday they were looking into AIDS. There is a report, also from March 1983, which is [DHF0017178]. In fact we can tell from the database that this is dated 1 March 1983 and it was sent to the DHSS on 11 April 1983. I guess this was probably written by Dr Craske. Would that be your expectation? Again we don't have a name on this.

A. Yes, either that or the chairman of the -- Dr Craske wouldn't have been the chairman of the working party, as he is not a haemophilia doctor; he is virologist. So it might have been written by the chairman of the working party.

Q. In any event, the same material is set out about what has been happening so far, particularly if we look at page 3. We can see that there is reference to all the different groups of people who so far have been noted to suffer from AIDS. Then the writer advances three theories but really the first two appear to be

advanced to be discounted, and the third theory, which we can see on the following page, is the one about transmission of an infectious agent. So certainly it looks as though this body -- that is, the working party of the UKHCDO -- was on the side of the infectious agent theory. Do you think that would reflect the virological input?

A. I think by that stage all haemophilia clinicians were signed up to the infectious theory because of the evidence of the San Francisco child. There was no other construction you could put on that evidence. So I think these minutes are just reflecting -- they are setting out the other theories and discounting them because of the new haemophilia data.

Q. What about the part on page 5, if we can look? That's DHF0017182, a discussion of the progression of the disease. If you look at that, there is a sentence in the middle of the first paragraph:

"It is therefore evident that the disease is not universally fatal and some patients may recover."

In hindsight that rather stands out. Is there a basis for saying that?

A. I think they seem to have the right data but the wrong conclusion. They set out actually really pretty well a lot of the major clinical problems that people with

AIDS experience in that first half a dozen lines and then they say not everybody may progress to AIDS -- or that's the sentiment, which is fine. So I don't know on what basis they then say some patients may recover because clearly that wasn't the case. So I think that's the phrase that stands out as being in retrospect not appropriate. Everything else they are saying actually, 25 years on, still looks pretty accurate.

Q. Even at the time, Dr Winter, was there anybody who had recovered from AIDS?

A. No. So that's my point, that the phrase, "Some patients may recover," is clearly not true. So that is not correct. But everything else they say actually stands up pretty well.

THE CHAIRMAN: In the last sentence they really do appear to nail their colours to the mast on the effect of the epidemiological evidence. It is all consistent with the existence of a transmissible agent.

A. Yes, I think by this stage all the haemophilia clinicians believed in the transmissible theory.

MS DUNLOP: We need to look at what was happening at a regulatory level. Could we go, please, to [DHF0017168]. This is a letter from the National Institute for Biological Standards and Control to the DHSS. I know, Dr Winter, that you weren't yourself

involved in matters regulatory, but where do NIBSC fit in?

A. "NIBS and C", we call them. They are a regulatory organisation based in north London that are responsible for biological standards, with quite a wide remit. They are still in operation, perhaps with a different title, now. Our interactions as haemophilia doctors with them were not very great. They would be more relating to blood transfusion centres rather than to haemophilia centres.

Q. This seems to be the first mention that we have been able to find of the possibility of discussing the problem at the Committee On the Safety of Medicines. In fact, I think the abbreviation CSM(B) is the biological subcommittee of the Committee On the Safety of Medicines.

A bit of redaction but in fact from the first names in the last paragraph we can, with some certainty, work out who is being referred to. I think the first blank is probably Professor Bloom, saying that:

"At such a meeting it would be extremely helpful to secure the advice of Professor Bloom, who acts as chairman of the Haemophilia Unit Directors' Group."

Then also the next blank that -- what would be needed would be the latest information on surveillance

undertaken by CDSC at Colindale, possibly, and I guess that's Dr Galbraith, Spencer Galbraith, asked to provide the up-to-date picture.

So I suppose inviting Professor Bloom along is really to get the user perspective, is it, at least the clinicians' perspective on the significance of the products?

A. Yes, because this is an organisation which is not clinical at all. This is an organisation whose functions are regulatory and to do with safety of blood. So, as I say, they would be mainly interacting with the blood transfusion services on a day-to-day basis and not with haemophilia centres and, as it states here, they wouldn't be involved in any sort of clinical investigation of the potential epidemic. That was done by the CDSC, who were the British equivalent of the CDC and based in Colindale in north London.

Q. The writer of this letter to the DHSS is thinking about licensing in mooting discussion at the Committee On the Safety of Medicines, is he not -- he or she?

A. Yes, they would have a mandate, as I say, for all matters relating to the regulation of blood and blood products. So they would have been the ones that would issue licences to the individual commercial manufacturers for the product to be used in the UK.

Q. Yes. As we will go on to see, that did happen. It was a discussion in the context of licensing later in the year.

Before we look at that, however, our preliminary report mentions, and you have also commented on, the letter that was sent by the Haemophilia Society in May. It is [DHF0014474]. I think this is a circular letter sent out by the Haemophilia Society but obviously with the chunk in the middle written by Professor Bloom, because we can see his name. We can see that among a number of statements approximately half way through the middle chunk it says:

"The cause of AIDS is quite unknown. It has not been proven to result from transmission of a specific infective agent in blood products. The number of cases is small, neither have any cases been reported from Germany, and it would be counter-productive to alter our treatment programmes radically."

I just wanted to have a quick look, having looked at the letter, which was sent out. It is dated, as we can see, 4 May 1983. Just to have a look at what else was happening at that time.

I'm actually going to start with the Daily Mail, which is [DHF0014328]. If we look on the left, this is the Daily Mail of 2 May 1983. It says that:

"There is a discovery that two men given routine blood transfusions for haemophilia are now seriously ill apparently suffering from AIDS."

A little more detail on that, if we look also at [PEN0150244]. This is a bulletin for the week ending 6 May 1983, and we can see:

"Acquired Immunodeficiency Syndrome Cardiff. Acquired Immunodeficiency Syndrome has been reported in a 20-year old man with haemophilia in Cardiff."

Professor Bloom was the director in Cardiff was he not, Dr Winter?

A. He was the director of the Cardiff centre.

Q. "This is the first report of AIDS in a patient with haemophilia in the United Kingdom known to CDSC."

I accept that to a slight extent one is speculating in saying Professor Bloom must have known about the patient in hospital in Cardiff. I think it is probably justified to infer that. Why do you think he composed the passage in such reassuring terms?

A. I'm not sure that, you know, he had much -- maybe he considered he didn't have an option to do it any other way. He must have known about the Cardiff case. He must have been aware that by this stage a significant number of American haemophiliacs had AIDS, and he would certainly have been aware of the San Francisco baby. He

presumably might have considered that he didn't have any other way forward in terms of writing such an article. As yet, haemophilia doctors did not have any agreed way forward as to how to cope with the evolving situation.

If he was here now, he might say, "What could I have said? Would you have expected me to write, it looks as if commercial concentrates can transmit a new disorder and we are looking into it?"

So I think it is probably -- I can only assume it was the lack of more detailed information and the lack of a clear action plan as to how to respond to this data that led him to set out, I agree what does seem inappropriately complacent in retrospect. It seems wrong that he was, in essence, reassuring people but then that's probably what he had been asked to do by the Society who had probably said to him, "Would you please write an article for our bulletin to reassure people that everything is all right".

Q. Dr Winter, he does say in terms:

"We are unaware of any proven case in our own haemophiliac population."

If he himself had a patient in his own unit, a patient with haemophilia who was ill with AIDS, there must be a degree of playing with words going on there:

"We are unaware of any proven case."

Are we back to Koch's Postulates?

A. Professor Bloom was not a clinician, as were many of the people of his generation. They were not clinically trained, and it is possible that Professor Bloom was not aware of this patient because he actually did not directly look after patients. Professor Bloom was laboratory-based. He was head of the centre. He was chairman of the haemophilia centre's organisation. But many of these people of that vintage, who had not received clinical training after qualification, spent their lives in laboratories, actually did not look after patients.

So, you know, you have put forward a theory that he is playing with words; another theory would be that he didn't actually see patients on a regular basis. It was looked after by his colleagues and the senior registrars, and because he was very, very busy his other work as chairman of the directors and going to the CBLA and NIBSC, it is possible he hadn't been told.

I mean, here we are in a situation trying to look back 30 years and trying to work out why doctors wrote certain things in a certain way, and we can only speculate looking back. Professor Bloom was a very charming, genuine, honest, caring man, and I find it very hard to believe he would deliberately mislead

people. He was a laboratory-based doctor who contributed enormously to the benefit of haemophilia patients through his laboratory-based research work. He was not a clinically-trained doctor.

THE CHAIRMAN: Dr Winter, I have some problems with that defence. If he were involved with a laboratory, I would find it difficult to understand that he wouldn't know what was passing through his lab, and the examination of the samples and so on of a patient in his hospital, one might think would pass through his lab; but is there another possible explanation, that he composed the article much earlier than its date of publication?

A. Yes.

THE CHAIRMAN: So it really is speculative to try to relate his knowledge to the date of publication.

A. I'm sure Professor Bloom would regret his choice of words but I'm absolutely sure he would not have deliberately misled the people. He was a very honest, caring doctor.

MS DUNLOP: Is does say in the bulletin, Dr Winter, that for three months the patient had had certain symptoms. I mean, there are a number of possibilities. One possibility is that it is the use of the word "proven" which is crucial:

"Unaware of any proven case."

A. I'm pretty sure that Professor Ludlam was a senior registrar in Cardiff at this time. When he comes to give evidence to you next week, I'm sure he can give you a much more helpful response than I have able to do.

THE CHAIRMAN: I don't know that we are going to get much more help than you are prepared to give us, Dr Winter, but we will see. However, as you will readily appreciate, coming to a conclusion that Professor Bloom was deliberately misleading the haemophilia community is something that one would do with very great care and indeed hesitation.

A. I'm absolutely sure he was not doing that.

MS DUNLOP: You say, Dr Winter, in your statement for us at 0295 -- we don't need to go to it -- that the tone appears in retrospect inappropriate. I simply wanted to ask you that actually, even at the time the tone is probably inappropriate, given all the information we have been looking at: the information from America, the fact that there is a patient in Cardiff, which one might say was likely to have been known to him even at the time.

A. I completely agree. Any clinician of the time asked to set out an exposition of the current state of play would not have written sentiments like that. I think the other factor we have to consider was that he was writing

to patients and maybe, you know, there was something there that he just didn't feel able to say the sort of things he would have said to other doctors. You know, again we look back in time but maybe that was part of the agenda.

Q. Yes.

THE CHAIRMAN: But wouldn't one rather say nothing in those circumstances?

A. Again, one agrees. If one was asked by the Society to write an article reassuring patients, an appropriate response might have been to say, "We really are very concerned about the evolving situation and we will provide the patients with clear information once we have it".

MS DUNLOP: Yes. Just, Dr Winter, to take forward the mention of Germany and other countries, there was a Council of Europe resolution in the summer of 1983, and we do have a report which appears to have been prepared in advance of that meeting, the meeting of the Council of Europe. Could we have a quick look at that? It is [DHF0014394].

We can see that this is dated 28 April 1983. It's at first sight not entirely easy to follow what has happened but if we look towards the back of the document at DHF0014406, we can see information from Canada. Just

in case anyone is wondering: if this is the Council of Europe, what's Canada doing there? Probably the explanation is on the very first page of this, which says:

"Information on the present situation in Council of Europe member states and in other countries represented on the committee ..."

That's the committee of experts on blood transfusion. So one could perhaps speculate that there must have been a Canadian on the committee. Question 1 that everyone seems to have been asked to answer, if we look only the next page. I'm only doing this because not all the countries repeat the questions. It is a problem we have had ourselves. If you ask questions, people sometimes give you the answers without the question:

"Number of known cases, including mortality rate, which have occurred in your country since 1981."

Then if we look to the next page, question 2. This is 4408:

"Measures introduced by transfusion centres for the selection of donors."

Bearing in mind that those are the questions, can we go back, please, to [DHF0014394]? Countries are in alphabetical order. So if we start with Austria,

perhaps just as we pass, we can see that they have two cases in Vienna, a third case is suspected; a patient who is a haemophiliac is still alive. Then Belgium and so on. If we move through to 4397, we can see Germany, the Federal Republic of Germany:

"18 cases of AIDS have occurred so far in the Federal Republic of Germany (16 homosexuals and two haemophiliacs)."

I accept, Dr Winter, the point you make about, that we don't know when Professor Bloom's letter was drafted and so on, but in retrospect, the statement that there have been no cases reported from Germany when in fact it looks as though, by the end of April there have been two cases in people with haemophilia in Germany; it is unfortunate that the letter contains that as well, isn't it?

A. Yes, I mean, I don't find any of this evidence straightforward. You are asking me about the words of a doctor who has been deceased, bless him, for many years and asking me to explain why he wrote in a certain way, and I obviously don't know.

Q. Yes. In a wider sense, though, Dr Winter, you have mentioned Germany a few times and it does look as though there was a developing problem in Germany too, doesn't it?

A. Eventually, unsurprisingly given their very heavy usage, the German problem did evolve. The Germans used a lot of concentrate from a local German-Austrian manufacturer, called Immuno. So I would expect that the rate of viral infection amongst their donors was significantly less than amongst American donors.

Q. Right. Just to finish that little excursus into the Council of Europe, we can look at the resolution that appeared [DHF0022149]. We can see that this is from 23 June 1983, and just to note perhaps that the recital refers to:

"A new and severe health hazard that may be caused by an infectious agent transmissible by blood and blood products ... recalling previous work."

Then going on to the following page, 2150. A recommendation, the governments of member states, which I think one could perhaps summarise as: avoid, inform and prevent:

"To avoid, wherever possible, the use of coagulation factor products prepared from large plasma pools ... Especially important for those countries where self-sufficiency in the production of such products has not yet been achieved ... Inform attending physicians and recipients, such as haemophiliacs of the potential health hazards of haemotherapy, and to provide all blood

donors with information so that those in risk groups will refrain from donating."

A. Can I just say, despite their grand title, the Council of Europe was not a body with whom we had any interaction. I had never previously heard of them. Their pronouncements were never, ever circulated through the UKHCDO, very worthy though I'm sure they were.

Q. Perhaps we can get some insight as to how they were seen within the DHSS as well, just before we break. If we have a look at [DHF0022148]. We can see that this is a memo headed up "Recommendations, resolutions et cetera by international bodies":

"From time to time we submit to ministers international instruments which involve DHSS interests. It is normal practice during the preparation of these documents to ensure that the UK is not committed to policies which would not otherwise be followed, so that there is correspondingly no action to be taken if and when they are adopted."

This is referring to that recommendation we have just looked at, R(83)8. So it does rather look, Dr Winter, as though the policy seems to be that we don't sign up to anything that we wouldn't do otherwise so that we don't have to take any specific action anyway. That seems to be a rather crude summary of

what's being said, doesn't it? In particular perhaps we should note paragraph 5:

"The recommendation does not prevent the United Kingdom from continuing to import Factor VIII concentrate from the USA on whom we currently rely for about 50 per cent of our supply."

A. I have read these recommendations and, you know, I don't find them very sophisticated. It doesn't make any recommendation of the use of alternative products for people with haemophilia, like the use of DDAVP, desmopressin, which by that stage was widely available and would have been available for the treatment of people with mild haemophilia. And, you know, the statement on page 2 of its original recommendation to avoid, wherever possible, the use of coagulation factor products prepared from large plasma pools, well, that was the only concentrate there was, apart from cryoprecipitate. So if I may say so, this document has clearly been written by people who aren't haemophilia people.

Q. I quite accept, Dr Winter, that where possible it is, to say the least, question-begging.

THE CHAIRMAN: I think that we could assume that the ultimate outcome was the result of a great deal of negotiation and compromise and probably reflected the

anxiety of several of the parties to avoid being committed to any particular approach. I think that might characterise many of the pronouncements of the Council of Europe.

MS DUNLOP: Sir, it is 11 o'clock. I don't know if it would be a good time --

THE CHAIRMAN: I think it is a good time. We will have a break.

(11.02 am)

(Short break)

(11.28 am)

THE CHAIRMAN: Dr Winter, I gather you have been having some difficulty in hearing me. You are not unique in that but will you tell me if you are finding difficulty, please? And I'll do my best.

A. Thank you. My hearing is not good, I am afraid.

THE CHAIRMAN: I think sometimes my diction cannot be all that good either. But please do tell me. Don't be in any difficulty.

MS DUNLOP: Thank you.

Dr Winter, I wanted to take you next to a meeting of the reference centre directors in the UK, and the minutes I hope are LOT0032858. Is that the wrong one? Sorry. This is a document which has a number of different references.

THE CHAIRMAN: What is the date of it?
MS DUNLOP: 13 May 1983. If we look at -- no, that's not the right one. [DHF0014384]. I think the advantage of the "LOT" reference, sir, is that it is a later arriving set of minutes which has all the names in it. So this is probably -- yes, this is a redacted document.

But this is a special meeting of the reference centre directors which took place at St Thomas' on 13 May 1983. It was chaired by Professor Bloom. Dr Craske was there, Dr Kernoff, Dr Ludlam, Dr Rizza, Dr Diana Walford. We can see that the purpose of the meeting was solely to discuss AIDS. You will have seen these minutes before, I expect, Dr Winter, have you?

A. Yes.

Q. Yes:

"To date in the United Kingdom, one haemophiliac is suspected of suffering from AIDS."

Then some echos of the competing theories about aetiology:

"Many individuals with evidence of impaired cell-mediated immunity."

Then perhaps what's more important for today's purposes is to look at the following page. We can see a paragraph beginning:

"The steps to be taken ..."

This is what should happen if a patient should develop AIDS and what treatment they should continue to receive in the form of concentrates. And then a paragraph:

"With regard to general policy to be followed in the use of Factor VIII concentrates, it was noted many directors have reserved a supply of National Health Service concentrates for children and mildly affected haemophiliacs. It is considered it would be circumspect to continue with that policy. It is also agreed there was, as yet, insufficient evidence to warrant restriction of the use of imported concentrates in other patients in view of the immense benefits of therapy."

I suppose if you weren't a director until December of 1983, you personally won't have been directly responsible for treatment policy in May 1983. Is that correct?

A. I would not have been directly responsible, no.

Q. Do you remember this debate?

A. Yes. So the first part of this, going back to the evidence that people with haemophilia could have low immune function, what they are saying in the first of these paragraphs is that if a patient with haemophilia actually acquired AIDS, would it make his situation

worse if he got a certain concentrate that might be more likely to make that immune function even worse, and they are saying they don't see any evidence for that.

So they are making a perfectly reasonable decision not to alter therapy for someone who has AIDS. That's the first part of that. Then now we are into familiar territory: what to do about the use of concentrates. So it was my recollection that from this meeting, more or less formally it was adopted that for children and irregularly treated patients and people who had never been treated before, they should have National Health Service concentrate rather than commercial concentrate. They, again, don't seem to mention and stress the use of the DDAVP, which they might have done given that that drug had been licensed for six years by this time.

Then the final sentence -- you know, there is not enough evidence -- that has to be made against a background of a country, or England, where there was not enough NHS concentrate to go round. 50 to 60 per cent was imported; centres like mine were using more or less exclusively imported concentrates. Beyond going back to cryoprecipitate, there really wasn't any other option. So that's why their hands are so tied at this time, even in a position when they are being faced

with this sort of evidence.

Q. Were you still at Guy's in May 1983?

A. I was still at Guy's in May 1983. At my subsequent centre we more or less exclusively used commercial concentrate. At Guy's most of the concentrate that was used was commercial.

Q. Use of cryo, the possible use of cryo; you alluded earlier to difficulties of supply. In Guy's, for example, if it had been decided around this time, May 1983, to revert to cryo, would there have been enough?

A. We were advised no by the regional transfusion centres who were the people who manufacture the cryoprecipitate. It is a quite a laborious process to manufacture it. It comes in individual bags, and we were told that there was not enough cryoprecipitate to allow a decision of abandoning commercial concentrates to be made.

Q. And do you know what the position would have been in Kent?

A. The same. It all comes within the same regional health authority. So the whole of the southeast of England is under the blood transfusion centre at Tooting in south-west London, which covers the whole of London and the south. So they would have been the transfusion centre to which we would have related.

Q. You mention DDAVP and actually I think it does feature in the letter that was sent out to haemophilia directors after this meeting. It is actually in the preliminary report. This is discussed in paragraph 8.36. Perhaps we can look at that. We can see that Professor Bloom and Dr Rizza -- at this point we didn't, I think, appreciate that this was a circular letter. It appears to have gone to all haemophilia directors. If we look at [SGH0022175].

A. If I can point out that the minutes of the reference centres would not have been circulated to other haemophilia centres. They would only have been circulated to the reference centres. Hence the need for a separate letter to all haemophilia centres.

Q. Thank you. This seems to have been the letter of 24 June and this sets out recommendations. This does mention DDAVP. Perhaps you could very briefly explain to us; DDAVP is a synthetic drug. Is that right?

A. It is a synthetic drug called desmopressin, and it is a synthetic analogue of a naturally occurring brain hormone called vasopressin. And in about 1977 it was discovered by Professor Mannucci, who at that time was working at St Thomas' Hospital, subsequently in Milan, that if you gave DDAVP by injection to people with mild haemophilia and von Willebrand's disease, it released

supplies of Factor VIII and von Willebrand factor from the lining of the blood vessels, and that this increased release lasted for about five days and the injection could be given under the skin.

It did not work in more severely affected patients but it was a very effective, and remains so, treatment for mildly affected haemophilia, haemophilia carriers, von Willebrand's patients, because it gets them through episodes of surgery, dentistry and trauma, and it obviates the need for the use of coagulation factor concentrates.

Q. Right. Would it ever have a role to play in somebody who was severely affected and who could sense that a bleed was coming, or is it not --

A. No, if you give DDAVP to people with severe haemophilia, it does not increase their Factor VIII level. It is effective in people with mild haemophilia and mild von Willebrand's, so it could not be given to the other groups, but it is an extremely important and effective treatment and very simple for mildly affected patients. And I must say, one of the more poignant aspects of the HIV epidemic was a good number of people in Britain with mild haemophilia and mild von Willebrand's disease, and who were haemophilia carriers got HIV, and one wonders why they were ever treated with concentrate. Because

they would have been suitable to have DDAVP treatment.

Q. We have looked, Dr Winter, at spreadsheets for the Scottish centres, and at least our understanding based on the spreadsheets is that they don't include any patients with mild haemophilia who acquired HIV from the treatment that they received. So it may be that that problem didn't occur in Scotland, as far as we can detect.

THE CHAIRMAN: Dr Winter, you have several times now referred to the fact that in Kent you couldn't get NHS Factor VIII, and you have now told us that you are part of a very wide geographical area in which presumably some people did. Why couldn't you get it in Kent?

A. We were part of this wide geographical area, including the whole of South London, not North London, who related to the Edgware blood transfusion centre. So we would have certainly had the three big teaching hospitals in the south of London and the whole of the south of England. My understanding was that there was a formula that the regional transfusion centres collected blood and they sent that blood off to Elstree to be fractionated into Factor VIII, and how much Factor VIII they received back related to how much blood they sent. And I suspect, therefore, that there was some logistical or political issue that the amount coming back to the

Blood Transfusion Service at Tooting, perhaps combined with the fact that it was covering such a wide area, was such -- they were getting very little in the way of NHS concentrate back, which in any case was distributed round a large number of hospitals, including three of the biggest hospitals in England. So I suspected it was for a combination of all those reasons that there was relatively little NHS concentrate available in the southeast of England.

THE CHAIRMAN: You mean, you just didn't have the clout in competition with the big teaching hospitals?

A. I suspect there were political machinations in operation to which I was not privy.

THE CHAIRMAN: I see. Perhaps we shouldn't follow that too far.

A. I would not wish to imply that there was a preference to send blood to London.

MS DUNLOP: Can we just finish looking at that letter. If we could scroll down, please, there is a mention of haemophilia B:

"Evidence to incriminate Factor IX concentrates in AIDS is even less. It seems logical to continue to use our normal supplies of NHS concentrate."

A. Yes, there was an important point here, just to make sure that you have this on record.

The way in which Factor IX concentrates are manufactured is different to that of Factor VIII and because of that, thankfully, it proved much harder for viruses to be transmitted. So whichever country's statistic you will look at, you will see that a far lesser proportion of Factor IX deficient than Factor VIII deficient patients were infected with viruses, and that was related to the nature of the concentrate manufacture.

Q. Yes. There was never anything like the same use of commercial product for haemophilia B as there was for haemophilia A; is that not also true?

A. I don't know why that should be so. They are clinically the same and the patients, by and large, bleed as frequently and the Factor IX concentrate was as available as the Factor VIII concentrate. So I think we certainly do ascribe the lesser incidence to the nature of the manufacturing process.

Q. Then --

THE CHAIRMAN: I think we would have formed the view that self-sufficiency in Factor IX was achieved very early in the history of domestic production of factor products. Both in England and Wales and in Scotland.

MS DUNLOP: There are some graphs, sir, which we are going to look at in a minute, which seem to make that point.

THE CHAIRMAN: Thank you.

MS DUNLOP: Just to complete, there is a second point made there about trials of hepatitis-reduced Factor VIII concentrates. Just to perhaps note that without comment at this stage. If we can move over to the letter to see the conclusion of that paragraph. Move over to the next page.

Dr Winter, there was a meeting, a significant meeting, at Karolinska in Stockholm in June 1983. Did you attend that?

A. No, I didn't. This is the bi-annual meeting of the World Federation of Haemophilia.

Q. I think then perhaps if you weren't there, we should just note for the record that there is a, again quite a detailed account of events in Douglas Starr's book, pages 281 to 282. That's [LIT0012936] at 2951. Perhaps we could just quickly look at that. We can see that again in fact there seems to have been a bit of a clash perhaps between Dr Evatt and Dr Aledort:

"Bruce Evatt had been invited to speak. He felt himself set up in a way. Aledort swung into a lengthy discourse on how little scientists knew about the disease, and Dr Evatt felt he had to defend how much they did know."

Then we can see from the next page, 282, that

a proposed resolution -- insufficient evidence to recommend any changes in the treatment of haemophilia -- was actually carried despite attempts, in particular, of the Dutch representatives.

World Federation of Haemophilia, Dr Winter, how influential was it?

A. They would be very influential because they are the global body representing patients with haemophilia. As I say, their bi-annual meetings would be attended by nearly all the haemophilia community, not only doctors and scientists and nurses but also patients. So it was the most important gathering of haemophilia clinicians and patients in the world.

Q. I want to ask you next, Dr Winter, about Dr Galbraith's paper. We looked earlier at the reference in the spring to the possibility of discussing imported concentrates at the Committee On the Safety of Medicines' biological subcommittee, and we know that Dr Galbraith sent a letter, which is dated 9 May, with a paper on the topic. It's easier if we look at, not the original version because that's rather faint, but a retyped version, which is [MIS0010005]. I should say, sir, for the record, that the original rather faint version of the communication is [MIS0010001].

Just before we look at the terms of the letter, it

is perhaps worth noting that firstly in the Daily Mail piece that we looked at earlier from May, there was a reference to there being no question of stopping imports, that being the position of the DHSS. Secondly, there is an internal DHSS memo specifically in response to this letter in similar sorts of terms. But if we look at the letter, we can see that this is Dr Galbraith writing to Dr Field. He is mentioning the case in Cardiff. I should say we are pretty sure the date is 9 May, although there is a question mark there. But he has done a bit of research also on the Spanish cases, that they received American Factor VIII concentrate, a tally of 11 reported cases in haemophiliacs in the USA, and a paper describes a case in a multiply transfused child in the USA:

"I have come to the conclusion that all blood products made from blood donated in the USA after 1978 should be withdrawn from use."

He sets out a paper, giving that recommendation in more detail. He is also recording surprise that the American manufacturers haven't informed their customers of this new hazard. No official warning in the United Kingdom. You must be familiar with the paper, Dr Winter. I expect you have seen it before. If we go on and look at it, it comes, I think, on the next page.

It's called "Action on AIDS", if we look at 0006. He sets out the data with which we are now quite familiar about what has happened so far. It says in paragraph 3 that although the absolute number is small, this may not indicate that the risk is small. Incubation period is long. This is going on to the following page. Factor VIII concentrate and pooled product would appear to have a high risk of being contaminated with the AIDS agent.

Just before I ask you about this, can you look too at the internal DHSS memo, which is [DHF0014387].

I'll just let you take a minute to look at that. We can see that the writer of the memo is somebody who has been at the reference centre directors' meeting on 13 May because that's quoted. He or she thinks the suggestion is premature and unbalanced. What do you think?

A. I think scientifically everything that Dr Galbraith says is true and accurate. I keep on referring back to what it was like at the time in terms of the choices available, and I cannot stress too much the times that the other doctors had lived through and the patients had lived through before the introduction of concentrate. There was very major concern about the possibility of cerebral bleeding because that's what had happened in

the 1960s, when the doctors at the time were trying to look after people with haemophilia, and that's what the concentrate was all about and the prospect of bleeding into the brain and dying, which was clearly the common dying event in people with haemophilia, was held in terror, quite rightly, by the patients and their families and with great concern by the doctors. That was the place that they had been to and that's what the concentrates offered freedom from.

So that was setting the bar, if you like, at a level where to move away from any sort of concentrate usage, to put you back into the risk of giving your patients the possibility of another cerebral bleed was something that would only have been taken with very, very great reluctance by doctors and by patients, although Dr Galbraith's comments, of course they are accurate and of course he is right, the only choice that they could do at the time beyond these relatively minor amendments affecting the mild patients and the children, the reality of the day was there was not enough concentrate to go round in England at least -- I know the Scottish situation was different but in England 50 to 60 per cent was not English.

So the prospect of overnight withdrawing 60 per cent of the nation's concentrate supply and saying to

patients, "You are not having any more concentrate, we will give you cryoprecipitate if you come into hospital with a bleed," that would have been an act that would have been bound to increase the risk of cerebral bleeding in those patients and that was the reality.

They were very, very restricted as to which of these two choices they could make. And of course, Dr Galbraith is accurate and of course it would have saved some lives, one suspects, if his recommendation had been introduced in terms of lives saved from those patients who went on to get HIV and die of AIDS.

On the other hand, you could speculate that other patients would have died of cerebral bleeding. So this was, you know, yet another highly critical time where, whichever side of the seesaw you fell off, it had lots of problems attached to it.

Q. In fact, we know that the paper was considered at a meeting on 13 July. We have a suggested agenda for that, which I'm not going to go to, but just for the record, it is [DHF0014587], particularly at 4588. That sets out, really in advance, an approach that might be taken at the meeting on 13 July and then we also have the minutes, which we will look at. That's [MIS0010291].

We actually have two different redacted versions of

these minutes, sir, and they are redacted in different ways, which really means that it is probably better to look at them both, but this one is useful because it does at least have the names of some of the attendees.

We can see that Mr Watt was there and obviously we saw Mr Watt, in fact, in a television programme and we will come to look at that, but I think not with you, Dr Winter, but with those witnesses who can more specifically comment on the position in Scotland and then if we look at the next page.

Yes, from the other set of minutes we can see that, because there is less redaction, Professor Bloom, I think Dr Craske, Dr Galbraith, Dr Gunson all appear to have been there, although that's not entirely clear because their job descriptions are given in the other set of minutes but not their names. But looking at the conclusions, 5.1:

"The cause of AIDS is unknown, but an infectious aetiology seems likely."

Then 5.2:

"Patients who repeatedly receive blood clotting-factor concentrates appear to be at risk ... this risk is small."

Back to the balance:

"... balanced against the risk of AIDS (...

transmitted by blood products) are the benefits [of the use of concentrate]: in the case of haemophilia they are life saving ..."

That's the point you have just made, Dr Winter:

"The possibility was considered of withdrawing clotting factor concentrates from the market and replacing them with cryo-precipitate. It was concluded that this is not feasible in the UK on grounds of supply.

"The possibility was considered of withdrawing US preparations ... this is not at present feasible on grounds of supply. Moreover, the perceived level of risk does not at present justify serious consideration of such a solution."

Of course, some of these points about supply might have been different in Scotland, Dr Winter, and I suspect, as a general proposition, you couldn't dispute that. We would need to ask the Scottish clinicians and suppliers about that but --

A. I would have expected it to be different in Scotland with its much higher, relatively speaking, supply of locally donated blood for concentrate manufacture.

Q. Yes. So I suspect from what you have already said that, looking at these minutes now and trying to put yourself in the position of the time, you don't find these

conclusions that surprising?

A. I don't find them -- they really were between a rock and a hard place, and even if the doctors decided to go down the pathway of not using commercial concentrate, which in centres like mine might have effectively meant cutting your use down to about 10 per cent, trying to persuade the patients to agree would have been something that would have been very difficult as well.

Q. I suppose, Dr Winter, the only point that might strike one about this committee is that in terms of the legislation it is looking at the quality, safety and efficacy of a product; and at first blush, questions of supply don't seem relevant to that, do they?

A. That reflection doesn't alter the choice that was in front of them, does it? There were only two options they could use to respond to this quite properly articulated situation, and whichever way they went, they had problems. I mean, the Committee on the Safety of Medicines were not -- you notice that none of the people on the committee are haemophilia doctors. As you say, their main mandate was for safety. Issues about supply and efficacy were actually not quite their main concern.

Q. Although they were, we know, guided by Professor Bloom, who was presumably talking about these matters at the meeting, one would jalouse?

A. Yes.

Q. Just in passing, I think we should note, without any particular comment at this stage, that the following day the question of the cause of AIDS in people with haemophilia arose in the House of Lords. Look at [SGH0026720]. Then note at the bottom of the page a question from Baroness Dudley about AIDS and then an answer from Lord Glenarthur on the following page, 6721, which contains the wording at the top:

"Although there is no conclusive evidence that AIDS is transmitted by or blood products ..."

I'm noting that at the moment and I want to come back and ask you about that a little later in 1983, but I thought, particularly in view of what you have just said about usage at the time, we should also look at the annual returns for 1982, which are dated from the end of July 1983. This is [SNB0017540]. This just gives us some information about the shape of the usage up until 31 December 1982. Interestingly under the heading "Treatment of patients" we can see 48 per cent were receiving replacement therapy in 1982, 1,101 on home treatment. 50 per cent of severely affected patients are on home treatment. Nearly 10 per cent of mildly affected haemophiliacs are receiving home treatment.

Two things to note about that. The first is in

light of what we said yesterday about whether definitions had changed over time, that the reference to mildly affected haemophiliacs is given as being people whose Factor VIII is above 10 per cent. So that looks as though at least in some circles at that time --

A. And the severely affected is registered as being below 2.

Q. Yes. It does look as though there was a slightly different gradation in those days, at least as far as some people were concerned. But the other thing is this comment:

"It is interesting that nearly 10 per cent of mildly affected haemophiliacs are receiving home treatment."

Was that the wrong thing to have been happening at this time?

A. If they were genuinely mildly affected patients, and if they had been shown to be responsive to DDAVP -- not everybody is -- then one wouldn't have expected them to have been treated with concentrates. The way in which these returns are done are by the forms going out to 105 centres and a doctor or a nurse working their way down the list of patients registered for each centre, and one of the lines would be: is this patient on home treatment? And it might be, for instance, that a patient with mild haemophilia said, "I do a lot of

travelling around the world and I would like to take some Factor VIII with me, would that be okay?" And they had a supply for that sort of purpose.

So I think there is a lot of different sort of ways of looking at that data. I don't think it really means that a significant number of people with mild haemophilia actually were being treated at home because by definition, people with mild haemophilia don't need much treatment. If they do, it can usually be with DDAVP and there could have been other possible explanations of the type I have outlined to you.

Q. Right. Just to revert quickly to the point that was made a short time ago about haemophilia B, if we go through to what is table 7; that's page 9 of [SNB0017540]. We can see haemophilia B, NHS Factor IX, 9,252,000 units. That's then shown as total units. It does look as though there really isn't anything like the same amount of commercial haemophilia B treatment going on?

A. Yes, it may have been, relatively speaking, the amount of Factor IX concentrate being produced by BPL was relatively greater than the amount of Factor VIII. Whereas, across England certainly, with haemophilia A patients it might have been 30 to 40 per cent receiving NHS product. With Factor IX that percentage receiving NHS product appears to be a little greater.

Q. Sir, I referred to the graph. If we go to 7555, still in this same document, we see there is four lines. Perhaps the easy one to note from the start is the third line, the line for plasma, which has shown a drop since 1969. Then we can see NHS Factor IX, which is the line with the crosses and total Factor IX, which is the empty circles, that they are almost the same.

So that, I think, really makes the point but in a different way. We should, for completeness look at the page before, which is Factor VIII, 7544, of course this is the UK, sir, so it's giving, I think, truly the UK; it's giving the picture for Scotland, England, Northern Ireland and Wales. We see the total and then commercial is the triangles and then NHS.

In fact, it looks from the other tables in this, Dr Winter, as though the ratio at that time was roughly twice as much commercial as NHS, which no doubt reflects the position in England. It's about 44 million units to 22 million units, very roughly speaking.

Just for the record, I think that's on 7545. But we don't really need to go to that.

This line:

"There is no conclusive evidence that AIDS is transmitted by blood product".

Perhaps there is a bit of a contrast with what was

being said in the United States. If we look at [DHF0014724], I just want to highlight a statement in the right-hand column:

"The best evidence for transmission of AIDS through blood products is the occurrence of AIDS in a small number of haemophilia patients receiving large amounts of Factor VIII, a clotting substance in blood."

This is issued by the American Department of Health and Human Services. So we have the DHSS, they have the DHHS. This is September 1983 but really quite a different line from what we saw in the House of Lords in July 1983, no conclusive evidence.

Do you agree with the proposition that this is actually the best evidence for transmission of AIDS through blood products, the occurrence of AIDS in a small number of haemophilia patients. That was really the best there was at the time, wasn't there?

A. If I have understood you, it doesn't surprise me that in the House of Lords somebody stands up and makes very, very generic comments about a disease that was not at all well understood. So I personally don't read too much into the rather non-specific nature of the comments made by that politician.

Q. We are coming back to that, Dr Winter, I'm not just going to drop it yet. I want to go back to the

reference centre directors, who met again in September. I have two different references for this one. We could try [LOT0032862].

THE CHAIRMAN: What's the precise date of this one?

MS DUNLOP: Sorry, sir, this is 19 September.

This is the reference centre directors' meeting again, and we have all the names. This is a slightly different topic here, Dr Winter. If we look at page 3, which is 2864, we can find Dr Walford talking about the possibility that some centralisation and control of supplies of commercial Factor VIII would be introduced by the DHSS:

"It was felt that there was a strong case for all orders of Factor VIII, both NHS and commercial, to be made via the Blood Transfusion Service mechanism. Many of the directors had grave misgivings about this scheme but since the DHSS recommendation had not yet been circulated, discussion was limited. Dr Walford assured the reference centre directors they would be involved in any discussions."

Then if we look at page 5 of [LOT0032862], we can see that there is another document going to be circulated by the Haemophilia Society and that Professor Bloom has again been involved in the drafting of that. In fact, he has read it out to the reference

centre directors.

Just holding both these points in our minds, if we could look firstly at [DHF0014759]. This is an internal DHSS minute, 19 September 1983 also. This person has invited him or herself to the meeting to hear the latest on AIDS. This is paragraph 2:

"The relatives of the haemophiliacs who died of AIDS in Bristol have taken legal advice and are keen to sue [underlined] the manufacturers. If they go ahead this could put the cat amongst the pigeons."

I mean, I suppose in general terms we can just note that it seems to be a fear of litigation, which maybe is not that difficult to understand. But on the point about supply, at the end of paragraph 4:

"I took the opportunity to mention to directors further consideration is to be given ..."

I think this does read very much as though it is Dr Walford:

"... further consideration is to be given to rationalising the purchase of blood products ... this was to be considered by the Advisory Committee on the NBTS. I promised that the Directors would be given an opportunity to comment on any proposals to change the present system of FVIII purchase and distribution. (It is clear that this is a fertile ground for almost wilful

misunderstanding on their part)."

What do you think is meant by that?

A. I think the person writing this would have been aware that their proposal would have been extremely unpopular with the haemophilia directors because the haemophilia directors would lose control over the type of concentrate that was being purchased on their behalf.

Haemophilia doctors had specific preferences over which type of commercial Factor VIII and Factor IX they might want to use for their patients. Haemophilia doctors liked interacting directly with the companies and talking to them about their products and putting in orders to cover a year's supply, and the idea and the prospect that that in future might be carried out by someone at the DHSS would have been guaranteed to have been received extremely poorly.

Q. So this was a bit of a long-running debate?

A. In the end, by the time I became a consultant, three months after this, I think the idea had not been taken any further. Probably because of the rude reception it got from the haemophilia directors.

Q. Then the other point that we noted in that meeting was the reference to another circular from the Haemophilia Society that would seem to be [DHF0014767].

THE CHAIRMAN: Just before leaving that explanation, was it

appreciated at the time that by taking such a stance, the haemophilia directors might be thought to have accepted full responsibility for the selection of products and the consequences of their use?

A. I think the haemophilia directors were comfortable with that. I think it was, you know, they saw it that it was a clear remit for them as director of a centre to be at all times responsible for the type of blood products that was being used in their centre. And part of that was to form a view as to what they felt about NHS and commercial concentrates, and then that would relate to how much NHS or commercial concentrate they were able to obtain. Once they knew how much NHS concentrate they were likely to get in one year, they could then enter into negotiations with a commercial company alongside the hospital's supply department for the best deal for the commercial concentrate of their choosing. So I think that was taken for granted by haemophilia doctors, that they alone were responsible for the type of concentrate being used in their centre.

THE CHAIRMAN: There are two quite different aspects to that, it seems to me. The total autonomy to select might not be thought to be dependent on whether they were getting any NHS products. If it were simply a case of resolving on the purchase of a balance after

exhausting the available NHS prospects, one might take one view, but if the selection of commercial products was thought to be within their autonomy to the extent that they could do that to the exclusion of available NHS products, one might take a different view. What was the extent of the autonomy that was asserted?

A. There was autonomy. For instance, I can remember clearly a meeting which was convened at St Thomas', shortly after I became a consultant, where we looked at the amount of NHS concentrate that was going to be available throughout London and the southeast. London and the southeast had an number of small haemophilia centres that would not have had dedicated budgets for the purchase of concentrate. And at that meeting it was therefore decided that the two major centres, which at the time were St Thomas' and my centre in Kent, because we had budgets for commercial purchase, that they would take very little, maybe none at all, NHS concentrate and the NHS concentrate would also be then preferentially distributed to these very small centres, of which there were perhaps 15 throughout London and the southeast, because they didn't have the wherewithal financially in terms of budgetary structure to start purchasing their own commercial concentrate and, you know, that situation certainly happened for a number of years.

It saved the smaller centres problems in the sense that they didn't have to seek finance to buy commercial concentrate. They didn't want to buy commercial concentrate, they just wanted to be given a relatively modest supply of NHS concentrate to keep themselves going with their relatively modest supply of patients. So this was another reason why the proportion of NHS concentrate used in my centre and at St Thomas' was relatively slight because we had preferentially given it, once we knew the distribution from the blood transfusion centre, to the smaller haemophilia centres.

THE CHAIRMAN: Yes, thank you.

MS DUNLOP: Again just the other point that we saw in the reference centre directors' meeting, that there was to be another circular from the Haemophilia Society. We have it on the screen in front of us. The factsheet contains important information concerning Acquired Immunodeficiency Syndrome, 22 September 1983.

Could we go to the next page, please? Firstly we note on the left-hand side that members of the Society had been at the Karolinska congress:

"A medical board of WFH emphasised and confirmed the points made in our last letter sent in May."

Then in bold further down on the right-hand side:

"Our message remains unchanged. The advantages of

treatment far outweigh any possible risks. The risk of AIDS is tiny compared to the risks from untreated bleeding episodes."

I'm not going to ask you for any comment on that, Dr Winter, it just looks as though the position is consistent?

A. Yes.

Q. In October 1983 there was an annual general meeting of UKHCDO and you weren't at that, at least if the minutes are correct. But I suppose you will have been aware of it?

A. I would have been aware of it.

Q. Yes. Just to look at a section in the minutes, [SNB0017517] are the minutes. Can we look at 7526. A Dr Chisholm has raised the problem of patients refusing to take up commercial Factor VIII because of the AIDS scare. I think Dr Chisholm was in Southampton?

A. She was the director in Southampton.

Q. Yes, we did try to trace Dr Chisholm as part of our research for the Inquiry but we were unable to make contact with her despite the number of different attempts and she was wondering about reverting to cryoprecipitate, and she says she could get unlimited supplies of cryoprecipitate. I think there was a very specific reason for that, was there?

A. Yes, because the Blood Transfusion Service for the region was in the same city.

Q. Then on the following page, 7527, a paper from Dr Craske about AIDS. He is describing proposals to investigate UK cases of AIDS and haemophiliacs and look at a control group:

"There was some discussion regarding the two cases of AIDS in haemophiliacs in the UK ... Dr Craske urged Haemophilia Centre Directors not to put the word 'AIDS' on pathology request forms."

Why was that? Why would that be? Was that about stigma?

A. Can I just ask to you repeat that bit?

Q. Yes. It was just the section where Dr Craske has urged haemophilia centre directors not to put the word "AIDS" on pathology request forms. Do you think that would have been a fear of stigma?

A. Yes, I mean, AIDS was a communicable disorder, so you had to notify cases to CDSC. What you were supposed to do was label all pathology request forms with a sticker that said "danger of infection", and that applied to any infectious disorder, hepatitis, et cetera. As you say, there was widespread stigma at the time but I can't see particularly why the word "AIDS" shouldn't be used on pathology request forms. The important thing from the

health and safety point of view would have been that the pathology request forms were being labelled as being "danger of infection", so that in the event of a needle stick injury by a pathology technician, advice could have been taken.

But maybe there had been some examples of pathology staff being uncomfortable in handling blood samples where the word "AIDS" was stamped all over the request form.

Q. As with other UKHCDO meetings, we have got other notes of the meeting, Dr Winter. Just look at [SNB0017531]. Again we will have to ask Dr Perry, when he comes, but this looks as though it may have been Dr Perry's note, and he has recorded perhaps a little more detail of the presentation on AIDS at 7532. Quite a lot of statistics. Then on to 7533. The conclusion, which looks to have been a conclusion he is noting on the basis of this presentation:

"Serious disease in haemophiliacs, a low possibility??"

Is that likely to have been based on the sorts of figures we see immediately above: 1.2 in 1,000 at risk?

A. Sorry, that doesn't seem to be on my -- oh, the screen at the top?

Q. Yes.

A. A crude interpretation. Oh, well, that's based on the number of haemophiliacs in Britain and two patients have got AIDS. So when it says "crude", it is crude.

Q. From the other paper, [SNB0017535], again this is Dr Boulton, and we know because he has signed it. We see a number of points referred to but, most interestingly perhaps, on 7537 -- again this is from Dr Craske's presentation on AIDS:

"No evidence of AIDS entering the general population."

Perhaps a slightly surprising notion, as if certain groups already referred to are not in the general population. Moving on to the next page, we can see the familiar arguments, 7538, looking at the passage just above the report of the working party chairman, Dr Craske:

"Dr Jones argued there was no case for stopping the use of commercial Factor VIII."

There was a case for it, wasn't there, Dr Winter? It was just a question of whether one found that more compelling than the case for continuation?

A. Sorry, I'm not quite sure I can identify the right lines.

Q. Sorry, it is the sentence that's just above the heading marked "5":

"In view of the AIDS incidence in haemophiliacs in the USA, it was felt there was no logic in not using imported Factor VIII. Dr Jones argued there was no case for stopping the use of commercial Factor VIII."

A. Yes. I mean, the sentence itself doesn't make sense, does it:

"In view of the AIDS incidence in haemophiliacs in the USA ... there was no logic in not using it."

I would have thought there was pretty good logic to not using it, but it is back to this agenda that we have been discussing for some time now of there were only two fairly stark choices open to haemophilia clinicians and on balance most of them came down on the side of not stopping using commercial Factor VIII.

THE CHAIRMAN: Doctor, I wonder if I could ask you something that's just slightly collateral to this at the moment.

I see that in fact there were only the two choices. I know you have mentioned that earlier there was pressure from the haemophilia directors for an increase in the domestic product, but at this stage were the haemophilia directors pressing for an increase in the production of the domestic Factor VIII product?

A. My recollection is -- because we discussed this yesterday -- that by this time the £20 million development at Elstree had already been announced,

I think in 1982, if I remember, because we saw evidence yesterday that the DOH official was looking at some data and didn't want to alter the decision to go ahead with that development. So I think by this time haemophilia clinicians knew that there was going to be expansion because that political decision had been made and finance had been put forward to Elstree for the development to occur.

THE CHAIRMAN: So people were just waiting for that to be implemented?

A. Yes, waiting for Elstree to kick in with the greater supply, which took longer than you might have expected.

THE CHAIRMAN: No, perhaps not.

MS DUNLOP: On the same day, 17 October 1983, there was a meeting of the advisory committee on the National Blood Transfusion Service in London. We have the minutes of that. That's [SGH0018446]. We can see that Dr Bell, whose name we have seen on a number of occasions, from the Scottish Home and Health Department was there. The paragraph I wanted to look at, Dr Dr Winter, is paragraph 23, which is on SGH0011849. I think there may be a typographical error in this:

"Dr Walford reported that to date, of the 24 cases of AIDS reported in the UK, two were haemophiliacs, of whom one had died. Comparison with reported incidences

in ..."

I suspect that's maybe meant to be "in the US haemophiliac population":

"... suggested that the UK could anticipate between two to four deaths amongst haemophiliacs from the disease."

Now, Dr Winter, a lot of what we have looked at is about balancing and to a large extent different judgments made by people from different clinical backgrounds, but this is a prediction which was very seriously an underestimate, was it not?

A. Spectacularly so.

Q. Yes. Do you have a figure in your head for roughly what the total is more likely to have been?

A. Of people with haemophilia in Britain who lost their lives to HIV through the use of contaminated blood?

Q. Yes.

A. I have a very good idea because I served on the Macfarlane Trust and we provided immediate funeral grants to people who died. So the figure of the 1,300 people registered with the Macfarlane Trust, about 900 have so far died. That's of HIV. Of course, some patients have died of hepatitis.

Q. Just to go back very briefly -- and then I promise I'll drop it -- to the no conclusive evidence or the no

conclusive proof line, Kenneth Clarke said that in The Commons on 14 November 1983 and I noticed, if we look first -- actually before we look at what he said, if we look at your submission to the Archer Inquiry -- that's [PEN0150283] at 0285 -- you say in that statement that:

"The Health minister, Kenneth Clarke, announced in Parliament that there is no evidence that AIDS is transmitted by blood products."

I mean, in those terms that would be a very reassuring comment. If we look at [DHF0015064], we can see on the right-hand side that what he actually said was:

"There is no conclusive evidence that Acquired Immunodeficiency Syndrome is transmitted by blood products."

Now, as you recalled it, you thought that in essence what he was saying was that there was no evidence, but he is saying there is no conclusive evidence. Do you think that people, including you, took the message to be that there wasn't really evidence of a connection?

A. Well, again, these things are occurring in Parliament, which is a relevant observation, to start with. Mr Clarke I know to be a man of the law. I doubt if he was an expert on Koch's Postulates, but technically it's

probably true. If you want to push Koch's Postulates to its ultimate, you could say: if it is caused by a virus, we don't have the virus yet so we can't demonstrate that the virus is in the blood product that was given to patient A, who got it from donor A, and therefore there is no conclusive evidence.

What, if you like, I objected to is the clear sentiment. The sentiment is saying, "We have no good evidence that AIDS is due to blood products." I mean, all haemophilia clinicians by this stage clearly believed that commercial blood products could and were transmitting AIDS. So it would have been more appropriate if the Secretary of State had said something to that effect, rather than using that form of words, with its implication that there remained doubt. Technically he was correct but I don't think he realised how fortunate he was, in terms of that, really.

Q. Yes.

THE CHAIRMAN: I'm not sure. You say he was a man of the law; I'm surprised that any lawyer should use the words, "No conclusive evidence", since we are much more accustomed to deciding things either on a balance of probabilities or on a test of beyond reasonable doubt, where every judge takes care to instruct every jury that beyond doubt does not require the exclusion of

possibilities, as on a test of mathematical certainty.

Now, my worry about "no conclusive evidence" is it tends to suggest that unless one had excluded all possibilities, there can be no proof, for otherwise why would one use the expression "conclusive" rather than a more conventional expression such as "beyond reasonable doubt"?

I take your point that, since it's in Parliament, one can't really perhaps analyse these things too closely, but it's a very worrying expression and I think that any help you can give to Ms Dunlop in understanding this is of advantage. So I, frankly, am not content that I understand it properly.

PROFESSOR JAMES: Lord Penrose, I would strongly suggest that these exact words were given to Mr Clarke by a civil servant.

THE CHAIRMAN: I'm sure about that.

PROFESSOR JAMES: My point is it is not his lawyer's words, it is what was thought at that time to be the most advisable phrase, by a civil servant from the Department of Health, to use.

THE CHAIRMAN: I trust that if I take up any expression of Ms Dunlop's, I can use the same defence when the final report comes out, but I'm not sure that I would get away with it.

MS DUNLOP: There is a little more information, sir, on how this line came to be used. Look at document [DHF0015006].

THE CHAIRMAN: Just before we go there, there's no doubt on "profesional" (sic) advice with one "S", as we see in the last sentence of the last reference.

MS DUNLOP: I didn't spot that, sir.

If we look at this, we can see again this is a selection of newspaper cuttings. The date of this is not immediately obvious but I think we can see from the top right that it is November 1983 -- the "11" and the "83" are not too difficult to make out -- and as far as dating goes, if we go to the bottom of the page, we can see that there is a handwritten date of 23/11.

But it is the exchange that's of some interest. Firstly -- sorry, we have to go back up -- we can see a cross has been put beside a quote from Dr Helena Daly and Dr Geoffrey Scott at Bristol Royal Infirmary. That's from the Lancet:

"It seems highly probable that the development of AIDS was related to this treatment."

This is the person with haemophilia who has died in Bristol:

"This case provides further evidence for a link between blood products and AIDS."

Someone has marked that with a cross. Then at the bottom it says:

"Have you seen? On X -- is it okay for me to continue to say, 'There is no conclusive proof that the disease has been transmitted by American blood products'?

"PS. Congratulations on your promotion."

And the answer is:

"Thanks. Yes, it is okay."

We have made enquiries about this, sir, and we have a letter which, for the notes, I should just refer to. It is [PEN0150484]. Just to highlight the penultimate paragraph:

"The note beginning, 'Have you seen ... ' on the document marked 2842.1 [which is the one we have just looked at] was written by an official ... The note in return, 'Thanks. Yes, it is okay.', was written by Dr Diana Walford. Dr Walford was the medical member of the secretariat to ACNBTS at this time."

I think that must stand for "Advisory Committee on the National Blood Transfusion Service", is it, Dr Winter?

A. Yes.

Q. Yes. So it does look as though there has been medical input to the formulation of the line?

A. And Dr Walford, as we have seen, had been attending some of the meetings of the reference centres, so it seems bizarre and inappropriate that she was continuing to offer that advice to the DHSS.

THE CHAIRMAN: Did we discover who wrote the original note?

MS DUNLOP: The, "Have you seen?"?

THE CHAIRMAN: Yes.

MS DUNLOP: We are only told that this was a middle-ranking official. I think I said yesterday, sir, that that's a term we have been given, "a middle-ranking official".

THE CHAIRMAN: Yes, it's a middle ranking official who seems to have perceived that he or she had the authority to make the statement.

MS DUNLOP: Yes. But has felt the need to check.

THE CHAIRMAN: Yes.

MS DUNLOP: Now, you do explain, Dr Winter, in your paper -- and this was more in connection with what Kenneth Clarke said -- that, strictly speaking, according to Koch's Postulates, the position may be defensible.

I understand that. But look at -- and this is fast forwarding -- the Sunday Times in March 1984. We will just do that now. This is [DHF0015335]. Firstly, looking at the article, it says:

"Doctors now have conclusive proof that the mysterious and generally fatal ailment known as 'AIDS'

has been passed to a hospital patient through a blood transfusion ... a feat of medical detection ... A man suffering from AIDS ... "

Has been admitted to hospital in Los Angeles and he told health officials that he had been a blood donor. His blood had been:

" ... given to two women patients ... [and] tests on the women showed the dangerous abnormality that is evidence of AIDS."

Then going on to show that one of these ladies had developed pneumonia:

"Doctors managed to save her but her outlook is grim."

This article too was noticed within the DHSS and actually what appears to have been the reverse of this photocopied cutting, [DHF0015334]. Three people have been shown this. We actually can work out who number 1 is. I think we are back to middle-ranking officials. Number 2, I think, is Dr Alison Smithies, and then there is a comment:

"We dropped, 'There is no conclusive proof that AIDS is transmitted through blood or blood products,' from our standard line some time ago."

That's 26 March 1984. I don't want to say actually definitively who wrote that, but what's interesting

about that, Dr Winter, is, if the reason for saying it before -- that's the autumn of 1983 -- was because, strictly speaking, Koch's Postulates couldn't be satisfied, had anything changed by March 1984?

A. I think that around then was the first report of the French virus. It's LAV. So I think that might have been a factor that would have changed there.

Q. Actually, the reports are slightly later than that, Dr Winter. I mean, if it's something to do with the fact that a donor has developed AIDS and patients who have received blood from that donor have gone on to develop AIDS, then that's really the situation that obtained at the end of 1982, isn't it?

A. Well, it is, as we have discussed at the start of evidence today. By that time you just couldn't have a tenable position that commercial concentrates did not transmit blood products, so these sentiments are inappropriate and you can't construct any argument or any reason why they have made them in this way, beyond what you might call matters political. A scientist and a clinician would clearly have said at the time, not just looking back, like we are today, "This statement is not true."

Q. Yes. Because time is short, I don't want to go to it, but the Haemophilia Society, in a report they published

on 9 January 1984, said that there was no reliable evidence of the connection between AIDS and blood products, which is obviously rather different from saying no conclusive evidence. Do you think that these statements, particularly statements made in Parliament, misled people?

A. I don't think statements in Parliament really had much effect on people with haemophilia or the clinicians. I think that the haemophilia community is a well defined one and the discussions that were going on at the time were amongst haemophilia clinicians working with the Haemophilia Society and then at centre level with the patients, and what a politician might or might not have said in Parliament, I don't think anybody would have taken any great notice of.

Q. Thank you.

I only have some more general and reflective questions to put to Dr Winter, sir. There are quite a few of them, though, so it might be better to stop for lunch now, if that's all right?

THE CHAIRMAN: Yes. I'm just getting concerned about how far I should go in antagonising the whole political world, Dr Winter. If I took your last answer, I might be inclined to do so but I may have to be more circumspect than that.

(12.50 pm)

(The short adjournment)

(1.50 pm)

MS DUNLOP: I should say for the record, sir, that in relation to the topic of the line which was formulated and maintained within the DHSS, we did have an exchange of letters with Dr Walford, which are [PEN0100156]. Perhaps we could just briefly look at that.

It's a request for a witness statement and then a particular reference to these documents and then the reply is [PEN0100079]:

"I can confirm that given the state of knowledge about AIDS and its causative agent at that time, this was the appropriate answer to the question as posed."

Dr Winter, I wanted to ask you about heat-treated commercial products and that, I think, for you really takes us into 1984. Before we look at the question more specifically, I want to mention in passing a letter which is [DHF0030892].

This is another circular letter. It's actually from Professor Bloom and Dr Rizza and it is to do with:

"... four commercial companies being about to introduce preparations of Factor VIII, possibly Factor IX, being processed in an attempt to reduce the risk of transmitting Hepatitis B and non-A non-B."

Just to say for the record that on reflection, the date, 11 January 1982 would really be very early for this to be accurate, that four companies are about to introduce heat-treated products. To cut a rather long and tedious story short, the team has become convinced that it is one of these January letters where someone has forgotten to change the year and it would be correct perhaps to see this as being from January 1983.

I mention that, Dr Winter, because it's probably important, given the context of this, to understand the timeframe within which heat-treated concentrates started to come through.

I intend to return to this, sir, to explain why we think that it was probably 1983 but now is not the time perhaps.

You, Dr Winter, made a decision to use heat-treated product and you narrate that in your statement to the Archer Inquiry at [PEN0150283] but at page 0285.

If we look at the bottom of that page you say:

"By early 1984 a number of commercial companies had begun to work with heat-treated concentrates based on the observation that heat treatment might theoretically inactivate viruses present in the concentrates."

You mention Alpha Therapeutics. Just at this point it may be useful for our reference to look at an article

published about ten years later, a little less than ten years later, in a journal called "Transfusion". This is [SGH0021947]. This article is interesting from a narrative point of view but also useful in that it contains, if we go through it, a number of tables. Go to 1952, which is page 427 of the article. This is where the tables begin.

We can see that there is a table of concentrates marketed by Armour and we can see a heat treated Factor VIII, given an FDA, Food and Drugs Administration, licence in January 1984. We can see on the following page concentrates marketed by Alpha, and we can see Profilate heat-treated. I guess that must have been your one, was it, Dr Winter?

A. That would be Profilate heat-treated.

Q. Yes. Then if we look at the next page, SGH0021954:

"Concentrates marketed by Hyland, a division of Baxter."

We can see Hemofil T, which was licensed in March 1983. Do you know anything about that particular preparation, Dr Winter?

A. No, I think by the start of 1984, we were aware of the commercial companies looking at heat-treating Factor VIII to try and eliminate the putative hepatitis virus, the one that proved to be Hepatitis C. None of

these concentrates were available on licence in the UK.

In early 1984, because we were already purchasing commercial supplies from Alpha Therapeutics, they approached me and my colleague at St Thomas' Hospital and at Sheffield and University College London to say that they were introducing, or they were evaluating heat-treated Profilate, the commercial name for the Alpha product, and would we be interested in using it, or evaluating it. We could get that on a named patient basis, even though it didn't have a formal product licence. We were able to use it on a named patient basis.

This was against the background, obviously, of UKHCDO at that time not making any very strong recommendations about looking to use heat-treated concentrate and, as I have set out earlier, it was against the context of many, indeed the majority, of haemophilia clinicians holding a view that NHS concentrates were very much less likely, maybe completely unlikely, to transmit this new disease, which was presumably viral in nature.

So there then followed some very difficult decisions. I would say probably the most difficult and important decision I ever had to make in my time as a consultant, and I would record that I was greatly

influenced by my colleague at St Thomas', Professor Geoffrey Savidge, who felt very strongly that it was going to be very likely that all forms of concentrate would prove to transmit the putative virus.

There were reasons for believing experimentally that heat treating might get rid of a virus and he was very strongly of the view that we ought to switch over, even though we were in a very small minority, even though the new product was 50 per cent more expensive than the old one and we didn't have any money for it.

I first used the product in May 1984. Perhaps I could just set out one or two things for you just to set the sensitivity of this time; which is yet another of these absolute landmark periods where terribly important decisions had to be made.

In April 1984, one month before I first used heat-treated Factor VIII, a four-year old boy was diagnosed as having mild haemophilia in a hospital 12 miles from mine, was given unheat-treated Factor VIII and got HIV, and I looked after him for 14 years until he died in the week of his 18th birthday.

In May 1984 the first person I treated was a man who had never had Factor VIII before, and he presented to me with haematuria, which was severe. So I gave him heat-treated Factor VIII. That was the first time in

his life he had ever been treated. One month later, at a hospital west of my hospital, he was seen in the casualty department because he had cut his hand on a glass window, he was given unheat-treated Factor VIII and he got HIV.

Before he died of AIDS, he passed on that virus to his wife. So for people with mild haemophilia and mild von Willebrand's, these were times of the greatest significance as to potentially what sort of Factor VIII you were given by the doctor.

In England, BPL did not start making heat-treated Factor VIII until April 1985 and I do not believe that the country had switched completely to heat-treated Factor VIII until July 1985. I believe I'm right in saying in Scotland heat-treated Factor VIII came in in December 1984. So this period from spring of 1984 to the summer of 1985, where the speed of transition to heat-treated Factor VIII was of very great significance for patients with mild haemophilia and mild von Willebrand's, who, for whatever reason, were considered as not being appropriate for DDAVP therapy.

I wanted at this time, if I may, to extend that to the evidence of Dr Peter Kernoff at the Royal Free because in my view his research is of quite extraordinary importance in understanding the HIV

outbreak in British haemophiliacs and trying to answer the question whether it might have been prevented or not.

Dr Kernoff, as we have heard, was the director of the centre at the Royal Free Hospital, one of the largest in Britain. He had the admirable practice of always storing blood on his patients whenever he saw them. They were having blood tests done anyway. He would store it in a deep freeze. In October 1984 we had the HTLV-III antibody test, as it was then known, introduced. Dr Kernoff identified in his centre more than 100 patients with HIV, as we now know the virus. He was then able to go back to his frozen stored blood samples and thaw them and he could try and answer the question: when did these patients get the virus?

He made two observations, which I believe are absolutely critical to our understanding of the whole epidemic. Firstly, he found that nearly all the patients were infected at some stage between 1980 and 1982. So all these discussions one can have about switching in 1984, April or July or November or right until July 1985, for most patients was not relevant because we now know through Dr Kernoff's data that actually these patients by and large had already been infected with HIV.

The second terribly important observation that Dr Kernoff made was that he couldn't find HIV in his stored blood samples from before 1979. That is a terribly important observation because you can look at the hepatitis outbreak in people with haemophilia and, as we have done, you can do the mathematics and come to a firm conclusion that actually it didn't matter whether you received commercial concentrate or NHS concentrate during the 1970s because these concentrates were derived from 20,000 or so blood donors, it was more or less inevitable that you acquired the virus now known as Hepatitis C if you had Factor VIII during the 1970s. If you had it regularly, it was an absolute certainty.

So you can conclude that, in my view, if the initiative of Lord David Owen in 1976-ish had been successful and this country had become more or less self-sufficient in blood products, it would not have made any significant difference to the outbreak of hepatitis in haemophilia patients because of the natural vulnerability of the concentrate system.

Through Dr Kernoff's data we can say that the HIV evidence is different to that in an important way because there does not seem to have been HIV in the blood supply before 1979, whether that concentrate was commercial or NHS.

So one could speculate -- and I stress this is speculation -- that if Dr David Owen's initiatives had gone forward in, say, 1977, let us just say that the UK had become completely self-sufficient by 1977/78, we would have been moving from a situation where in England at least 60 per cent of the concentrate was coming from a donor population where there was a relatively high incidence of HIV to a situation where we might have been sourcing concentrate exclusively from a local donor population, who almost certainly had a much lower incidence of HIV.

So you might consider, as a result of all that evidence produced by Dr Kernoff, that if there had been self-sufficiency towards the end of the 1970s, there might have been some reduction in the number of HIV cases that eventually occurred. It absolutely certainly would not have prevented the epidemic but it might have reduced the numbers from 1300 to a figure that was much lower than that.

So I feel of all the evidence I have given you, that's probably the most important because I'm saying to you as a doctor that my opinion is that the hepatitis outbreak in haemophilia patients could by and large not have been prevented for regularly treated patients. For mildly affected patients, that might be different. And

that for people with HIV, it might have been the case that the scale of the catastrophe could have been significantly reduced if -- and it seems that the DOH were very frustratingly very close to doing it; they even held a press conference -- a decision had been made to go ahead with Lord David Owen's initiative and to get this country self-sufficient by 1977/78, at a time when HIV was not in the blood supply.

Q. Dr Winter, this may seem a bit like stating the obvious but I think I need to ask it just to be sure that I haven't misunderstood. If we take what you have said for England at the end of the 1970s and try to apply it in Scotland, we have already seen that around 1980, taking the adult centres in Glasgow and Edinburgh, which numerically accounted for the majority of patients with haemophilia in Scotland, that both those centres in 1980 were using of the order of 90 per cent NHS material. So not quite self-sufficiency but pretty close to it.

The children's hospital in Glasgow is in a different category because there was a very high use of commercial material there and that we need to look at separately. But taking the adult centres for Edinburgh and Glasgow, does it follow that if they had not been able to use such a high proportion of NHS material, the figures for HIV infection in haemophilia in Scotland would be

higher?

A. It seems certain that the Scottish experience would have been like the English experience, where 80 per cent plus of the regularly treated patients got infected with HIV. That's the implication of the fact that happily, for Scotland, by the early 1980s, 90 per cent of the supply was NHS-based, and that was a very, very important development in Scotland; and because it did not happen in England, 1,000 people got infected with HIV.

That might have happened anyway to a lesser degree, but if you follow my reasoning, the logic is to believe that the numbers in England -- very much less so in Scotland, because of the minority use of commercial concentrate -- might have been reduced if the whole country had been completely self-sufficient.

Q. I have a number of questions from what you have told us about the use of heat-treated commercial product, and I think the first thing, which you mentioned in your answer and which you also mention on page 0286 in your statement, if we can just go to that. That's page 4 of [PEN0150283]. The paragraph that begins:

"In May 1984, therefore, I approached a small number of patients who required major surgery or suffered acute trauma, and who had had little or no Factor VIII. I offered them the choice."

You said this a moment ago, but may we therefore take it that you didn't shift all your patients on to heat-treated commercial product?

A. At that time in May -- and this is a reflection of how concerned we were -- I could only get hold of a very small supply and I targeted those patients who I was especially concerned about, which would be the patient I told you about, who had never been treated before, and people who needed surgery which was urgent, who only had mild haemophilia and hadn't been heavily pre-treated.

By July 1984, two months later, I was able to get sufficient supplies to completely switch all of my patients, not only to Factor VIII but Factor IX, and that was on 1 July 1984. The St Thomas' centre and my centre in Kent, from that moment we only exclusively used heat-treated concentrate.

I should say another controversy in relation to this was that there was some sort of theoretical consideration that the heat treatment might alter the nature of the Factor VIII molecule. About 20 per cent of people with haemophilia get inhibitors, antibodies, against the Factor VIII and there was a significant concern expressed by those clinicians who didn't agree with us, that they had real reservations about using heat treated because they were very concerned that the

heat treatment process would alter the antigenic nature of the Factor VIII molecule and that these patients would then develop an inhibitor, which was clinically a very significant adverse development.

So that was one of the major reasons why the other doctors of the time said to us, "We really don't know why you are doing what you are doing". They too, if you like, were following the Tarzanoid philosophy. They didn't believe that British Factor VIII was likely to be a significant problem or may be a problem at all, and they didn't want to use heat treatment in any case because it wasn't licensed, it might alter the molecule, and also because it was 50 per cent more expensive.

So these were the dynamics around this argument at that time in the summer of 1984, for each haemophilia clinician: should they switch to heat treated, unlicensed, more expensive, and American, and then try and sell it to the patients? Or should they stay on British, free, volunteer donor? That was the major, major dynamic at that time. And again a very, very difficult time for haemophilia doctors and patients.

Q. That change that you made in July 1984, where only heat-treated Factor VIII and Factor IX was used in your centre, that was actually too late for a number of patients in the centre, wasn't it?

A. Well, it was, because from Dr Kernoff's data -- I did not have stored blood samples. I started there at the end of 1983, but most of the regularly treated patients, one assumes, had already been HIV positive for three or four years, particularly as nearly all the concentrate in my centre was commercial in origin.

Q. Yes. Another point that you have made, I think, in your written statement, on one view, what you did was actually contrary to what Professor Bloom had said in the letter of 24 June 1983 about heat-treated commercial product. Perhaps we should just have a look at that. That's [SGH0022175].

If I may say, Dr Winter, I'm not referring you to this as a criticism. I think perhaps it reflects exactly the sorts of dilemma that you are describing, but if we look towards the end of the letter:

"The proposed trials of hepatitis-reduced Factor VIII concentrates ... no evidence the processes inactivate any other hypothetical viruses."

Then on to the next page, please:

"It is still important that the effectiveness of ... these products is subjected to formal clinical trials in mild haemophiliacs ... directors are urged not to use these concentrates randomly on a named patient basis."

Is there a bit of a conflict between your decision

in May and what had been said in that letter?

A. Very much so. The actions we took in May were firstly contrary to the extant policy of UKHCDO, which was that clinicians should go on using unheat-treated concentrate, with the reservations about the use of commercial for mildly affected patients and children, and maximising DDAVP usage, but also as related to the recommendation in Professor Bloom's letter.

One of the problems that was subsequently faced in evaluating heat-treated concentrates follows from our discussions that it was more or less inevitable that if you had received Factor VIII you would have hepatitis. So you couldn't use the new heat-treated Factor VIII to work out whether it was safe or not because nearly all the patients were already infected. So that meant -- which was a particularly unhappy situation -- that the only subgroups of patients you could use to evaluate the new type of Factor VIII -- and this is still the situation today -- were people who had never had it before, who, by definition, were children or mildly affected patients having surgery. There weren't many of either of that category around. So we felt that we couldn't wait. It would be two years before you could get enough patients to do a trial giving them heat-treated Factor VIII to see whether it was safe or

not, and we just didn't feel that they could wait that long.

But that, as I say, was a particular issue, and remains so to a degree. Even today new genetically engineered Factor VIIIs, they are evaluated on what are called PUPs -- previously untreated patients -- and they are very often children or now, in this day and age, they are patients in developing countries who may never have been treated before.

Q. Yes. Another point that should be made -- and this is partly why we were looking at the tables earlier in the article. I asked you about Hemofil T, the Baxter-Hyland Travenol product, which had its FDA licence in March 1983. So one might look at that and think, gosh, from March 1983 there was something out there but can we look at a letter of Dr Walford's. It is [DHF0025668].

Simply to record, Dr Winter, that there do appear to have been problems with that early heat-treated product:

"Three chimpanzees which received the Hyland heat-treated Factor VIII developed hepatitis."

Just to ask you -- and I think I have to remind you about the microphone, I'm sorry, because I'm not sure we are getting all your answers through the microphone -- do you think that put people off the heat-treated

concentrates in 1983, that news came through that they still transmitted hepatitis?

A. My personal view is that it did not particularly deflect clinicians. I think there was a view that data obtained from primates was not necessarily transferable, and later on the heat-treated concentrates that had been completely safe when given to primates did actually, on some occasions, transmit hepatitis and HIV to people with haemophilia.

So I think we learned that you shouldn't pay too much attention to data derived from monkey and chimpanzee studies. They weren't necessarily extractable to the patients. I mean, Travenol may have been licensed by the FDA in 1983 but it certainly wasn't available in the UK. None of these products had a product licence, and to my knowledge the Alpha product was the first one that was made available on a named patient basis.

Q. I see.

THE CHAIRMAN: Doctor, I think I picked up that there did emerge evidence that the failure to transmit infection to primates was not a reliable equation for the risk to humans, but this is talking about actual transmission of hepatitis. Is that not in rather a different position?

A. This is the other way round, isn't it?

THE CHAIRMAN: Yes.
A. Yes.
THE CHAIRMAN: It could hardly be transmitted unless it was there and carried in the product.
A. Yes, so the early heat-treated products, in retrospect they didn't heat for long enough and to a high enough temperature. So they were pretty soon changed after the patient outbreaks on heat-treated Factor VIII to a higher temperature for a longer time. These early concentrates would have been at 60 degrees centigrade for 30 hours.
THE CHAIRMAN: So Dr Walford's letter on this occasion could have been a warning to the profession generally that there was a risk?
A. It could have been but my recollection is that those who were opposed to heat treatment were not using this so much as their major evidence; it was rather the fact that firstly they didn't think it was necessary. Here was a choice between heat-treated American Factor VIII, unheat-treated British, they preferred the latter, and secondly they were worried about the inhibitor theory. Those were the two main arguments.
THE CHAIRMAN: Thank you.
MS DUNLOP: Of course, you know that in Scotland, in Edinburgh, there was a very significant episode of

infection of individuals from NHS product, and I wanted to ask you to look at a letter, which is [SNF0013211]. This is a letter from Dr Ludlam to Miss Spooner at Oxford Haemophilia Centre. It's actually about the subject we have been discussing, Dr Winter, which is trials of the commercial treated concentrates, and what Dr Ludlam says is:

"Most of our patients have been treated exclusively with SNBTS F8. I'm therefore very reluctant to consider using any of our patients as trial subjects for any of the commercial hepatitis-reduced Factor VIII concentrates. As you probably know, we have been testing a new higher purity heat-treated SNBTS Factor VIII concentrate and at present I should like to reserve any patients we may have for this product."

Was that a reasonable line to take?

A. Well, there would be two reasons for wanting to consider using the heat-treated product. The first one would be to try and reduce hepatitis and the second reason would be to reduce the putative new virus that was the cause of AIDS.

If you had a population of the type that Professor Ludlam did, where most of the concentrate was of local voluntary donor origin, you might not necessarily have been that much concerned about the new

disease, if you held the majority view. But it would still have been -- you know, the introduction of hepatitis-reduced Factor VIII, heat-treated Factor VIII, would still be considered by clinicians to be very important if you believed, as clinicians did, that it was inevitable that if you gave somebody unheat-treated Factor VIII, you gave them hepatitis, which was widely accepted at this time.

So the important sentiment is that doctors should have been looking by then to use or consider heat-treated Factor VIII, whether that was of commercial origin or of local Scottish origin obviously relates to the local situation, and a clinician would understandably have preferred the local product because of the donor origin.

Q. So is that a yes in answer to the question if it was reasonable?

A. Yes, it was reasonable.

Q. Right. Can we just go back to Dr Craske for a moment? To a letter which is [PEN0150250]?

You refer to this letter in your original Archer statement at 0288. Just for the record. But if we could keep the letter -- actually there are two letters, because there was one in October -- relating to what appeared to be contamination of English product, and

then this is the letter of 30 November 1984 going to Dr Ludlam. This is to do with the infection in Edinburgh but the terms of the letters are very similar.

If we can turn to the second page, and this is Dr Craske setting out what he says are some of the facts, is there anything in particular -- and actually you have commented on this letter also in your supplementary statement on 0300, but without going to that, you say in your supplementary statement that there are a number of comments subsequently shown to be untrue in this letter. I just wondered what in particular would you highlight?

A. Well, in section 3 he says that you can see:

"It is likely that a significant proportion of patients will remain in good health."

Which proved not to be true, particularly, obviously. And then that last paragraph:

"It is likely that the proportion of patients who contract HTLV-III infection who develop AIDS will be of the order of 1 in 100 to 1 in 500."

I don't know on what basis he made that judgment, but of course that too proved to be very inaccurate.

Q. Yes. Right. Dr Winter, I want to ask you one or two general reflections in conclusion. Sorry, actually there are more than one or two but the first is about

the relevance in this story, the story in particular of the use of commercial products, of financial contributions by drug companies.

It may be that there is evidence that that occurred to a greater extent in England than it did in Scotland. The Inquiry has investigated this as far as it can and really all that we have discovered is support given to conferences and seminars and gatherings and so on by drug companies. So there might be a symposium, say, which was sponsored by a particular drug company.

Against the background then that the support seems to have been of that sort of level, what effect, if any, do you think that had on decision-making?

A. I don't think it had any significant effect on decision-making. I assume you are commenting on purchasing of concentrate.

Q. Yes.

A. Yes, because that process would have been done in conjunction with the hospital's supply department. It would not have been done independently by a haemophilia doctor because there were a number of regulatory processes that had to be followed, even in those days. But the relationships between the haemophilia centres and the companies was a close one and sort of symbiotic, I guess, in that here was the haemophilia community in

the middle of this evolving crisis.

It proved extremely difficult to get extra resources from the NHS to respond to the crisis. It was a time of great clinical difficulty. You could approach a company, for instance. You might choose to approach a company and say, "I have a new nurse and I would like her to go on a course about AIDS so she can learn all about it". You wouldn't have been able to get funding from the NHS for that.

There were a number of activities that we have discussed, for instance, like producing patient information sheets. We spoke about the filo-factor, where we wanted much better, accurate information about the use of concentrates in the home setting. There was no way that that would ever have been funded by the National Health Service. That was funded by a commercial company, who contracted another company to make the custom-designed filo-factors as they were.

I think on occasions some of the major centres may have had a kick-start funding for, shall we say, a post for a counsellor perhaps. One of the ways of getting a permanent post on the NHS is to find funding yourself for the first couple of years, get somebody into that post and then you say to the NHS, how would you like to make this temporary post more permanent because the

person is very good and we could do with their services longer at the moment.

So I think there were some of the major centres that may have had some priming help for various posts from the companies, particularly in relation to HIV and counselling services or getting extra nursing support. That was the way the sort of level of support went. It was done to that degree. It was probably done variably by various of the commercial companies. In return, the haemophilia centres would have done teaching and training for the companies, provided advice for them about the way forward in terms of manufacture. So it was quite a two-way process.

Q. We have also seen, Dr Winter, that over the period we have looked at, which is really, I suppose, the summer of 1982 onwards, particularly into 1984, there really doesn't seem to have been much difference between the sort of line about the use of concentrates that was taken by the Haemophilia Society and the line that was taken by UKHCDO. Is that a reasonable summary of the position?

A. I think that's true. I mean, because the Haemophilia Society had their own medical advisory panel who consisted of haemophilia directors.

Q. There is a bit of overlap apart from anything else?

A. Yes.

Q. Yes. I just wanted, though, to get your comments on something that Douglas Starr says. If we look at pages 293 to 294, which is [LIT0012936] at 2963, the context of this is that an incident is being related where somebody in Austin, Texas died of AIDS. He was named in the newspaper. The local plasma centre manager checked her records and found that they had purchased plasma from him 48 times in the previous year. Cutter Laboratories were involved and they recalled whatever they could.

Then he says:

"Meanwhile the NHF, the National Haemophilia Foundation ..."

I think it is, which would be roughly equivalent to the Haemophilia Society, would it?

A. That's correct, yes.

Q. Yes:

"... continued to assure the nation's 20,000 haemophiliacs that clotting factors were basically safe."

He goes on to refer to the mother organisation, which, I suppose is the NHF, the pharmaceutical firms. If we were crossing the Atlantic and thinking of the United Kingdom, we might add in the UKHCDO and the

Government, and he says:

"It seemed no one was telling haemophiliacs the truth."

Would that reflect the position in Britain?

A. Well, we have been discussing this, haven't we?

Q. Yes.

A. Firstly, nobody knew what absolute truth was. We didn't have a virus identified at that time as the cause of the new disease. There were a whole range of questions that we didn't know the answers to. I do think that the Haemophilia Society statements that we have been looking at have not been worded in a way that was necessarily as accurate as they might have been. I think by the time those pamphlets were written, there was good evidence that AIDS could be transmitted by commercial concentrates and there was every reason for there to be concern.

Obviously, though, you have to put that in the context of the time at which the pamphlets were written and the Society saying to the medical advisory panel, "WE really hope you can come up with some documents which will reassure our patients because we are getting a number of worried people in contact with us". So that would have been the context in which this information was passed on.

The only alternative way in which it could have been done, which maybe would be the way it would be done now, would be a doctor would have written, "There appears to be a new disease in America, which is affecting people with haemophilia. It looks as if you can get it from commercial concentrate. There is no test for it. If you get the disease, it looks like it will kill you." That would not have been a very reassuring message to the patients, but I accept it probably would have been nearer to the truth.

Q. Yes. Just briefly, I wanted to look at what happened in -- it is really three other countries. The first is Australia. I have a couple of articles there. The first is [LIT0010548]. It is entitled "Hepatitis and haemophilia therapy in Australia". It was published in the Lancet on 17 July 1982. What's interesting in the summary is the statement that:

"Commercial blood products are not used in Australia. The patients were treated with products of blood from unpaid donors, screened for Hepatitis B surface antigen."

Then in the introduction there is reference to:

"The treatment of haemophiliacs with blood products is associated with a high frequency of post-transfusion hepatitis."

The article goes on to look at the incidence of non-A non-B hepatitis in that study, and we can see in the next page, page 147 on the left-hand side, there were 66 episodes of presumed non-A non-B hepatitis during the study, giving an overall incidence of 27.2 per cent.

Then under the discussion:

"This study has confirmed several previous observations on the frequency of liver function abnormalities in patients receiving treatment for haemophilia and related disorders. The major treatment agent during the study period was cryoprecipitate."

Then they say that:

"The findings emphasise the greater risk of liver disease for patients with severe haemophilia."

And they say in the middle of the following paragraph:

"The relatively high frequency of liver abnormalities in our patients is disturbing since all plasma for Factor VIII preparation is obtained from voluntary, unpaid and Hepatitis B surface antigen-screened donors."

Then just on the last page, comments that are not surprising given all that we have looked at. On the left-hand side:

"At present Australia uses much less Factor VIII than is used in major centres in the UK, the USA and West Germany ... lower usage due primarily to Australia's policy of attempted self-sufficiency."

Then they give the use as a percentage of what's used in Germany, the USA and the UK. You see that the import of commercial products was actually prohibited. That raises the question: well, what happened as far as HIV was concerned? And if we look at the second article, which is [PEN0120255], this is an article from the Australia and New Zealand Journal of Medicine in 1987. Just to go straight to it, this is from the abstract:

"The prevalence of HTLV-III antibodies in 1985 was 40 per cent. The highest frequency being in those with severe haemophilia A, 78 per cent, and the lowest in patients with haemophilia B."

I don't want to take up a lot of time with this. We can read it for ourselves, Dr Winter, but in short Australia ended up with a significant HIV problem in people with haemophilia, despite actually having banned the import of commercial concentrates. I think you referred to that in your evidence to the Archer Inquiry?

A. I did. I mean, the study is of interest in that regard really, because it is underscoring the point that the

safety of your voluntary donor panels relates to the type of voluntary donors that they are. I think it is accepted and set out in Starr's book that one of the gay groups of the 1960s and 1970s did have altruistic activities as part of their communion, as it were, and one of these was to go and give blood on a regular basis.

So our understanding of this data was that a significant number of gay Australian donors were donating blood and that that, if you like, skewed the incidence to a much higher degree than you might have expected, and certainly higher than other countries where they had voluntary donation systems.

Q. Another country to look at by way of comparison is Belgium. Look at Douglas Starr, page 346. Which is [LIT0013015] at 3016. There is actually a very interesting table published in a Council of Europe publication, which gives rates for many European countries, but I am afraid I have not managed to print it out. I think you have to buy the book.

But we can see here that Belgium is referred to and it's the same figure as is in the Council of Europe's table. Belgium, which used many cryoprecipitates from local donations, suffered a rate of only 7 per cent.

So for whatever reason, Belgium seems never to have

switched wholesale to concentrates from cryoprecipitate. I don't know if you know anything about Belgium, Dr Winter. I don't want to take up time on this but it has obviously been a different course that has been followed there.

A. I think that's correct. The Dutch have their own national blood product plant, the Belgians do not and they didn't have much local concentrate; they didn't use much concentrate, they used cryoprecipitate. They didn't get much HIV but they did get patients with significant arthritis and bleeding as a result. I have met Belgian clinicians who said that was the outcome of that decision.

Q. Another country which is nearly at the bottom of the Council of Europe's table is Finland. We do have a statement from Professor Leikola on what happened in Finland. It is [PEN0131396]. If we look at that, we can see, just in passing, that Professor Leikola was involved in the activities of the Council of Europe in May and June 1983. He was one of the drafters of recommendation R(83)8. If we look to the next page he sets out how haemophilia A patients were treated with cryoprecipitate and then coagulation factor concentrate:

"... is further processed from cryoprecipitate."

But he says in paragraph 9 that:

"Finland continued to use cryoprecipitate between 1980 and 1984 simply because there was no domestic concentrate available."

Then paragraph 10:

"Because of the known, since 1983, risk of AIDS from American commercial Factor VIII concentrates, the Finnish haemophiliacs were persuaded not to use imported products, should they be introduced to the Finnish market. Commercial preparations did not come to the Finnish market in the 1980s."

Then finally in 16, 17 and 18, which are on the next page, he narrates the number of cases in Finland, which is extremely small.

A. Can I make the point that section 16 -- it's a very important point, isn't it, they have cases from cryoprecipitate. All the discussions we were having earlier about would a switch to cryoprecipitate have been a good idea, you can still get virus infections from the cryoprecipitate, even though the donor pool you are being exposed to might only be 20 to 40 rather than 20,000, it does not mean to say you will not get a virus infection when you treated with a cryoprecipitate.

Q. Yes. Just finally, Dr Winter, you have been sent a series of articles written as recently as 2007 by Dr Evatt and Dr Aledort. Well, Dr Evatt's is an article

and Dr Aledort's is a response. Perhaps we could have them up. The fist is [PEN0150265]. It is entitled "The tragic history of AIDS in the haemophilia population, 1982 to 1984". Had you seen this article before we sent it?

A. I had previously seen this article. You will see it was published by the World Federation of Haemophilia.

Q. Yes. It's really a narrative, isn't it, of the key period?

A. Well, it is but it is a very helpful one because it really, in his reflections, mirror the evidence I have been given of the variability of view held by various haemophilia clinicians at the time, the reluctance of haemophilia clinicians to accept the evolving data, the confusion as to what to do next.

Q. Yes. He mentions Dr Ratnoff, he mentions the transfusion in the infant in December 1982, the events of 4 January 1983, which he describes as possibly the most discouraging and frustrating day of the epidemic for CDC. That's on 2298. Perhaps we can go forward to that. That will be, I think, page 4. So page 267. Well, I'm not sure if I have --

A. I actually think there is a page missing here. I noted that in the documents you sent to me because 267 does not seem to go on to 268. The bottom of 267 is the

middle of a sentence.

Q. I don't know quite what has happened. The hard copy which I have, since I like to have these things in my hand as well as on the screen, does go from page 2297 in the article to page 2298, but it may be that for some reason that's not in there, but anyway it's not essential.

It provoked a response, I expect you had seen the response as well, have you?

A. I have seen the response.

Q. Yes. [PEN0120179].

A. I mean, you will note that MASAC didn't recommend a switch to heat treatment until October 1984, which, given all the evidence we have heard and seeing the number of cases in America at that time, really does seem quite a late recommendation.

Q. I think we can see, Dr Winter, that Dr Aledort didn't like Dr Evatt's article. Do you think that Dr Evatt's article is a "self-serving, inaccurate paper"?

A. I'm firmly on the side of Dr Evatt, who was a heroic figure and had no particular points to prove, and I think Dr Evatt's record is very helpful for just, as I say, really affirming what we knew: that a number of very distinguished and leading figures on the National Haemophilia Foundation and the American treating

organisations held the view that the new disease wasn't going to be important for people with haemophilia. I recall a very distinguished American physician saying that he didn't think AIDS would ever be a problem for people with haemophilia. So I think that the tension that's apparent in the reply reflects all the previous events that's happened to MASAC in those important years.

THE CHAIRMAN: I think that's what occurred to me, that Dr Aledort really had been a leader of the opposition as it were to Dr Evatt's initial forays into this field.

A. Dr Aledort in particular had stood up at a meeting in 1983 and said clearly that AIDS could not be caught from commercial concentrates and wouldn't be a significant problem for people with haemophilia.

MS DUNLOP: Then on the following page Dr Evatt's response to Dr Aledort:

"He graciously accepted Dr Aledort's expression of his personal thoughts on Dr Evatt's article."

And he made some selected points he picked up and responded to, and then at the end a general comment:

"The AIDS epidemic will not be the last human plague. Group dynamics observed during this epidemic replicate how experts faced with little or incomplete scientific data often adhere to existing paradigms

rather than embrace new unproven ideas to make critical decisions."

Dr Winter, my colleague Mr Gardiner is going to ask you one or two questions about individual doctor/patient interactions. I don't know, sir, whether it would be appropriate to have a short break at the moment and then we might have more stamina to continue a little bit longer.

THE CHAIRMAN: I don't know who is losing stamina, Ms Dunlop.

MS DUNLOP: Probably only me.

THE CHAIRMAN: The other question you might like to consider if we do have a break is whether Mr Di Rollo and others might respond to what you have done so far and leave Mr Gardiner's contribution to follow that. I don't know. I don't know what's going to happen. But if that would suit people better, it might help.

MS DUNLOP: So long as we can keep this a short break.

THE CHAIRMAN: Yes, let's try to do that.

(2.59 pm)

(Short break)

(3.10 pm)

MR GARDINER: It has been decided that Mr Di Rollo will now ask some questions and them come back to me, if that suits, sir.

Questions by MR DI ROLLO

MR DI ROLLO: Dr Winter, I just wanted to ask you one or two questions.

Just one issue in relation to epidemiological matters. In relation to Hepatitis C, I think we have understood that the position was that if a patient received concentrate, then it was the position that they would inevitably contract Hepatitis C virus. This is between 1975 and 1980 or in the late 70s. When we get to HIV, the position appears to be -- or an understanding that we may have is that the more factor concentrate or commercial factor concentrate you get, the more likely it is that you are going to get HIV. I realise that's a rather simplistic way of putting it but is that a correct understanding?

A. Yes, that is broadly correct. The incidence of HIV in the commercial donor community was clearly significantly higher than that in donor communities which were local and voluntary. As of course is the case with hepatitis, but the particular difference between the two was that hepatitis appears to have been around for a long time in the blood supply, whereas HIV didn't really appear to have been there before 1979. That's the crucial difference between the two viral outbreaks in haemophilia patients. Not so much the difference

between the commercial and the voluntary donors but the fact that the HIV appears to be a relatively new virus in the blood supply at that time.

Q. But in relation to HIV, you don't necessarily get it if you get factor concentrate, even commercial factor concentrate. But the more often you get commercial factor concentrate, then the more likely it is that you are to contract HIV?

A. That would apply obviously to any infectious agent. The more you had of it -- I mean, another factor would be that the incidence of Hepatitis C in American blood donors at the time we know to be about 1 per cent, shall we say. We have seen evidence that maybe the incidence in voluntary donors was 10 to 20 to 50 times less than that. But we did the mathematics, if you remember, so if you were having concentrate from 20,000 donors, one in 100 of them have Hep C, you are going to get Hep C but even if you are from a voluntary donor panel with 1 in 1,000, shall we say, there is still a jolly good chance you are going to get Hepatitis C. So with Hepatitis C it seemed to be inevitable that during the 1970s you would get it if you had commercial Factor VIII.

The incidence of HIV would have been a lot less than that. It would be difficult to put a figure on it but

it would certainly, in commercial blood -- it certainly wouldn't have been more than 1 in 1,000, perhaps a lot less than that, I don't know. So that's the difference between the likelihood of getting HIV and hepatitis. There wasn't as much HIV around in the blood supply in terms of donor incidence as there was hepatitis at that time.

Q. Right. Can I just turn to a matter in relation to information and knowledge in 1983? It really relates to material that we have already seen but I just wanted to go back, first of all, to the Council of Europe document at R(83)8, [DHF0022149].

One of the comments that was made this morning, I think, in passing, as we went through this document, was in connection with how this might be implemented nationally. If we look over the page on the second page of the document, so that would be 2150, we see that the ministers say that:

"... take all necessary steps and measures with respect to Acquired Immunodeficiency Syndrome and in particular to avoid, wherever possibly, the use of coagulation factor products prepared from large plasma pools. This is especially important for those countries where self-sufficiency in the production of such products has not yet been achieved."

You made a comment, I think, this morning, that that's all very well but if there is no option but to carry on, then you have to carry on. I think that's essentially what you were saying?

A. I was saying that the recommendation not to use coagulation factor concentrates derived from large plasma pools is the same as saying you shouldn't use coagulation factor concentrates, because that's the only concentrates that there were. They all came from large plasma pools.

My understanding from the manufacturers is you need about 20,000 donors because the Factor VIII circulates in the blood in such tiny amounts, only in 1 millionth of a gramme. So that's why so very many blood donors are needed to make a meaningful batch and why there had been no treatment of haemophilia for 2,000 years.

Q. Obviously it's to avoid wherever possible the use of these and I'll come back to that in a moment, but what I want to ask you that you didn't comment on this morning was the next matter, which is:

"... to inform attending physicians and selected recipients, such as haemophiliacs, of the potential health hazards of haemotherapy and the possibilities of minimising these risks."

That particular requirement or recommendation, if

you like, does contrast, does it not, what in fact haemophiliacs were being told about the hazards or potential hazards at this time, when we look at the document which was distributed by the Haemophilia Society, said to be on the advice of Professor Bloom. Is that reasonable?

A. Yes, I have already said today that nobody actually saw these Council of Europe recommendations in the haemophilia world. They were not circulated to UKHCDO to my recollection, or to haemophilia centres. I have already given evidence that I do not think that the statements that were made to patients in the Haemophilia Society leaflets were as accurate as they should have been. The actual advice that was given, given the very difficult choices available for haemophilia doctors, and all the potential dangers already outlined about moving back to cryoprecipitate, was a very balanced decision: haemophilia patients had always faced risk, the concentrates had huge advantages, it would have been dangerous to not use them while more information was being garnered. I don't see any particular problem with that advice.

I would agree, however, that the quality of the information actually given to the patients was not what it might have been but, as we have discussed, that may

just have been because of the culture of the day; they did not want to concern patients about what was potentially, and indeed proved to be, a grave situation.

Q. It does appear -- and nobody could argue with this, I don't think -- that the patients wanted the product because, as we have seen in the programme and you have explained in your evidence, there was a very clear desire to continue with the treatment. That's undoubtedly what you have told us, isn't it?

A. The Society actually wrote to the DOH, asking him not to ban the impart of commercial concentrates.

Q. But the Society obviously is entirely dependent upon medical advice in relation to obviously medical matters. It is dependent upon the doctors to tell the Society as to what the medical advice should be, is that not fair?

A. By and large, yes. I mean, patients do have strong views, quite rightly, and did so in those days. But, yes, I mean, that was the point of having a medical advisory panel of the Society so that the Society could form a formal view about medical matters.

Q. You have told us this morning that by at least March 1983, you said:

"I think by that stage, all haemophilia clinicians were signed up to the infectious theory because of the evidence of the San Francisco child. There was no other

construction you could put on that evidence."

So I think that that's what you indicated, that by March of 1983 it was clear to the doctors that the blood-borne route of the AIDS infection had been established, that was what their understanding was. Is that what you are telling us?

A. That's the evidence I gave, yes.

Q. So it does appear that if one was to rely on what was being said apparently by Professor Bloom -- and we had better have the document up, [DHF0014474]. The preamble to it is:

"In view of the unduly alarmist reports on AIDS, which appeared in the press over the weekend, we are writing to reassure members of the Society about the true position. We have been in touch with Professor Arthur Bloom, chairman of the haemophilia centre director, a senior member of our own medical advisory panel and a member of the Central Blood Laboratories Authority, who has kindly written to us all as follows."

Obviously it is not clear as to when he provided this information, but if it is being represented as being the position as at May 1983, it is clearly misleading in terms of the understanding of the doctors at that time, isn't it?

A. Well, we did discuss this, surely, in great detail earlier in the day, and I did point out to you firstly, I couldn't account for the way in which another doctor wrote to people 25 years ago, and I did very clearly give evidence that I don't think his comments are appropriate because by then the dangers of commercial concentrates were known. But I'm not quite sure how you would have expected the letter to have been written given the brief by the Haemophilia Society of:

"Our patients are very worried about this new disease. Please will you write something that will reassure them."

It might have been better if Professor Bloom had said to them, "Actually, we are really worried about this situation because we think that this new disease may well be transmitted by commercial concentrates". So I don't think a short article of this type is appropriate at the moment. What would be much better and more helpful for patients is a detailed list of advice and recommendation once we have a very much clearer view of this situation.

But, you know, as a doctor and a colleague of Professor Bloom, I fully accept that the information in that short article is incorrect.

Q. Well, I'm not asking you to criticise him. All I'm

asking you to do it to agree with the proposition that what is contained there is misleading, and that is correct, isn't it?

A. It is.

THE CHAIRMAN: Dr Winter, did any patient bring you this letter, having regard to the invitation at the end, to seek further advice from your own centre director?

A. I don't recall, sir. Of course, I was not a consultant at the time that this letter was written but I don't remember any of my local patients at Guy's talking about this letter. Of course, only a percentage of patients with haemophilia belonged to the Haemophilia Society. So this letter only would have gone out to, you know, maybe half the haemophilia people in Britain.

THE CHAIRMAN: And another question is: do you remember seeing the document at the time it was issued?

A. No, I don't.

THE CHAIRMAN: Yes. Sorry, Mr Di Rollo, I'm just trying it find out whether it made an immediate impact.

MR DI ROLLO: Yes, thank you.

A. And I'm assuming that Professor Bloom was acting in his capacity as chairman, and certainly the contents of the letter would not have been discussed with other haemophilia clinicians. This would have been an article he was asked to write by the Haemophilia Society as

chairman.

MR DI ROLLO: It is obviously readily understandable that patients would have absolute faith in their doctors. One of the reasons for that would be the very significant achievement in protecting them from the disease of haemophilia in the golden period that you referred to. They would understandably have absolute faith in the haemophilia doctor. Is that not right?

A. Well, the relationship between haemophilia patients and their doctors is understandably a really close one because here is a disorder that you are born with, your earliest memories are of going to hospital with a pain in your knee and seeing somebody like me who would stick a needle in it and make it better.

So, yes, people with haemophilia do have very, very close relationships with their doctors, that impacted in a way -- maybe we will talk about this in a few minutes -- it impacted on the way in which people were told of their HIV status and responded to that.

But, yes, relationships have always been close and a patient -- as often was said to me -- I would say to a patient, "We have options A, B or C for your treatment", and the patient would look rather bemused and say to me, "You have looked after me all my life. I don't expect to make the decisions myself. I expect

you to, as my doctor. Give me the best advice and give me the best treatment."

So obviously there is a close relationship and, of course, yes, patients are very reliant on their doctors for the best of advice and one accepts this was not the best of advice.

Q. I'm suggesting to you, and obviously we have heard the evidence, that this is what the patients did want to hear for understandable reasons?

A. I think that's very important. That was the remit of the whole thing, wasn't it, the article? The Society clearly are saying, "People are worried; they want to keep on with the treatment. We, the Society, want to keep on with the treatment. Let's commission a haemophilia doctor to write an article about how the treatment is still okay."

Q. But ultimately, tempting though it is to tell somebody what they want to hear, the duty of the doctor is obviously to try and give them an accurate understanding rather than an inaccurate one.

A. I just think it is helpful to understand that's the background of the whole article, and it was probably also the background from which Professor Bloom was coming. He was trying to be reassuring but of course, he has ended up by not stating scientific truth.

Q. Can I just move on then. I appreciate we have been over some of this ground a bit before. One of the things that you have described in quite significant detail is the hard choice that one would have to make if the only option with a severe haemophiliac was, as you have explained, either you take commercial concentrate or you don't treat them at all. And you say that cryoprecipitate in reality wasn't an option for reasons which you explain, there isn't really much of a choice there. You really have to go with the commercial concentrate. I think that's what you were telling us this morning. Am I right about that?

A. Very much so, particularly coloured by the experience of the previous 20 to 30 years of people dying from cerebral bleeding and the major quality of life that the concentrates afforded.

Q. If you did have a choice -- and I'm putting a hypothetical situation -- between treatment with commercial concentrate or treatment with NHS concentrate, which, in your view, is the appropriate choice to make?

A. And we are talking about the late 1970s or something like that?

Q. We are talking about 1983?

A. We are talking about 1983. Well, by choice, if the

choice is between NHS and commercial concentrate, I don't think you would find a haemophilia clinician who would choose commercial concentrate. The UKHCDO were unanimously signed up to approaching the DOH to encourage self-sufficiency. There are ways, of course, in which you can moderate the treatment, both as a doctor and a patient. If you were really concerned about concentrate safety, you might not use so much of it, you might postpone surgery. A patient who had two days of treatment for a bleed, you might not give Day 3 on the basis that you thought things had settled. You might reduce the dose of treatment you were giving on each occasion. You might not implement prophylaxis programmes, which were going by the early 1980s.

So there were ways of cutting down the amount of concentrate that was being used, although that wasn't of course what the patients wanted. The patients were enjoying the fantastic improvement in quality of life that the concentrates afforded. They didn't want any change. They wanted to be reassured by their doctors that all was well and they could go on using it, but all was not well.

Q. If they had had an informed choice they may well perhaps have accepted some of the modifications that you have indicated.

A. I mean, in 1983, if you had stopped using concentrate, if you were a patient and said, "I'm so worried about this situation. I'm not going to use any more concentrate, I will go to hospital for cryoprecipitate when I really have a big problem," you effectively would be saying, "I'm going to go back 50 years in my treatment. I'm going back into the times where daily I'm at risk of serious internal haemorrhage." That's the danger of that decision.

Remember, haemophilia runs in families. So haemophilia patients would say, "Yes, my uncle died of a bleed into his brain when he was 22". And that, for years and years and years, was what everybody dreaded, and that was what the concentrate was protecting you against. So even knowing what we know now, you know, if I had been a haemophilia patient in 1983, I don't think I would have chosen not to have any concentrate. I might have looked at the way I was giving it to myself and reduced it to the absolute minimum.

Q. It's that modification I was referring to. You might reduce it to a minimum, you might defer treatment, operations, you might not go with the prophylactic treatment?

A. I accept your point, which is, I think, that if the patients had had fuller information, starker

information, they might have modified the use of Factor VIII in the home setting. That is fully accepted.

Q. That would perhaps at least have reduced the possibility in certain cases of contracting the HIV virus?

A. It might have reduced it to a degree but it's hard to quantify.

Q. All right, thank you.

THE CHAIRMAN: Mr Anderson?

MR ANDERSON: I have no questions, thank you, sir.

THE CHAIRMAN: Mr Sheldon?

MR SHELDON: I have no question, thank you, sir.

THE CHAIRMAN: Thank you very much.

Questions by MR GARDINER

MR GARDINER: Dr Winter, I would like to ask you some questions in connection with information that was given to patients about the risks of treatment.

I want to ask you about testing for HIV and also I want to ask you about the information that was given to patients about infection after they had been diagnosed. We have touched on that a little bit but I want to expand a little bit in that area. We have been calling this the B5 topic. We have chopped up the topics. So this is the B5 topic.

Could I look, first of all, at your submission to

the Archer Inquiry, which is [PEN0150283]. Which is at page 9. That's page 9 of your submission. Just in the middle of the third paragraph, right at the very end you say:

"In looking back at this time, it is unreasonable to apply the standards of today to the early 1980s. Things were very different then, in particular medicine was more paternalistic."

I wonder if you could explain what you meant by medicine being more paternalistic in the 1980s, and could you explain how that affected clinical practice?

A. Well, firstly let's talk about diagnosis. Nowadays it goes without saying, it is standard that you always tell the patient a diagnosis. At that time that was by no means a standard practice. The standard chain of events you were trained as a doctor to do was, if you had a patient with a serious illness, such as cancer or leukaemia -- I being a leukaemia doctor -- the first course of action was to go and talk to the relatives. You would say, "I'm sorry to say that your husband, father, has acute leukaemia and it is a very serious disorder and it may end their lives. Do you think he would want to know? What's your advice? We are very happy to tell him but we have come to you first for your view." And sometimes the relative, next of kin, would

say, "I really don't want you to tell him". Sometimes they would say, "Yes, of course, he must be told".

So that was really standard practice, as I say, particularly for any serious disorder. That was the way medicine was at that moment, together, of course, with a culture, which in my view, and as set out in my Archer submission, was completely changed by AIDS, the epidemic in general.

There was no culture of doctors and nurses working with patients. If you were a patient, you were a passive vehicle with the illness, you went into hospital, where an active vehicle, the doctor or the nurse, made you better. It was not expected of you as a patient that you would have a view about your treatment. So you would be told your treatment but you wouldn't be offered choices about it. You would be told you have an illness, here is the treatment, and you will get better.

That culture, I think, was particularly the case in haemophilia. I generalise obviously, but you can imagine, as a haemophilia patient you are brought up all your life and every time you have a problem you go to the same centre and you see the same doctor and the same nurse to try and make it better. From your earliest memories. So that, I think, did breed a culture of

passivity when the HIV epidemic broke. And remember, by this time I was an HIV physician. I had 100 gay patients. The gay patients were completely the other end of the spectrum. They wanted to know every single thing about their illness. They wanted to be involved in every single decision about their treatment, all quite rightly. And I have always felt that it was this new disease, affecting, as it did, such a very articulate and intelligent group of people; they were the ones that in my view changed the nature of medical practice because it started to get doctors and patients working together as a relationship for the first time, and it meant that the doctor for the first time was really an adviser. He was not somebody who came through the door in a striped suit and a patrician air and said, "We have got this treatment for you which will make you better". That was changed into the role of doctor as an adviser, quite rightly, who fully informed the patient of everything, good and bad. Then set out various choices and let the patient decide which of those treatment choices was appropriate. That, in my view, was all new because of AIDS.

As I say, when one did that to the haemophilia patients, you were sometimes met with bemusement. "Why are you asking me? You are the doctor. You get on with

it." There was a very striking contrast between these two groups of patients.

Q. Thank you.

Just to move on to advising patients of the risks, I think it is clear to all of us from the World in Action documentary that haemophilia patients were aware of the risk of hepatitis from fairly early on. Are you clear that in about 1983 your patients were aware of the risk of contracting the new virus, if it was a virus, from continuing to use concentrates?

A. Remember, I started December 1983. So that's when I first come on board as a consultant. You know, my first week, I'm straight into the crisis because of all the data that's there, and within a few weeks I'm discussing with Professor Savage at St Thomas' about the offer from Alpha of heat-treated.

So really, within a couple of months of taking up my post as a consultant, I would have been talking to patients about the possibility of using heat-treated Factor VIII and what did they think about it.

Q. So you never had the occasion to discuss with your patients the possibility of simply giving up factor therapy completely?

A. I would have done that when I was a senior registrar at Guy's, all the things we have been talking about today.

And my recollection is that it nearly always went along the lines of one which we have said really, that there was this data which was rather worrying and was being followed and, you know, we were trying to find out more as quickly as we could, but in the meantime, exactly as Dr Kernoff's statement that we have seen earlier today, it was perceived that the advantages outweighed the disadvantages and the medical advice was to carry on with the treatment.

Q. But that's a choice that you gave to your patients, is that --

A. I gave them the choice, yes. Most of the patients I looked after do as I said, which I'm rather sad about because, you know -- but that was the way of the time, you know. Patients didn't say to their doctors, "Actually, thank you for offering this treatment, I'm not going to agree with you, I'm going to do something quite different". That was a very, very unusual thing to happen. Within a couple of years of AIDS becoming identified, it became very commonplace.

Q. Yes, thank you. You have told us about switching to the heat-treated product in May 1984, and if we could have a look at your paper to our Inquiry, which is page 8 of [PEN0150292], at paragraph 1.19. We discussed this:

"Heat-treated concentrate, commercial in nature, was

first used in my centre in May 1984 ... especially critical time ... patients were being asked to switch from concentrate of UK origin to US original."

You say:

"Considerable time had to be spent with each patient and their family to explain the basis of this recommendation."

Could you just describe in a bit more detail what your discussions with patients would have consisted of about that decision?

A. These discussions were not easy or straightforward against a background of the patients quite rightly preferring concentrate of UK donor origin to concentrate of US origin. For their doctor to then sit down with them and say, "I'm going to recommend to you that we use Factor VIII of American rather than British origin" was naturally of great concern to them first of all.

So it was by no means an easy interview but it would have been along the following lines really, that I would have said to them, "There is increasing evidence that the new disease of AIDS ..." which they have heard of "... can be transmitted through the use of Factor VIII". That this is a matter of increasing concern, and that we now have access to a new type of Factor VIII, which is heat-treated, which in theoretical reasons, but not

practical ones, because it had never been done, could be considered to get rid of any viruses. That this new Factor VIII wasn't licensed and that it was from American blood donors, but that essentially the choice was between having the current, licensed commercial concentrate or the current licensed NHS concentrate, which, remember, we had very little of anyway. And I would have said to them, "We have pretty good evidence that that's going to give you hepatitis anyway, if you haven't got it already, and it might well give you this new disease because it seems to be giving other patients like you the same disease when they have it." So that's choice number one.

"Or we could give you this second new treatment, which is heat-treated, yes. It's from American blood donors but it is designed to knock out hepatitis viruses and maybe this new virus as well, if it is a new virus." Which it was. "You have to have the Factor VIII because you are just about to have your stomach removed. If we don't give you Factor VIII, you will die of bleeding. So here we are in this pretty stark situation where, if you use the current concentrate that's available, it seems certain you are going to get hepatitis. If you haven't got it already, you might get the new virus. If you use the new heated concentrate, whilst we can't be sure, you

might not."

That was really the base for this very difficult conversation. For what it's worth, the patients agreed to have the heat-treated and then we had the switch in July 1984, and none of the patients asked to switch back.

Q. Would you be able to give an estimate of how long an interview like that could take?

A. Half an hour, usually with the family as well.

Q. Thank you.

Just to move on to the question of testing now, and if we could go to your submission to the Archer Inquiry at 0287, which is page 5. It is the second paragraph and what you say is:

"In the summer of 1984 HIV was isolated for the first time and by August of that year a blood test (then known as the HTLV-III antibody) had become available in the UK in the laboratory of Dr Richard Tedder at University College Hospital. UKHCDO arranged for all samples from patients with haemophilia, who might have been exposed to HIV, to be forwarded for testing to Dr Tedder's laboratory."

Just reading that short, if we go down a paragraph and pick it up:

"In our centre we informed patients that a blood

test was now available and that their blood was being sent to UCH for testing. In some other centres they saw the availability of the new test as merely an extension of their pre-existing screening programme and did not perceive any need to inform patients."

So could you just elaborate on how this was done: informing the patients about the blood test and so on?

A. So the practice was firstly, if I can just take you back from the start of what we call comprehensive care, when concentrates were introduced in, say, 1973. Very soon after that doctors were aware that some patients had hepatitis like pictures. So a standard part of care that was done every few months, the patient would come in, have a clinical review and then they would have blood tests to see what their blood factor level was; did they have an antibody against their Factor VIII? And have their liver function test, and routinely a test for all known viruses.

So it was absolutely routine to test for viruses in haemophilia centres on regularly treated patients and it was perceived as being a core part of care, and because it was a core part, there was no need to talk to patients about it.

In October 1984 Dr Tedder at university college in London had developed the test or had access to the test.

I knew him because it was the hospital I had been in. He made an arrangement with UKHCDO to test all haemophilia patients in the country. Some centres would have had stored blood samples. So they would have had a letter from Dr Tedder or Professor Bloom saying there is this arrangement in place, you can send your blood sample to say, this doctor in London and they will do this new test.

So some centres may have said, "That's good, we already have the patient samples in the deep freeze". So they would have probably just gone off to the deep freeze and thawed them and sent them because they would have thought this is just yet another virus test. The test is now available, we don't need to tell the patient because we haven't got to bleed them. We haven't got to tell the patient because we don't tell the patient anyway about blood tests.

So that would have been some centres. If you had to call for the patient to have blood taken, as I did, that was different because the patient would come in and say, "Why have you called for me?" So if you like, in other centres because they had had to summon the patients, inevitably they would be saying, "I know you were only here a month ago for your review but we have asked you to come back because we have now got access to this new

blood test and this is what it's all about".

Q. And that's what happened in your centre?

A. That's what happened in my centre.

Q. Is that because --

A. Because I did not have any stored blood.

Q. Thank you.

If we could have a look at page 5 of your submissions to Archer, which is 0287. The second last paragraph on that same page. You say:

"In 1984 there was, of course, no concept of pre-test counselling. This concept only emerged years later as a result of the HIV epidemic and the impact that a positive test had on a patient's lifestyle including the possibility of not obtaining life insurance and mortgages."

Could you perhaps explain to us what pre-test counselling consists of?

A. So the way in which the AIDS test changed the whole practice of taking blood tests from patients was as follows. It became apparent a few months after the AIDS test became available that if you had this test performed and the result was negative, an insurance company or mortgage adviser might subsequently want to either decline your proposal or increase the premium on the basis, presumably, of, "We think you might have been

something of a risky individual to have wanted that test done in the first place".

Never before in medical practice had there been a blood test where just by having it changed your prospects for things like insurance and mortgages. Whatever the result was. So for the first time in medicine, I think, it became necessary to talk to patients who had come in and say -- these are all patients -- remember, I'm an HIV physician.

A patient would come in and say, "I split up with my boyfriend six months ago and I'm in a new relationship and I would like to have this test done". To reassure them you would say to them, "Before you do that, there are things we need to discuss. If you have this test done, even if it is negative, you might find it more difficult to get life insurance. If you have this test done, even if it is negative, you might find it more difficult to get a mortgage."

So you talked the patient through really what the consequence was of a negative result and what the consequence was of a positive result. And that was a completely new concept, now standard; and that was what pre-test counselling became.

Q. Thank you.

When, to your recollection, did that start, that

concept.

A. I would say mid 1985 onwards. So the haemophilia patients would have been bled in the autumn of 1984.

Q. So am I right in thinking that this concept of pre-test counselling is really something that comes from this particular disease?

A. That is my opinion.

Q. Can I just backtrack slightly, Dr Winter, and ask you a hypothetical question about testing blood at that time. If you had had stored blood samples, would you have sent them to be tested by Dr Tedder without asking your patient's permission first?

A. I may well have done, the point I'm trying to make is there was no special stigma about having a blood test done and there had never been any impetus for doctors to tell patients that they were having a certain blood test done. And that was because the act of having the test had not actually affected the patient. I mean, I probably would have done, yes, but I wouldn't have done mid-1985.

Q. No. Thank you.

Moving on to the question of diagnosis, the results of tests, and reading the last paragraph on page 5 of your submission to the Archer Inquiry, here you say:

"In November 1984 I received the results of the 30

or so patient samples that I had sent to Dr Tedder's laboratory. These showed that in all but one case the patients were positive for the new virus. 18 of these patients were children."

Then you have put here what did the phrase "HTLV-III antibody" mean, and so on. Could you explain to us how you interpreted these results when you got them back at that time?

A. So this is a test not for the virus but for the antibody that the immune system makes against the virus. So for sure you could say that the patient had been exposed to the virus. With the proviso, which made life difficult for us, that there was some possibility, it was considered, of getting false positive results.

Some doctors were rather reluctant to tell their patients in the first instance because they said, "How do I know the result is accurate?" They might have waited for two results. Anyway, be that as it may, if the result was accurate, it meant the patient had been exposed to the new virus.

The next difficulty was what did that mean, because in many medical disorders, if you have antibody against a bacterium or a virus, you are immune to it. On the other hand we knew by then that AIDS patients had HTLV-III antibody. So we had to assume that the

antibody was not protecting them. So our assumption -- and it was an assumption -- was that although they had the antibody, it didn't mean they were immune. This meant they had the virus, which was proved to be true.

Q. And how did you interpret that in terms of a prognosis for the patient at that time?

A. Well, you couldn't know what the prognosis was going to be. We have already seen the wildly inaccurate estimates of figures of survival today and progression to AIDS today. So all you could do was sit down with the patient and say, "You have heard about this new disease, AIDS. We have now, as you know, the patient, because I have told you, tested your blood. These tests show that you have been exposed to this virus. Only a very small number of people with haemophilia in the world so far have AIDS. So we are going to monitor you and follow you extremely closely and look out for any signs of problems. There is a great deal of research going on which will help us to understand this disorder better."

At that stage, I think, early on, as we have seen, the recommendations were talking about the possibility of sexual transmission. We would have had the families in as well. Probably a bit later on we would have started talking about hygiene around the house and

sharing razor blades and toothbrushes and things like that.

In the first instance, this interview, which you will understand was a difficult one -- 18 of these people were children -- we would have kept it pretty short and then followed it up two or three weeks later with another such interview, just to reinforce the points.

This was at a time of very great stigma. We had people who lost their jobs, people who had their doors painted in red paint, "You have got AIDS", school kids who were on the bus, they chanted, "You have got AIDS," a dry cleaner's wouldn't press trousers because the patient had haemophilia. So this was not a disorder you could talk about with anybody else. Some of our patients never told their families, outside of the immediate family. They may actually have died of AIDS without their family knowing.

So this was a very, very stigmatic illness. This was a very shocking interview for the patients and a very distressing one. The news was potentially very bad, we couldn't give them very clear information, there was the possibility of sexual transmission, and it was the new disease that was all over the papers: could you get it from mosquitoes, bed bugs, commune chalices,

et cetera. So it was a very harrowing and difficult time for them.

Q. I think on page 6 of your submissions to the Archer Inquiry you explain that you told each of the patients that they had tested positive for the new virus. When did you do that? When did you --

A. To my recollection, Professor Tedder's results took about a month, so this would have been from November 1984 onward.

Q. Yes. So how much time elapsed between you receiving the results and you passing --

A. I think I got going straight away over a period of a few weeks.

Q. Thank you. Just to backtrack slightly to the question of how to interpret the result of the test, how much guidance were you getting from other specialists at this time? I think we have seen Dr Craske's letter, where he made the prediction that 1 in 100 to 1 in 500 would contract AIDS. Was there any more advice than that?

A. I have made the point previously there was no standard virological body giving standardised advice, as happens at the moment with variant CJD, for instance. So that was a major problem. We were haemophilia doctors, we were not virologists. We knew nothing about sexual transmission. We had never spoken about sexual activity

with our patients. This was completely new territory.

Dr Craske in his letters to us, which is in your preliminary report, says something like:

"Ideally, I think the patient should be told but it depends on whether they are requesting information."

So that's more interesting for what he is not saying. He is not saying it is very important that everybody should be told, firstly because it's important medical information and, secondly, because of the risk of sexual transmission. He is not saying that, and he is the virologist giving us advice.

That is why the practices I have described in my centre were followed exactly by some other centres and very, very differently by some other centres. Some centres did not tell patients for some time. One centre in England sent the results out by post. You got a letter saying, "You seem to have this new virus. If you are worried about it, please go and discuss it with your general practitioner."

So there was great variability of practice, much of it inappropriate, as to how the patients were told their HIV status.

Q. Are you able to give us an estimate, Dr Winter, of what the prevailing approach was to informing patients about the results of their tests?

A. It is very hard. I don't think there were centres where patients weren't told but it was done in a very variable way, an unstandardised way. It might have been done by a doctor or a nurse, it might or might not have included sexual advice and they weren't following any standardised recommendations, which would have been extremely helpful.

Q. Sir, I think I should just record in passing that the letter from Dr Craske that Dr Winter is referring to is in the database at [SNF0014020]. We don't need to look at it at the moment, but just for the record, as they say.

I think you just mentioned again there, Dr Winter, that most haemophilia centre directors had not been clinically trained and you mentioned that about Professor Bloom as well. Did that make a difference, in your opinion, to the way information was passed to patients about these things?

A. Some of my colleagues were rather dismissive about my remarks to the Archer Inquiry about this, but actually I do feel it is relevant. There was a sea change in the training of haematology doctors in 1976 because from that moment onward, if you wanted to be a consultant in haematology, you had to have the membership of the Royal College of Physicians examination, which you took

two to three years after you qualified. It was no longer possible for you to become a consultant haematologist without doing clinical medicine after you qualified. So that led to a new generation of haemophilia doctors, of which I was one.

We had spent three years, after we qualified, dealing with cancer and leukaemia patients. We had been trained about bad news, we had been used to sitting down with people whose lives were ending and telling them that. We had been used to following those patients on a daily basis until they died.

For the older doctors, they had never done any of that. They had no training about bad news, they weren't clinically trained about telling people bad news, they weren't used to looking after very sick people, and I do think that made a difference when I hear about those centres that didn't communicate very well with their patients. I do have a view that they were run by the elder generation of doctors, who were very brilliant academically, very clever in the laboratory, but they were not clinically trained and it showed at time when patients needed very sensitive disclosure and advice about this potentially devastating illness.

Q. And I suppose those doctors wouldn't be used to dealing with sexual matters with patients?

A. Absolutely not.

Q. Dr Winter, I have nearly finished. I have just got one question for you. Could I ask you to look at your paper for us, the Penrose Inquiry, at page 0301. This is the last page. We have touched on this already but this is your answer to a question. The question you were asked was when, in your view, the balance shifted from the paternalistic approach that you have told us about to the more modern, patient-centred approach, and at paragraph 1.24 you say:

"As set out in my Archer submission, the onset of the AIDS epidemic changed for ever the nature of medical practice in this country. Never before had there been a situation in clinical medicine in which the performance of a blood test -- even if the result of that test was negative -- could have profound lifestyle consequences ..."

You also talk about the fact that AIDS was very likely to be fatal, the treatment choices complex, and so on. Is there anything else that you would like to tell the Inquiry about that whole topic that's in that paragraph there, 1.24?

A. No. I think, on behalf of my colleagues, I'm sure we would say as an organisation that in retrospect the way in which some patients were told of their HIV status was

not handled as well as it might have been, even given the standards of those days. I think we do make a case and can explain why patients weren't told that the test was being performed, and I'm sure very few people were probably told that the test was being performed. But as for the actual telling of the news, which one accepts was a very difficult process, I think that our organisation would accept that it didn't always happen in a way that was as good as it might have been, even though it was done with the best of intentions. And the lack of training, the lack of standardised virological advice and the lack of information. We didn't know what the phrase meant. Professor Ian Weller in London, who was the major AIDS treater at the time, in the Simon Garfield book, "AIDS, the End of Innocence," he is saying the same thing. They are the major AIDS treatment centre. They didn't know really what to say to people who had HIV antibody, in terms of the obvious questions the patients would then ask: What does it mean? Am I going to get ill? Am I going to die? When will I die? We didn't know.

Q. Thank you very much, Dr Winter.

I have no further questions, sir.

Further questions by MR DI ROLLO

MR DI ROLLO: Just one very quick matter. Just for

clarification, you didn't keep blood samples of patients, you had to get their consent and you had to take a blood sample, in order for it to be tested. Other centres did keep blood samples of the patients. Can you explain why there was a diversity of practice there?

A. I had taken over the directorship of a centre from another doctor whose practice it had not been to store blood samples. Again there was nothing mandatory about that; it just seemed like a good idea. You were in a field of medical practice where patients were getting viruses from their treatment, we knew that from 1974, so how could you be sure that more viruses might not appear in the blood? If you look at Dr Kernoff's data, HIV had been around in the blood supply for three or four years without anybody realising it, so wouldn't it be a good idea to store blood from the patient on the basis that maybe they have already got a virus that you don't yet know about and that would be very useful in three to four years' time, when the virus became identified. You could then test for how long it had been present.

So, although it was not a formal recommendation, a lot of haemophilia doctors did have the practice of storing blood in a deep freeze. You were taking blood from the patients anyway for liver function tests. You

could just walk into the laboratory and say, "Could you put that into the deep freeze? I might need it at some stage."

Q. Do you know when that practice actually started?

A. No, I suspect around the time when concentrates were introduced. I was a registrar in the Middlesex Hospital in 1976 under Professor Jimmy Stewart. One of the first things he ever said to me was, "It's a very good idea to store patients' blood." It was something he did, and he was doing that in 1976.

Q. Thank you.

THE CHAIRMAN: Mr Anderson?

MR ANDERSON: Thank you, sir, I have no questions.

THE CHAIRMAN: Mr Sheldon.

MR SHELDON: No questions, sir, thank you.

THE CHAIRMAN: Dr Winter, as you will appreciate, I have got a long way to go and the assessment of your evidence will have to take into account evidence from all sorts of other people before the end, but I think I can say and speak for everyone in saying thank you very much for a very clear account you have given of your evidence in this matter and for all the help you have given the Inquiry. Thank you very much indeed.

A. Okay.

THE CHAIRMAN: Are we going at that point or do you have

other business and we can allow Dr Winter to go?

MR GARDINER: I think it is time to go, sir.

THE CHAIRMAN: Time to go.

(4.12 pm)

(The Inquiry adjourned until 9.30 am the following day)